OLD DOMINION UNIVERSITY
STANDARD CONTRACT

Contract No. 24-ODU-05-CCC-M

This contract entered into by and between **Aetna Life Insurance Company** (hereinafter the "Contractor"), and Old Dominion University (hereinafter the "University").

I. **WITNESSETH** that Contractor and the University, in consideration of the mutual covenants, promises and agreements herein contained, agree as follows:

II. PERIOD OF PERFORMANCE:

The contract period shall commence upon final contract acceptance and execution, as evidenced by the latest execution date on the contract signature page, and will be in effect through July 31, 2025.

Upon mutual agreement between both the Contractor and the University, this contract and subsequent period(s) of performance may be renewed for up to four (4) additional one (1) year periods.

The Contractor agrees that as part of this agreement, Contractor's response to the University's RFP #24-ODU-05-CCC, including any and all associated terms and conditions, scope of service, and related pricing for same shall remain in effect throughout any and all "periods of performance", unless otherwise modified.

III. CONTRACT AGREEMENT:

University and Contractor agree that this contract agreement clarifies certain aspects of the administration of the health insurance plan purchased by the University and underwritten by **Aetna Life Insurance Company**. However, the University and Contractor specifically understand and acknowledge that the health insurance plan to be offered by the Contractor is described in various insurance policy and related documents required to be filed in and approved by the Commonwealth of Virginia (the "Filed Document"). The parties intend for this agreement to be consistent with the terms of the Filed Documents and that any inconsistency between this contract agreement and any Filed Document should be reconciled wherever possible (and as permitted by State law) so as to give full force and effect to both the terms of this contract agreement and the Filed Documents. However, in the event of an irreconcilable conflict between the terms of this contract agreement and the Filed Documents, the terms of the Filed Documents shall govern.

The contract agreement shall consist of the following documents:

A. This signed Contract Agreement
B. The original Request for Proposal and Contractor's response to same, specifically (i) any and all response language to support services delivery, terms and conditions, and exceptions, (ii) Contractor's "Pricing Schedule", as specified in section IX and the Exhibit A;
C. Contractor's pricing as detailed in the Policyholder Application/Rate Proposal Binder, specified in Exhibit A for 2024-2025 Policy Year;
D. Contractor's Insurance Plan as detailed in the "Student Health Plan Design and Benefits Summary", as specified in Exhibit B,
E. Where this Contract Agreement is silent, the University's original Request For Proposal, all associated attachments, addenda, and all written negotiated changes shall control.

IV. STATEMENT OF NEEDS:

The Contractor shall provide Health Insurance for the University's Medical Students at the Virginia Health Sciences program as outlined in the original RFP (#24-ODU-05-CCC), the original response to same by the Contractor to include all additional and clarification documents provided, and all addendum.

A. General Conditions:

1. The Contractor shall be (i) properly licensed to do business in the Commonwealth of Virginia, and (ii) is an established industry leader in providing insurance programs, associated coverages and claim services to Universities in the Medical Health Care markets. The Contractor must have a local and a national PPO network which includes the major local (Hampton Roads Area) hospitals and adequate physician access within most specialties. Program plan coverage and requirements can be defined as follows:
   a) All Virginia Health Science Students for both medical and health professional students who are registered and take full-time credit hours are automatically enrolled in the Health Insurance plan.

2. Contractor shall deliver the required health insurance and claims services, and be able to provide the following:
   a) Certification and/or documentation that validates Contractor authority to provide specified services in the Commonwealth of Virginia;
   b) Contractor's Rating - Insurance Company's ratings by A.M. Best Companies or others.
   c) A 'management team' assigned to the University's account to ensure continued program growth, expansion of service offerings and continued development and support of marketing, outreach, and planning strategies.
      (1) Contractor shall maintain a staff with the qualifications and areas of expertise of those designated, in the following areas:
         (a) personnel that will be involved in underwriting, contracts, enrollment, etc.;
         (b) personnel for technical support of dedicated website; and
         (c) those sub-contractors approved by the University.

