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

Rocky Vista University

Policy Year: 2024–2025
Policy Number: 474910
https://www.aetnastudenthealth.com
(888) 978-8355

This is a brief description of the Student Health Plan. The Plan is available for Rocky Vista 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://www.aetnastudenthealth.com.** If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

Rocky Vista Health Center – Englewood Campus

The Rocky Vista Health Center is the University's on-campus health facility. It is a one-stop destination that can take care of most your medical and healthcare needs. They offer a wide range of services, including internal medicine, Primary care, sports medicine, and osteopathic manipulation with their staff of 52 residents and three Internal Medicine board certified physicians. They also offer all vaccinations, including TB titers, flu, Hep B, and COVID. It is open weekdays from 8:00 a.m. to 5:00 p.m. during the Fall and Spring semesters.

For more information, call the RVHC at **(720) 875-2880** or visit **www.rockyvistahc.com**. In the event of an emergency, call 911 or the Campus Security at **(720) 875-2892**.

Rocky Vista Health Center – Ivins Campus

The Rocky Vista Health Center - Ivins Campus offers a variety of services including primary care, pediatrics, women's health services, and telemedicine appointments.

For more information, call the RVHC at **(435) 233-9500** or visit **www.rockyvistahcinvins.com**. In the event of an emergency, call 911 or the Campus Security at **(435) 222-1300**.

Coverage Periods

Students: Coverage for all insured students enrolled for coverage in the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated.

Coverage Period	Coverage Start Date	Coverage End Date	Waiver Deadline
Annual	08/01/2024	07/31/2025	See below

Waiver Deadlines

Incoming MSBS Students	08/14/2024
Incoming DO Students	07/24/2024
Incoming PA1 Students	09/05/2024
Incoming MMS Students	07/24/2024
Continuing Students	07/24/2024

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as Rocky Vista University administrative fee.

2024-2025 Student Rate	
Annual	
Student	$5,101

Student Coverage

Eligibility

All students are automatically enrolled in the Rocky Vista University Student Health Insurance Plan at registration and the premium for coverage is added to the tuition billing. Enrollment can be waived if proof of valid and comparable insurance is furnished and approved by submitting a waiver at the time of registration. Please see the Waiver Process section below for additional information.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Part-time students, independent study, internet classes and television (TV) courses may not fulfill the eligibility requirements that the covered student actively attends classes. If the eligibility requirements are not met, Aetna's only obligation is to refund the premium, less any claims paid.

Enrollment

Eligible students will be automatically enrolled in this Plan, unless the completed waiver application has been received by Rocky Vista University by the specified waiver deadline date listed above.

The Enrollment and Waiver process is administered by HSA Consulting, Inc. (HSAC), the Rocky Vista University(RVU) student insurance plan administrator. To enroll in the RVU student insurance 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/rvu. Once you are enrolled in the plan, there are no refunds or cancelations.

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 other than under a school-approved leave of absence within 31 days after the policy effective date, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded. If the withdrawal is more than 31 days after the policy effective date, your coverage will remain in force through the end

of the period for which payment has been received and no premiums will be refunded. If you withdraw from classes to enter the armed forces of any country, coverage will terminate as of the effective date of such entry and a pro rata refund of premiums will be made if you submit a written request within 90 days of withdrawal from classes

In-network Provider Network

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

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

Precertification

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

Precertification 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 30 days as long as you remain enrolled in the plan.

Coordination of Benefits (COB)

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB). A complete description of the Coordination of Benefits provision is contained in the certificate issued to you.

Description of Benefits

The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Summary document will tell you about some of the important features of the Plan, other features that may be important to you are defined in the Certificate. To look at the full Plan description, which is contained in the Certificate issued to you, go to **https://www.aetnastudenthealth.com.**

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

	In-network coverage	**Out-of-network coverage**
Policy year deductibles		
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$1,250 per policy year	$2,500 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 Family planning services - female contraceptives • In-network care and out-of-network care for Routine Cancer Screenings • In-network care and out-of-network care for Physician Office Visit Expense • In-network care and out-of-network care for Outpatient Mental Health & Substance Abuse Office Visit Expense • In-network care and out-of-network care for Consultant Expense • In-network care and out-of-network care for Walk-In Clinic Visit Expense • In-network care and out-of-network care for Urgent Care Expense • In-network care and out-of-network care for Emergency Room Expense • In-network care and out-of-network care for Prescribed Medicines Expense • In-network care and out-of-network care for Pediatric Vision Services • In-network care for Pediatric Dental Services		
This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.		
Eligible health services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Eligible health services applied to the in-network policy year deductibles will not be applied to satisfy the out-of-network policy year deductibles.		

