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

Baptist University College of Osteopathic Medicine

Policy Year: 2025–2026
Policy Number: 246793
www.aetnastudenthealth.com
(877) 626-2308

Disclosure: These rates and benefits are pending approval by the Tennessee Department of Commerce & Insurance and can change. If they change, we will update this information.

This is a brief description of the Student Health Plan. The plan is available for Baptist University College of Osteopathic Medicine 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://www.aetnastudenthealth.com**. If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

Who is eligible?

All students at Baptist Health Sciences University College of Osteopathic Medicine (BUCOM) are required to enroll in the BUCOM plan or waive the student plan on a hard waiver basis. You must actively attend classes for at least the first 31 days after the date your coverage becomes effective. Enrollment and the insurance charge can be waived if proof of other health insurance is provided by submitting an online waiver with insurance coverage that meets all requirements set forth by BUCOM.

Coverage Dates and Rates

Coverage for all insured students will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated.

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

	Annual 07/01/2025-06/30/2026	Fall 07/01/2025-12/31/2025	Spring 01/01/2026-06/30/2026
Student	$3,816.00	$1,908.00	$1,908.00
Enrollment waivers must be submitted by: 06/30/2025			

Rates

The above rates reflect the total charge for students who enroll in the medical plan, including optional programs purchased by the school.

Medicare Eligibility Notice

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

Termination and Refunds

Withdrawal from Classes – Leave of Absence

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

Withdrawal from classes – other than leave of absence

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

If you withdraw from classes more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which premium payment has been received. 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. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to https://www.aetnastudenthealth.com.

Precertification 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:

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

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

We will provide a written notification to you and your physician of the precertification decision, where required by state law and within the timeframe as 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.

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 Tennessee Insurance Law(s).

Policy year deductibles	In-network coverage	Out-of-network coverage
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$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* • In-network care for *Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist, includes telemedicine consultations)* • In-network care for *Walk-in clinic (non-emergency visit)* • In-network care for *Urgent medical care provided by an urgent care provider* • In-network care for *Pediatric dental care Type A services* • In-network care for *Mental Health & Substance related disorders treatment - Outpatient office visits (includes telemedicine consultations)* • In-network care for *Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)* • In-network care for *Hearing exams* • In-network care for *Pediatric vision care* • In-network care and out-of-network care for *Well newborn nursery care in a hospital or birthing center* • In-network care and out-of-network care for *Outpatient prescription drugs*		

Maximum out-of-pocket limits	In-network coverage	Out-of-network coverage
Student	$7,150 per policy year	Unlimited

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care and wellness		
Routine physical exam performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Routine physical exam limits for covered persons through age 21: Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/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	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care and wellness (continued)		
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	60% (of the recognized charge) per visit
Preventive care immunization maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel		
Well woman routine gynecological exams (including Pap smears)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Well woman routine gynecological exam maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Maximum visits per policy year	1 visit	
Preventive screening and counseling services In figuring the maximum visits, each session of up to 60 minutes is equal to one visit		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
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	

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		
Routine cancer screenings performed at a physician's office, specialist's office, or facility	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Routine cancer screening Maximum	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Lung cancer screening maximum	1 screening every 12 months	
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		
Prenatal care - preventive care services only	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Important note: You should review the *Maternity care and Well newborn nursery care* sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation counseling services - facility or office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item

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		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item
Female voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	60% (of the recognized charge)
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a provider		
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	60% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Allergy injections treatment performed at a physician's or specialist office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Allergy sera and extracts administered via injection at a physician's or specialist's office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Physician and specialist surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	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 (non-emergency visit)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (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.*		
Hospital and other facility care		
Inpatient hospital (room and board and other miscellaneous services and supplies) Includes birthing center facility charges	$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission	60% (of the recognized charge) per admission
The following are not eligible health services: • All services and supplies provided in: - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps		
Preadmission testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	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 care - Inpatient facility (room and board and other miscellaneous services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospice care - Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Funeral arrangements • Pastoral counseling • Respite care • 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	$200 copayment then the plan pays 80% (of the balance 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		
Emergency room	$150 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
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 and coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this 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 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 emergency room copayment 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 will be waived and your inpatient copayment will apply. • Covered benefits that are applied to the emergency room copayment cannot be applied to any other copayment under the plan. Likewise, a copayment that applies to other covered benefits under the plan cannot be applied to the emergency room copayment**.** • Separate copayment amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These copayment amounts may be different from the emergency room copayment. They are based on the specific service given to you. • Services given to you in the emergency room that are not part of the emergency room benefit may be subject to copayment amounts that are different from the emergency room copayment amounts.		
Non-emergency care in an emergency room	Not covered	Not covered
The following are not covered under this benefit: • Non-emergency services in a hospital emergency room or an independent freestanding emergency department		
Urgent medical care provided by an urgent care provider	$30 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Non-urgent use of urgent care provider	Not covered	Not covered
The following is not covered under this benefit: • Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)		