B. Specific:

1. INSURANCE PLAN COVERAGE and LIMITS: The requirements as specified in the 'Student Health Plan Design and Benefits Summary', Exhibit B are to be considered as minimum coverage for the University's Medical and Professional Health Students, and their dependents.

   In addition, the Contractor's medical insurance plan must maintain the following program parameters [22 CFR 62.14] throughout the term of the contract:

   - Proposed plan(s) must comply with all applicable health insurance mandates in the Commonwealth of Virginia;
   - Plan provider must be licensed in the Commonwealth of Virginia. If non-employer insurance, the policy is filed and approved for sale in the Commonwealth of Virginia;
   - Provide benefits for treatment that is medically necessary as a result of most accidents or illnesses;
   - Allows for specific exclusions and limitations as identified in any associated insurance policy;
   - Provide for the essential health benefits (EHB) required by the Affordable Care Act ("ACA"), including minimum and maximum benefits for covered medical expenses, with no annual or lifetime maximum, as allowed;
   - Compliant with ACA regulations for student plans including coverage of pre-existing conditions on enrollment, coverage for ten essential health benefits, 100% coverage of preventive care;
   - Allow plan year starting August 1, 2024; Fall coverage August 1-December 31; Spring/Summer coverage January 1-July 31, with a 'no optional out' for summer coverage;

- No Evidence of Insurability shall be required, and only primary insurance shall be considered;
- Associated premium rates shall be the same regardless of age or gender; the University will not consider plans where premiums are based on age groupings;
- Coverage for pre-existing conditions will be allowed:
    - All existing conditions now covered by the current insurer or any credible insurance coverage will be grandfathered into any program for the insurance year 2024-2025;
    - Any pre-existing condition shall have continuous coverage, provided that the student maintains continuous enrollment in the University's student health insurance plan or continuous coverage from another credible insurer;
- Expense(s) incurred at University's Student Health Services will be payable at 100% without a deductible, **Semester and Summer health fees at University's Student Health Services are not covered under the plan**;
- Outpatient prescription drugs must be covered with a tiered co-pay for generic/brand medications unless no co-pay is required in network (such as for FDA approved prescription contraceptives);
- No limits on benefits for services such as inpatient/outpatient surgery, daily hospital room and board, x-rays, labs, CT scans and other miscellaneous services;
- Preventive Care is covered without a waiting period;
- Medical evacuation and repatriation coverage and limits as defined [22 CFR 62.14]:
    - Expenses associated with the medical evacuation to his or her home country in the amount of $50,000;
    - Repatriation expenses for payment of the preparation of mortal remains and cost involved with shipment and funeral directors expense, and transportation of the body to their place of resident in their home country will be paid to their home country;
    - Repatriation of remains must be at least $25,000.
- Accidental death benefits of at least $15,000;
- Coinsurance of no lower than 75% as defined [22 CFR 62.14];
- PPO plan with a national provider network (list to be provided);
- Annual deductible less than $500 (reasonable $250, consider cost/benefit) as defined [22 CFR 62.14];
- 80%/50% coverage in/out of network;
- Out of pocket max (reasonable $4000, consider cost benefit) then plan covers 100%;
- Short term coverage available for ELC students & J-1 scholars and F-1s/J-1s on Optional Practical Training or Academic Training;
- Provides for a medical leave of absence provision (student may continue coverage while on medical leave of absence for treatment of serious health condition such as cancer);
- Include program plan coverage and associated premium rates for student only, spouse, child and children.
- The contract and provider shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Any contract and renewals shall be consistent with preliminary and forthcoming final regulations announced by the Department of Health and Human Service (HHS) relating to the Public Health Service Act and the Affordable Care Act and student health insurance coverage.