Maximum out-of-pocket limits		
	In-network coverage	**Out-of-network coverage**
Student	$8,550 per policy year	$8,550 per policy year
Eligible health services applied to the out-of-network maximum out-of-pocket limit will not be applied to satisfy the in-network maximum out-of-pocket limit and eligible health services applied to the in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.		

	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Maximum age and visit limits per policy year through age 21	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.	
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	100% (of the recognized charge) per visit Policy year deductible applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention	
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel		
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit No policy year deductible applies
Preventive screening and counseling services		
Preventive screening and counseling services for Mental health wellness exam, Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, sexually transmitted infection counseling & Genetic risk counseling for breast & ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit No policy year deductible applies
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies

	In-network coverage	Out-of-network coverage
Lactation support and counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	50% (of the recognized charge) per item Policy year deductible applies
Family planning services – female contraceptives **Counseling services**		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
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	50% (of the recognized charge) per item Policy year deductible applies
Female voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Male contraceptive methods, sterilization procedures or devices		
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist, includes telemedicine consultations)	$40 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$50 copayment then the plan pays 100% (of the balance of the recognized charge) per visit No policy year deductible applies

	In-network coverage	**Out-of-network coverage**
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	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Allergy sera and extracts administered via injection at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Physician and specialist surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Benefits/coverage (what is covered) – – Hospital and other facility care* section)		
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)	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Benefits/coverage (what is covered) – – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office		
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$40 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$50 copayment then the plan pays 100% (of the balance of the recognized charge) per visit No policy year deductible applies
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	$50 copayment then the plan pays 70% (of the balance of the negotiated charge) per admission Policy year deductible applies	$100 copayment then the plan pays 50% (of the balance of the recognized charge) per admission Policy year deductible applies
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-network coverage	Out-of-network coverage
In-hospital non-surgical physician services	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
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	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
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	70% (of the negotiated charge) per admission Policy year deductible applies	50% (of the recognized charge) per admission Policy year deductible applies
Hospice-Outpatient	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • Funeral arrangements • Pastoral counseling • Bereavement counseling • Financial or legal counseling which includes estate planning and the drafting of a will • Homemaker or caretaker services that are services which are not solely related to your care and may include: - Sitter or companion services for either you or other family members - Transportation - Maintenance of the house		

	In-network coverage	Out-of-network coverage
Outpatient private duty nursing	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Skilled nursing facility - Inpatient	$50 copayment then the plan pays 70% (of the balance of the negotiated charge) per admission Policy year deductible applies	$100 copayment then the plan pays 50% (of the balance of the recognized charge) per admission Policy year deductible applies
Hospital emergency room	$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered

Important note:

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

The following are not covered under this benefit:

- Non-emergency services in a hospital emergency room facility, freestanding emergency medical care facility or comparable emergency facility

Urgent care	$50 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit No policy year deductible applies	$75 copayment then the plan pays 50% (of the balance of the recognized charge) per visit No policy year deductible applies

<table>
<tr><th></th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td>Non-urgent use of an urgent care provider</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td colspan="3">The following is not covered under this benefit:
• Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)</td></tr>
<tr><td colspan="3">Pediatric dental care
(Limited to covered persons through the end of the month in which the person turns age 19)</td></tr>
<tr><td>Type A services</td><td>100% (of the negotiated charge) per visit

No copayment or deductible applies</td><td>50% (of the recognized charge) per visit

Policy year deductible applies</td></tr>
<tr><td>Type B services</td><td>70% (of the negotiated charge) per visit

No policy year deductible applies</td><td>50% (of the recognized charge) per visit