Eligible health services	In-network coverage	Out-of-network coverage
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	70% (of the negotiated charge) per visit	50% (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 services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Pediatric dental care exclusions

The following are not covered under this benefit:

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

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Eligible health services	In-network coverage	Out-of-network coverage
Pediatric dental care exclusions (continued) The following are not covered under this benefit: • 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
Family planning services – other		
Voluntary sterilization for males - Inpatient physician or specialist surgical 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
Voluntary sterilization for males - Outpatient physician or specialist surgical 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
Abortion - Inpatient physician or specialist surgical services (to the extent the pregnancy is the result of rape or incest, if it places the woman's life in serious danger or if pregnancy complications result in a non-viable fetus)	80% (of the negotiated charge)	60% (of the negotiated charge)
Abortion - Outpatient physician or specialist surgical services (to the extent the pregnancy is the result of rape or incest, if it places the woman's life in serious danger or if pregnancy complications result in a non-viable fetus)	80% (of the negotiated charge)	60% (of the negotiated charge)
The following are not covered under this benefit: • Reversal of voluntary sterilization procedures, including related follow-up care • Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care		
TMJ and 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		
Impacted wisdom teeth	80% (of the negotiated charge)	60% (of the negotiated charge)

Eligible health services	In-network coverage	Out-of-network coverage
Specific conditions (continued)		
Accidental injury to sound natural teeth	80% (of the negotiated charge)	60% (of the negotiated 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		
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		
Maternity care		
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
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
Note: *If applicable, the per admission copayment and/or policy year deductible amounts for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.*		
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 & testing. Includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage	Out-of-network coverage
Mental Health & Substance related disorders treatment		
Inpatient hospital (room &board and other miscellaneous hospital services and supplies)	$200 copayment then the plan pays 80% (of the balance 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	60% (of the recognized charge) per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Obesity surgery - inpatient and outpatient facility and physician 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
The following are not eligible health services: • Weight management treatment. • Drugs intended to decrease or increase body weight, control weight, or treat obesity except as described in the certificate. • Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes: - 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.		
Reconstructive surgery and supplies (includes reconstructive breast surgery)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Eligible health services	**In-network coverage** (IOE facility)	**Out-of-network coverage** (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Transplant services		
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received	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	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	

Eligible health services	In-network coverage	Out-of-network coverage
Transplant services (continued)		
Maximum payable for Lodging Expenses per companion	$50 per night	
The following are not covered under this benefit: • Services and supplies furnished to a donor when the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness		
Infertility services		
Treatment of basic infertility 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
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. • 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. • 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

Eligible health services	In-network coverage	Out-of-network coverage
Specific therapies and tests (continued)		
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received	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		
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
Transfusion or kidney dialysis of blood	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	Unlimited	
Chiropractic services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Diagnostic testing for learning disabilities	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
Other services		
Emergency ground, air, and water ambulance	$150 copayment then the plan pays 100% (of the balance of the negotiated charge) per trip	Paid the same as in-network coverage
The following are not eligible health services: • Ambulance services for routine transportation to receive outpatient or inpatient services		
Clinical trial - Experimental or investigational therapies	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
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 eligible health services: • Services and supplies related to data collection and record-keeping needed only for the clinical trial • Services and supplies provided by the trial sponsor for free • The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)]		

Eligible health services	In-network coverage	Out-of-network coverage
Other services (continued)		
Durable medical 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		
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, except as described above		
Prosthetic Devices & Orthotics Devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Cochlear implants	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	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids maximum per ear	One hearing aid per ear every policy year	
The following are not covered under this benefit: • A replacement of: - A hearing aid that is lost, stolen, or broken - A hearing aid installed within the prior 12-month period • Replacement parts or repairs for a hearing aid • Batteries or cords • 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
Other services (continued)		
Hearing exams	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (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		
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		
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 (includes comprehensive low vision evaluations)	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit	

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 vision care services & supplies - Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	60% (of the recognized charge) per item
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	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	
The following are not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		
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.		
Outpatient prescription drugs		
Copayment/coinsurance waiver for risk reducing breast cancer drugs		
The outpatient prescription drug copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs filled at a retail in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
Copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs		
The outpatient prescription drug copayment/coinsurance will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your outpatient prescription drug copayment/coinsurance will apply after those two regimens per policy year have been exhausted.		

Outpatient prescription drugs (continued)		
Copayment/coinsurance waiver for contraceptives		
The outpatient prescription drug copayment/coinsurance 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/coinsurance 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 100% (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	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
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 100% (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	$120 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered

Eligible health services	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 100% (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	$180 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
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 100% (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	$180 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Diabetic supplies, drugs, and insulin		
For each fill up to a 30-day supply filled at a retail pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
More than a 30-day supply but less than a 91-day supply filled at a 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
Diabetic insulin important note: Your cost share will not exceed $25 per 30-day supply of a covered preferred prescription insulin drug filled at an in-network pharmacy. No policy year deductible applies for preferred insulin.		
Anti-cancer drugs taken by mouth For each fill up to a 30-day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	100% (of the recognized charge) No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Preventive care drugs and supplements filled at a retail pharmacy For each 30–day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Preventive care drugs and supplements maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30–day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	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.	