2. PROGRAM ADMINISTRATION:

a) Contractor shall employ and dedicate:

(1) A minimum of two qualified, licensed principals or account staff for the University's account;
(2) Each dedicated staff shall have a minimum of five (5) years of experience in commercial lines related to the insurance coverage being proposed;
(3) Contractor shall have either a Chartered Property Casualty Underwriter or Associate in Risk Management designation.

b) Contractor shall have a named agent(s)/representative(s) that:
(1) Is/are fully trained by the company;
(2) Is/are available from 8:00 AM to 5:00 PM, Monday through Friday, to assist University with various requests for general information and services;
(3) Has/have direct contact information with toll-free numbers, available to students, scholars and University administrators from the Plan Administrator (claims and premiums) as well as a toll-free number to the agent responsible for services;
(4) Will provide a continued and on-going advocacy role for the students and the University administrators with assistance to resolve any problems, concerns or claims from the Plan Administer and agent, as applicable; and,
(5) Will be available to provide information during all orientation and registration sessions as requested and to assist with medical students up to twice a year.

c) The Contractor will request quarterly claims data from any associated insurance company and provide resulting information to the University;

d) The Contractor shall maintain data regarding plan design, enrollment, total premium, and year-end claims/loss ratios for five (5) years (as historical data);

e) The Contractor or its agent shall have a representative(s) available to provide information during all orientation and registration sessions as requested and to assist with medical students up to twice a year.

f) All students enrolled in the insurance programs shall be provided an identification card and a Certificate (policy) Booklet.

g) Master Policy Language modifications will be allowed, if required, when:
(1) A result of a Federal Law or new regulation, or
(2) Clarifying confusing policy language, and
(3) If the change(s) is agreed to by both the University and the Contractor, in writing.

h) Any adjustments in premiums and/or changes in policy language, along with appropriate documentation must be received by the University's Contract Administrator no later than the 15th day of February prior to each renewal period, or at a time mutually agreed to in writing.

i) The insurance policy shall be filed and approved in the Commonwealth of Virginia and meet all applicable federal and Virginia State regulations.

j) The Contractor shall provide consistency in printed materials from year to year, especially with respect to spacing, wording, and overall organization of materials sent to students. Any significant deviation in materials shall be agreed to mutually.

k) The Contractor must maintain constant benefits and exclusions unless approved by the University, or required by law. Any resulting contract shall comply with the Health Insurance Portability and Accountability Act of 2003 and the Patient Protection and Affordable Care Act, Regulations for Student Health Plans.

l) The Contractor shall not discriminate against students or their eligible dependents on the basis of sex, race, national origin, age, disability, sexual orientation, religion, veteran status, or pregnancy.

m) Covered Medical students may also enroll their lawful spouse, domestic partner (same-sex, opposite sex), and dependent children up to the age of 26. Dependent enrollment will take place via Contractor's Voluntary enrollment site.

n) Contractor shall keep complete, accurate and separate accounting records of its operation under this contract and the University shall have the right at any time during normal business hours and with advanced written notice, to request to examine and audit the books and accounts directly relative to any resulting contract to determine compliance with the Contractor's proposal for a period of up to one (1) year after final payment of premium by the University. The Contractor agree to the Commonwealth of Virginia in its role as auditor of public procurements having full access to and the right to examine books, records, and other documents directly relative to this contract.

o) Enrollment Support:
   (a) Prior to each open enrollment period, Contractor shall be responsible for providing brochure in English, and subject to the University guidelines, outlining the required health benefits and exclusions. Each brochure must be submitted to the University no later than 60 days prior to registration period, or a time mutually agreed to.
   (b) Contractor shall provide marketing services to advertise and market the health insurance plan(s).
   (c) Contractor shall support the University with an online/portal for waiver review process.