Policy year deductible applies</td></tr>
<tr><td>Type C services</td><td>50% (of the negotiated charge) per visit

No policy year deductible applies</td><td>50% (of the recognized charge) per visit

Policy year deductible applies</td></tr>
<tr><td>Orthodontic services</td><td>50% (of the negotiated charge) per visit

No policy year deductible applies</td><td>50% (of the recognized charge) per visit

Policy year deductible applies</td></tr>
<tr><td>Dental emergency services</td><td>Covered according to the type of benefit and the place where the service is received</td><td>Covered according to the type of benefit and the place where the service is received</td></tr>
<tr><td colspan="3">Pediatric dental care exclusions:
The following are not covered under this benefit:
• Any instruction for diet, plaque control and oral hygiene
• Charges submitted for services:
  - By an unlicensed hospital, physician or other provider; or
  - By a licensed hospital, physician or other provider that are not within the scope of the provider’s license
• 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 Benefits/coverage (what is covered) section
  - Facings on molar crowns and pontics will always be considered cosmetic
▪ Court ordered services, including those required as a condition of parole or release
• 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 and removal of implants</td></tr>
</table>

- Dental services and supplies that are covered in whole or part under any other part of this plan
- 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
- Experimental or investigational drugs, devices, treatments or procedures, except as described in the *Benefits/coverage (what is covered)* section
- Medicare: Payment for that portion of the charge for which Medicare is the primary payer
- Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist
- Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider

	In-network coverage	**Out-of-network coverage**
Cleft palate and cleft lip conditions	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
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

<table>
<tr><td colspan="3">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</td></tr>
<tr><th></th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td>Impacted wisdom teeth</td><td>70% (of the negotiated charge)

Policy year deductible applies</td><td>70% (of the recognized charge)

Policy year deductible applies</td></tr>
<tr><td>Accidental injury to sound natural teeth</td><td>70% (of the negotiated charge)

Policy year deductible applies</td><td>70% (of the recognized charge)

Policy year deductible applies</td></tr>
<tr><td colspan="3">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</td></tr>
<tr><td>Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment</td><td>Covered according to the type of benefit and the place where the service is received</td><td>Covered according to the type of benefit and the place where the service is received</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
• Dental implants</td></tr>
<tr><td>Clinical trial (routine patient costs)</td><td>Covered according to the type of benefit and the place where the service is received</td><td>Covered according to the type of benefit and the place where the service is received</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
• Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
• Services and supplies provided by the trial sponsor without charge to you
• The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna’s claim policies)</td></tr>
<tr><td>Dermatological treatment</td><td>Covered according to the type of benefit and the place where the service is received</td><td>Covered according to the type of benefit and the place where the service is received</td></tr>
</table>

The following are not covered under this benefit: • Cosmetic treatment and procedures		
	In-network coverage	**Out-of-network coverage**
Bariatric (obesity) 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
The following are not covered under this benefit: • Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity** except as described above and in the *Benefits/coverage (what is covered) – 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		
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	70% (of the negotiated charge) No policy year deductible applies	50% (of the recognized charge) No policy year deductible applies
Voluntary sterilization for males - 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	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Abortion - Outpatient physician or specialist surgical services	70% (of the negotiated charge) Policy year deductible applies	70% (of the recognized charge) 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

	In-network coverage	**Out-of-network coverage**
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis	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 Abuse Treatment		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	$50 copayment then the plan pays 70% (of the balance of the negotiated charge) per admission Policy year deductible applies	$100 copayment then the plan pays 50% (of the balance of the recognized charge) per admission Policy year deductible applies
Outpatient office visits (includes telemedicine consultations)	$40 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$50 copayment then the plan pays 100% (of the balance of the recognized charge) per visit No policy year deductible applies
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
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
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 • Travel and lodging expenses		
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