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Contraceptives (birth control) Brand-name prescription drugs and devices are covered at 100% at an in-network pharmacy when a generic is not available		
For each fill up to 12-month 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 to12-month 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 provider prescribes a covered brand-name prescription drug when a generic prescription drug equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost share for the brand-name drug. If a provider does not specify DAW and you request a covered brand-name prescription drug, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug. The cost difference related to a prescription not specified as DAW does not apply toward your policy year deductible or maximum out-of-pocket limit.		

Outpatient prescription drug exclusions

The following are not eligible health services:

- Abortion drugs used for elective termination of pregnancy except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products, and appliances unless listed as an eligible health service
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance, or increase sexual desire, including drugs, implants, devices, or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as an eligible health service

(continued on next page)

Outpatient prescription drug exclusions (continued)

The following are not eligible health services:

- Drugs or medications:
  - That are indicated or 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, non-prescription appetite suppressants or other medications except as described in the certificate
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service, or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as an eligible health service
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
- Infertility:
  - Prescription drugs used primarily for the treatment of infertility
- Injectables including:
  - Any charges for the administration or injection of prescription drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Prescription drugs indicated for the purpose of weight loss.
- 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 when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

Abortion drugs

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

Acupuncture

- Acupuncture
- Acupressure

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:
  - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work, or recreational activities
  - Transportation

Blood and blood products

- Blood, blood products, and related services that are supplied to your provider free of charge

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, except where described in the *Eligible health services and exclusions* 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 or changing containers and clamping tubing
- Watching or protecting you
- Respite care, adult or child day care, or convalescent care
- Institutional care, including room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and substance related disorder treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function
    - Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults
- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolectomy
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth
  - Prosthetic restoration of dental implants
  - Dental implants except when part of an approved treatment plan for an eligible health service described in the *Eligible health services and exclusions – Reconstructive surgery and supplies* section.

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

Educational services
Examples of these are:
- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations
Any health or dental examinations needed:
- Because a third party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, sporting event, or to join in a sport or other recreational activity.

Experimental, investigational, or unproven
- Experimental, investigational, or unproven drugs, devices, treatments, or procedures unless otherwise covered under clinical trials

Gene-based, cellular, and other innovative therapies

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

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 therapeutic 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.

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.

Medical supplies – outpatient disposable
- Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

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 charges that Medicare or another party is responsible for as the primary payer

Outpatient prescription or non-prescription drugs and medicines
- Specialty prescription drugs except as stated in the *Eligible health services and exclusions* section

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

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

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

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.

Sexual dysfunction and enhancement
- Any treatment, prescription drug, 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 of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance
- Services, devices, and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance, or physical performance

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

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 for physical therapy treatment
- Sensory or hearing and sound 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, unless 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* in this section

Work related illness or injuries

- Coverage available to you under workers' compensation or a similar program under local, state, or federal law for any illness or injury related to employment or self-employment

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

The Baptist University College of Osteopathic Medicine Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna 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 1-877-626-2308.

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.

Discrimination is Against the Law

Aetna Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). Aetna Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aetna Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 1-877-480-4161 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332
Woonsocket, RI 02895
Phone: 1-800-648-7817, TTY: 711
Email: **CRCoordinator@aetna.com**

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.
This notice is available at Aetna Inc.'s website: **https://www.aetnastudenthealth.com**

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 **1-877-626-2308** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-626-2308** (TTY: **711**).

አማርኛ**/Amharic**

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-877-626-2308** (መስማት ለተሳናቸው: **711**).

العربية**/Arabic**

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-626-2308** (رقم الهاتف النصي: **711**).

Bàsɔ̀ɔ̀ Wùɖù/Bassa

Dè dɛ nìà kɛ dyeɖeˈ gbo: ɔ juˇ keˈ m̀ dyi Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ juˇ nïˇ, nìïˇ à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpaˈa. Ɓaˈ **1-877-626-2308** (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 **1-877-626-2308** (TTY: **711**)。

فارسی**/Farsi**

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-877-626-2308** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d’une assistance gratuite dans votre langue en composant le **1-877-626-2308** (TTY: **711**).

ગુજરાતી**/Gujarati**

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે. કૉલ કરો **1-877-626-2308** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-626-2308** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-877-626-2308** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-877-626-2308** (TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-877-626-2308** (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 **1-877-626-2308** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-626-2308** (TTY: **711**).

Urdu/اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (**1-877-626-2308** (TTY: **711**) پر کال کریں.

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-877-626-2308** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-877-626-2308** (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).