p) Marketing Materials:
   (a) Contractor shall be responsible for all program related mailings, with the understanding that ALL PRINTED MATERIAL TO BE MAILED TO AND/OR READ BY THE STUDENTS MUST BE APPROVED, IN ADVANCE OF PRINTING, BY THE UNIVERSITY'S CONTRACT ADMINISTRATOR;
   (b) The quality of all marketing materials, coverage benefit booklets and insurance cards shall be consistent with that currently in use;
   (c) Once each year, at the time of renewals, the Contractor shall supply the University with a list of every information item which may be sent to the students during the year;
   (d) The list shall be reviewed and changed if necessary and, once approved by the University, the Contractor will not be allowed to send any other information to the students;
   (e) Student lists and mailing information may not be used by the Contractor or provided to other agencies of the Contractor for any other mailings, solicitations, contracts, etc, without written approval from the University.

q) Dedicated Website and Access:
The Contractor shall provide a dedicated website for students, scholars, and the University administrators that:

   (1) is password protected and has all appropriate backup, redundancy and security to protect all associated data and information;
   (2) will be available for access 24/7;
   (3) Allows the University's contract administrator to access at a minimum, the following access and information:
      (a) Aggregate claim information;
      (b) Aggregate online enrollment and enrollment updates;

(c) Verification of enrollment updates provided to administrator via e-mail notification;
(d) Ordering information materials and forms online;
(e) Access to information on emergency assistance services and contacts;
(f) University waiver status for mandatory populations;
(g) Any other services, as may be necessary or required.

(4) Allows students and scholars access, which at a minimum would include:
(a) Enrollment information;
(b) Checking on claim filing procedures and status;
(c) Information on the policy and benefits;
(d) General healthcare information including links to the University's Student Health Center, Counseling Services, and Medical Student Services;
(e) Access information on worldwide emergency assistance services and contacts;
(f) Any other services, as may be necessary or required.

(5) Allows Medical student dependents to make payment online through Contractor's protected web-site.

3. CLAIMS SERVICE SPECIFICATIONS: The services shall include the following minimum claims capabilities and support documentation:

a) Claims Procedure - The Contractor shall have specific, written procedures in place for the timely and accurate processing of claims by the insurer or company handling payment of claims.

b) Claims Agent - The Contractor shall have a clearly designated, named representative to assist the University with all claims processing, associated claims payment problems, forms preparation and information requests. Agency is not responsible for handling payment of claims unless the agent is directly affiliated with the company.

c) Reports - The Contractor shall provide the University with:
(1) monthly claims reports showing enrollment data and expenses, and information regarding claims which were denied;
(2) an annual report that provides detailed information regarding claim breakdown for each category of the University's students; and
(3) semi-annual enrollment lists and demographics of enrolled students, once per semester.
(4) Total Gross premium collected year to date by program source;
(5) Total claims Paid and Medical Loss Ratio to date by program source; and
(6) Other ad hoc reports associated with this plan with a receipt requirement within ten business days.

d) Claim Submittal - Submitted claims shall be accurate and complete and shall be paid within (30) working days of submission. Any requests for additional information must be sent within 10 business days and if a claim requires more than 30 days to process the contractor will notify the student and provide the status of that claim within 15 business days.

V. REPORTING AND DELIVERY REQUIREMENTS:

UTILIZATION OF SMALL BUSINESSES AND BUSINESSES OWNED BY WOMEN AND MINORITIES:

A. Any subsequent contract(s) that include a final Small, Women-owned, and Minority-owned Business (SWaM) Plan must provide for expenditure percentages for each proposed SWAM subcategory, as mutually negotiated and agreed to.

B. Periodic Progress Reports/Invoices: For those contract(s) that include a final SWAM Plan, the Contractor shall provide on a quarterly basis to the appropriate University contact, a report on involvement of small businesses and businesses owned by women and minorities. This report will specify (i) the proposed total spend percentage and proposed total spend in dollars during the contract term for each proposed SWAM subcategory, (ii) the proposed total spend percentage and proposed total spend in dollars during the contract term with each identified and specified business, (iii) the actual spend percentage and actual spend in dollars to date and/or current period with each identified and specified business. This information shall be provided separately for small businesses, women-owned businesses and minority businesses.