	In-network coverage	**Out-of-network coverage**
Comprehensive infertility		
Comprehensive infertility services - Inpatient and outpatient care	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: • Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue for non-iatrogenic infertility. • Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue for non-iatrogenic infertility. • The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers. • A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person. • 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	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Outpatient Chemotherapy, Radiation & Respiratory Therapy	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
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 or the place where the service is received	Covered according to the type of benefit or 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		
	In-network coverage	**Out-of-network coverage**
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Chiropractic services	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year	20	
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 and supplies		
Acupuncture therapy	$40 copayment, then the plan pays 100% (of the balance of the negotiated charge) per visit No Policy year deductible applies	$50 copayment, then the plan pays 100% (of the balance of the recognized charge) per visit No Policy year deductible applies
Emergency ground, air, and water ambulance	$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as in-network coverage
Non-emergency ambulance	$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as in-network coverage
The following are not covered under this benefit: • Non-emergency fixed wing air ambulance from an out-of-network provider • Ambulance services for routine transportation to receive outpatient or inpatient care		
Durable medical and surgical equipment	70% (of the negotiated charge) per item Policy year deductible applies	50% (of the recognized charge) per item Policy year deductible applies

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		
	In-network coverage	**Out-of-network coverage**
Nutritional support Treatment of phenylketonuria limited to covered males through age 26 and females through age 50	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, and other nutritional items, even if it is the sole source of nutrition, except as described above		
Orthotic devices	70% (of the negotiated charge) per item Policy year deductible applies	50% (of the recognized charge) per item Policy year deductible applies
Prosthetic Devices		
Prosthetic devices	70% (of the negotiated charge) per item Policy year deductible applies	50% (of the recognized charge) per item Policy year deductible applies
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 or misuse • Communication aids		
Hearing aids for minors		
Hearing exam	$40 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$50 copayment then the plan pays 100% (of the balance of the recognized charge) per visit No policy year deductible applies
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		
	In-network coverage	**Out-of-network coverage**
Hearing Aids	70% (of the negotiated charge) per item Policy year deductible applies	50% (of the recognized charge) per item Policy year deductible applies
Hearing aids maximum per ear	One hearing aid per ear every policy year	
Hearing aids maximum per ear Covered persons up to age 18	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		
Pediatric vision care **(Limited to covered persons through the end of the month in which the person turns age 19)**		
Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations)	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit No policy year deductible applies
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	50% (of the recognized charge) per item No policy year deductible applies
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

	In-network coverage	Out-of-network coverage
Maximum number of optical devices per policy year	One optical device	
***Important note**: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.		
The following are not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		
Adult vision care **(Limited to covered persons age 19 and over**)		
Adult routine vision exams (including refraction) performed by a legally qualified ophthalmologist or therapeutic optometrist, or any other providers acting within the scope of their license	$40 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit Policy year deductible applies	$50 copayment then the plan pays 100% (of the balance of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year	1 visit	
Adult routine vision exams - fitting of prescription contact lenses	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Fitting of Contact maximum per policy year	1 visit	
Eyeglass frames, prescription lenses or prescription contact lenses	70% (of the negotiated charge) per item Policy year deductible applies	50% (of the recognized charge) per item Policy year deductible applies
Maximum number per policy year: Eyeglass frames Prescription lenses	 One set of eyeglass frames One pair of prescription lenses	
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3-month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set	
***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: Adult vision care • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes Adult vision care services and supplies		

- Special supplies such as non-prescription sunglasses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a hospital or other facility for health care
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

	In-network coverage	Out-of-network coverage
Outpatient prescription drugs		
Copayment/coinsurance waiver for risk reducing breast cancer drugs		
The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
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 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.		
Preferred and non-preferred generic prescription drugs		
For each fill up to a 30-day supply filled at a retail pharmacy	$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$20 copayment per supply then the plan pays 80% (of the balance of the recognized charge) No policy year deductible applies

	In-network coverage	Out-of-network coverage
More than a 30-day supply but less than a 90-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	Not covered
Preferred brand-name prescription 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 80% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$150 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		
For each fill up to a 30-day supply filled at a retail pharmacy	$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$100 copayment per supply then the plan pays 80% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$250 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Specialty drugs		
For each fill up to a 30-day supply filled at a retail pharmacy or specialty 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 80% (of the balance of the recognized charge) No policy year deductible applies