C. Final Actual Involvement Report: The Contractor(s) shall submit to the appropriate University contact, within 60 days of contract completion, a report on the actual dollars spent with small businesses and businesses owned by women and minorities during the performance of the contract. At a minimum, this report shall include for each firm contracted with and for each such business class (i.e., small, women-owned) a comparison of the total actual dollars spent on this contract with the planned involvement of the firm and business class as specified in the proposal, and the actual percent of the total estimated contract value.

D. If at any time during the contract term, as evidenced by review of required quarterly and report submittals, the awarded Contractor fails to meet proposed SWAM expenditure percentages, the University may deem same in 'breach of contract', and take appropriate action as necessary, which may include:
   1. An agreed to period to allow Contractor 'time to cure';
   2. Cancellation of remaining term(s) of contract; or
   3. The withholding of funds due to Contractor equal to the difference between proposed expenditure amount versus actual expenditure amount for any and all SWAM subcategories.

E. In the event Contractor provides satisfactory resolution to any SWAM subcategory spend deficiency, the University will release to Contractor the associated funds withheld.

F. The University's right to withhold any funds due the Contractor pursuant to this section, shall not relieve the Contractor of their contractual obligations.

VI. TERMS AND CONDITIONS:

The following terms and conditions shall remain in effect for the duration of the contract period, including and all renewal periods:

A. **ADVERTISING**: Contractor agrees that that no indication of such sales or services to the University will be used in product literature or advertising during the contract term for supplies, equipment, or services resulting from this contract.

B. **APPLICABLE LAWS AND COURTS:** This contract shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The agency and the Contractor are encouraged to resolve any issues in controversy arising from the award of the contract or any contractual dispute using Alternative Dispute Resolution (ADR) procedures (*Code of Virginia*, § 23-38.90). The Contractor shall comply with all applicable federal, state and local laws, rules and regulations and policies of the University.

C. **APPLICABLE LEGISLATION AND MANUAL**: This contract is subject to the provisions of the Commonwealth of Virginia, specifically § 23-38.90 of the Code of Virginia and its associated Rules Governing the Procurement of Goods, Services, Insurance and Construction ("the

Rules") and the Purchasing Manual for Universities of Higher Education and their Contractors and any revisions thereto, which are hereby incorporated into this contract in their entirety. A copy of the manual is accessible on the Internet at www.odu.edu/procurement under "Information for Contractors".

D. **ASSIGNMENT OF CONTRACT**: This contract may be assigned by the Contractor, in whole or in part, to subcontractors hired specifically to perform services under this contract.

E. **AVAILABILITY OF FUNDS**: *The effect of termination of the Contract hereunder will be to discharge both Contractor and the University from future performance of the Contract, but not from their rights and obligations existing at the time of termination.*

F. **AUDIT**:
The University may inspect Contractor's books, records, and other documents directly relative to any resulting contract to determine compliance with Contractor's proposal for a period of up to one (1) year after final payment of premium by the University. Contractor agrees to the Commonwealth of Virginia in its role as auditor of public procurements having full access to and the right to examine books, records, and other documents directly relative to any resulting contract.

G. **CHANGES TO THE CONTRACT**: Changes can be made to the contract in any of the following ways:

1. The parties may *mutually* agree in writing to modify the scope of the contract. An increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the contract.

2. The University *and the Contractor* may order changes within the general scope of the contract at any time by written notice to the other party. Changes within the scope of the contract include, but are not limited to, things such as services to be performed, the method of packing or shipment, and the place of delivery or installation. The contractor shall comply with the notice upon receipt. The contractor shall be compensated for any additional costs incurred as the result of such order and shall give the University a credit for any savings. Said compensation shall be determined by one of the following methods:

   a. By mutual agreement between the parties in writing; or

   b. By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the contractor accounts for the number of units of work performed, subject to the University's right to audit the contractor's records and/or to determine the correct number of units independently; or

   c. By ordering the contractor to proceed with the work and keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The contractor shall present the University with all vouchers and records of expenses incurred and savings realized. The University shall have the right to audit the records of the contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the University within thirty (30) days from the date of receipt of the written order from the University. If the parties fail to agree on

an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this contract or, if there is none, in accordance with the disputes provisions of the Commonwealth of Virginia *Purchasing Manual for Institutions of Higher Education and their Contractor s.* Neither the existence of a claim nor a dispute resolution process, litigation or any other provision of this contract shall excuse the contractor from promptly complying with the changes ordered by the University or with the performance of the contract generally.

H. **DEFAULT:** In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies which the Commonwealth may have. *This section does not apply in the case of early termination by the University for no cause.*

I. **DISCOUNTS**

1. **Prompt Payment Discounts:** The University will pay within 30 days after acceptance. A prompt payment discount offered for prompt payment of (20) calendar days or longer will be calculated in determining net low proposal.

2. **Special Educational Or Promotional Discounts:** The Contractor shall extend any special
educational or promotional sale prices or discounts immediately to the University during the term of the contract. Such notice shall also advise the duration of the specific sale or discount price.

J. **DRUG-FREE WORKPLACE:** ***(the Rules §11.)***

During the performance of any resulting contract, the Contractor agrees to (i) provide a drug-free workplace for the Contractor's employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or Contractor.

For the purposes of this section, "*drug-free workplace*" means a site for the performance of work done in connection with a specific contract awarded to a Contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

K. **EMPLOYMENT DISCRIMINATION:** ***(the Rules §10.)***

During the performance of any resulting contract, the Contractor agrees to:

1. Not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor, and to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of the above nondiscrimination clause.

2. State in all solicitations or advertisements for employees placed by or on behalf of the Contractor, that such Contractor is an equal opportunity employer.
3. Certify all notices, advertisements and solicitations shall be placed in accordance with federal law, rule or regulation deemed sufficient for the purpose of meeting these requirements.
4. Include the provisions of foregoing paragraphs 1., 2., and 3. in every subcontract or purchase order over $10,000, so that the provisions will be binding upon each subcontractor or Contractor.

L. **EXCLUSIVITY:** The University reserves the right to procure goods or services covered under any resulting contract from a third party when, in the University's sole discretion, it is deemed to be in the University's best interest.

M. **FINAL INSPECTION:** At the conclusion of the work, the Contractor shall demonstrate to the authorized University representative that the work/service is operational and in compliance with contract specifications and codes. Any deficiencies shall be promptly and permanently corrected by the Contractor at the Contractor's sole expense prior to final acceptance of the work.

N. **FORCE MAJEURE:** Neither party will be responsible for any losses resulting from delay or failure in performance resulting from any cause, event, or occurrence beyond the control and without the negligence of the parties. Such events, occurrences, or causes include, without limitation: war, strikes or labor disputes, civil disturbances, government orders, pandemics, fires, natural disasters, and acts of God.

O. **INDEMNIFICATION:**
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P. **PAYMENT PROVISIONS:**
1. By the University:
   a. Prompt Payment: ***(the Rules §42.)***
      i. The University shall promptly pay for the completely delivered goods or services by the required payment date.
      ii. Payment shall be deemed to have been made when offset proceedings have been instituted, as authorized under the Virginia Debt Collection Act (§ 2.2-4800 et seq.) of the Code of Virginia.
      iii. Separate payment dates may be specified for contracts under which goods or services are provided in a series of partial deliveries or executions to the extent that such contract provides for separate payment for such partial delivery or execution.