	In-network coverage	Out-of-network coverage
Diabetic insulin		
30 day supply at retail pharmacy	Paid according to the type of drug per the schedule of benefits above	Paid according to the type of drug per the schedule of benefits above
90 day supply at 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
Contraceptives (birth control)		
12 month supply of generic and OTC drugs and devices filled at a retail or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
12 month supply of brand name prescription drugs and devices filled at a retail or mail order pharmacy	Paid according to the type of drug per the schedule of benefits above	Paid according to the type of drug per the schedule of benefits above
Orally administered anti-cancer prescription drugs For each fill up to a 30-day supply filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
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
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
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy 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
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	

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 except as covered in the *Benefits/coverage (what is covered) – Other services, Nutritional support* section
- 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
- Injectables including:
  - Any charges for the administration or injection of prescription drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception

- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
    - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
    - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
    - That are used for the purpose of improving visual acuity or field of vision
    - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
    - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide
    - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug. The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:

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

Out of Country claims

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

General Exclusions

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
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation
- Sexual deviations and disorders except as described in the *Benefits/coverage (what is covered)* section
- Tobacco use disorders except as described in the *Benefits/coverage (what is covered)– Preventive care and wellness* section

Beyond legal authority

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

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

Examples of these are:

- The provision of donated blood to the **hospital**, other than blood derived clotting factors
- Any related services for donated blood including processing, storage or replacement expenses
- The 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 *Benefits/coverage (what is covered)– 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 *Benefits/coverage (what is covered) Clinical trial therapies (experimental or investigational)* section in the certificate

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 *Benefits/coverage (what is covered) - Gender affirming treatment* section.

Court-ordered services and testing

- Court-ordered testing or care unless medically necessary, other than medically necessary behavioral health treatment described as covered in the *Benefits/Coverage (What is Covered)-Specific conditions section* and required by state law
- Unless the tests are a covered benefit under your plan

Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs.
Examples 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 except in connection with hospice care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training
- For behavioral health (mental health treatment and substance related disorders treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function
    - Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults

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

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

Educational services

Except as described as eligible health services for autism spectrum disorders, therapies for congenital defects and birth abnormalities and early intervention services in the *Benefits/coverage (what is covered) section*, examples of these services are:

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

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

- Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs). See the *Benefits/coverage (what is covered) – Other services* section.

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

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

Gene-based, cellular and other innovative therapies (GCIT)
The following are not eligible health services unless you receive prior written approval from us:
- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the Medical necessity, referral 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 *Benefits/coverage (what is covered) – 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

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 *Benefits/coverage (what is covered)* 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 provided by a family member

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

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

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

Sinus surgery

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

Specialty prescription drugs

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

Strength and performance

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

Students in mental health field

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

Telemedicine

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

Therapies and tests

- Full body CT scans unless precertified by the plan as medically necessary
- 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, hypnosis, other therapies and medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF).

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

Wilderness treatment programs

See *Educational services* within this section

Work related illness or injuries

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

The Rocky Vista 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 1-866-746-6747.

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 1-866-746-6747.

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

Language accessibility statement

Interpreter services are available for free.

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-866-746-6747** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-746-6747** (TTY: **711**).

አማርኛ**/Amharic**

ልብ ይበሉ: ኣማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጀተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-866-746-6747** (መስማት ለተሳናቸው: **711**).

العربية**/Arabic**

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-866-746-6747** (رقم الهاتف النصي: **711**).

Ɓàsɔ́ɔ̀ Wùɖù/Bassa

Dè dɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ dyi Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpáa. Ɖá **1-866-746-6747** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-866-746-6747** (TTY: **711**)。

فارسی**/Farsi**

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-866-746-6747** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d’une assistance gratuite dans votre langue en composant le **1-866-746-6747** (TTY: **711**).

ગુજરાતી**/Gujarati**

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે. કૉલ કરો **1-866-746-6747** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-866-746-6747** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n’efu, dịịrị gị. Kpọọ **1-866-746-6747** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-866-746-6747** (TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-866-746-6747** (TTY: **711**).
Estes serviços são oferecidos gratuitamente.

Русский/Russian

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-866-746-6747** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-866-746-6747** (TTY: **711**).

اردو/Urdu

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (TTY: **711**) **1-866-7746-6747** پر کال کریں.

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-866-746-6747** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-866-746-6747** (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).