   b. Defect Or Impropriety In The Invoice Or Goods And/Or Services Received: ***(the Rules §43.)***
      In instances where there is a defect or impropriety in an invoice or in the goods or services received, the University shall notify the Contractor of the defect or impropriety, if the defect or impropriety would prevent payment by the payment date. The notice shall be sent within 15 days after receipt of the invoice or the goods or services.

   c. Date Of Postmark Deemed To Be Date Payment Is Made: ***(the Rules §44.)***
      In those cases where payment is made by mail, the date of postmark shall be deemed to be the date payment is made for purposes of these Rules.

   d. Interest Penalty; Exceptions: ***(the Rules §44.)***
      i. Interest shall accrue, at the rate determined pursuant to subsection ii., on all amounts owed by the University to a Contractor that remain

unpaid after seven days following the payment date. However, nothing in this section shall affect any contract providing for a different rate of interest, or for the payment of interest in a different manner.

ii. The rate of interest charged the University pursuant to subsection i. shall be the base rate on corporate loans (prime rate) at large United States money center commercial banks as reported daily in the publication entitled The Wall Street Journal. Whenever a split prime rate is published, the lower of the two rates shall be used. However, in no event shall the rate of interest charged exceed the rate of interest established pursuant to § 58.1-1812 of the Code of Virginia.

iii. Notwithstanding subsection i., no interest penalty shall be charged when payment is delayed because of disagreement between the University and a Contractor regarding the quantity, quality or time of delivery of goods or services or the accuracy of any invoice received for the goods or services. The exception from the interest penalty provided by this subsection shall apply only to that portion of a delayed payment that is actually the subject of the disagreement and shall apply only for the duration of the disagreement.

iv. This section shall not apply to retainage on construction contracts that provides for progress payments, during the period of time prior to the date the final payment is due. Nothing contained herein shall prevent a Contractor from receiving interest on such funds under an approved escrow agreement.

v. Notwithstanding subsection i., no interest penalty shall be paid to any debtor on any payment, or portion thereof, withheld pursuant to the Comptroller's Debt Setoff Program, as authorized by the Virginia Debt Collection Act (§ 2.2-4800 et seq.) of the Code of Virginia, commencing with the date the payment is withheld. If, as a result of an error, a payment or portion thereof is withheld, and it is determined that at the time of setoff no debt was owed to the Commonwealth, then interest shall accrue at the rate determined pursuant to subsection 2. on amounts withheld that remains unpaid after seven days following the payment date.

2. <u>To Contractor:</u>
Under any resulting contract, Contractor is hereby obligated:

i. To submit all invoices for goods/services ordered, delivered and accepted directly to:
   a) Old Dominion University, Accounts Payable
      Rollins Hall, Room 2005
      Norfolk, Virginia 23529; or
   b) invoice@odu.edu

ii. All invoices shall include:
   a) Contractor Name, 'Remit To' Address, FEIN, or Social Security Number (Individual Contractor);
   b) Invoice Number, Invoice Date, Payment Terms and Discounts, and Payment Due Date;
   c) Purchase Order Number;

d) University Contact;
e) Description of provided goods/services;
f) Quantity Delivered per line item;
g) Unit and Extended Cost per line item; and
h) Total Amount Due

iii. Any payment terms requiring payment in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.

iv. All goods or services provided shall be billed by the Contractor at the agreed to contract price.

v. **Unreasonable Charges**. Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, Contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges which appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon determining that invoiced charges are not reasonable, the University shall promptly notify the Contractor, in writing, as to those charges which it considers unreasonable and the basis for the determination. A Contractor may not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve the University of its prompt payment obligations with respect to those charges which are not in dispute.

vi. When applicable, Contractor shall deliver to the University, on or before request for final payment, evidence and certification of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the SWAM procurement plan. Final payment under the contract in question may be withheld until such certification is delivered and, if necessary, confirmed by the agency or University, or other appropriate penalties may be assessed in lieu of withholding such payment.

3. To Subcontractors: ***(the Rules §45.)***
Under any resulting contract, Contractor shall be obligated:

i. To pay the subcontractor(s) within seven (7) days of the Contractor's receipt of payment from the University for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or

ii. To notify the University and the subcontractor(s), in writing, of the Contractor's intention to withhold payment and the reason.

iii. To pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the Contractor that remain unpaid seven (7) days following receipt of payment from the University, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier Contractor performing under the primary contract. A Contractor's obligation to pay an interest charge

to a subcontractor may not be construed to be an obligation of the University.

Q. **SEVERABILITY:** The provisions of any resulting contract shall be deemed to be severable, and should any or more of such provisions be declared or adjudged to be invalid or unenforceable, the remaining provisions shall be unaffected thereby and shall remain in full force and effect.

R. **TERMINATION WITH CAUSE:**

1. In the event that the Contractor shall for any reason or through any cause be in default of the terms of the contract, the University may give the Contractor written notice of such default by certified mail/return receipt requested.

2. Prior to termination of the contract, the University shall give the Contractor and its surety *thirty (30)* calendar day's written notice, during which the Contractor and/or his surety may rectify the cause of the termination. If rectified to the satisfaction of the University within said *thirty (30)* days, the University may rescind the notice of termination. If Contractor does not, the termination for cause shall become effective at the end of the *thirty-day (30)* notice period.

3. *{Deleted}*

4. *{Deleted}*

5. *{Deleted}*

6. *{Deleted}*

7. In the event of violations of law, safety or health standards and regulations, the contract may be immediately cancelled and terminated by the University and provisions herein with respect to opportunity to cure default shall not be applicable.

8. *University agrees with Contractor's right to terminate this agreement for nonpayment of premium in accordance with the filed and approved group policy and applicable law.*

9. *Unless otherwise agreed or required by law, either party can cancel by sending a written notice to the other at least 30 days in advance. The Contractor can terminate the arrangement sooner under certain circumstances. These include the enactment of new laws or regulations that do not allow the Contractor to write such a plan or the failure of the University to pay amounts owed when due, or within any applicable grace period. Termination requirements are the same regardless of whether the plan terminates on or off anniversary and would not relieve the Contractor from its obligations for the remaining 'period' for which any premium has been paid.*

10. *Contractor requests a thirty (30) day period to cure any issue that could lead to a default. Contractor does not agree to offsets for damages not awarded by a court of competent jurisdiction, thus, the Contractor would not agree to the University withholding payment on the grounds of damages. Contractor shall not be liable for any re-procurement costs as such costs are beyond the control of Contractor.*

S. **TERMINATION BY UNIVERSITY FOR CONVENIENCE:**

1. The University may terminate any resulting contract at any time for convenience, in whole or in part, upon giving the Contractor notice of such termination. Upon such termination, the Contractor shall immediately cease work and remove from the project

site all of its labor forces and materials that the University elects not to purchase or to assume in the manner hereinafter provided. Upon such termination, the Contractor shall take such steps as the University may require to assign to the University the Contractor's interest in all subcontracts and purchase orders designated by University. After all such steps have been taken to University's satisfaction, the Contractor shall receive as full compensation for termination and assignment the following:

i. All amounts due for work performed subsequent to the latest Request for Payment through the date of termination;

ii. Reasonable compensation for the actual cost of demobilization incurred by the Contractor as a direct result of such termination;

iii. The Contractor shall not be entitled to any compensation for lost profits or for any other type of contractual compensation or damage other than those provided by the preceding sentence; and

iv. Upon payment of the forgoing, University shall have no further obligations to the Contractor of any nature.

2. In no event shall termination for the convenience of the University terminate the obligations of the
Contractor's surety on its payment and performance bonds.

3. *Unless otherwise agreed or required by law, either party can cancel by sending a written notice to the other at least 30 days in advance. The Contractor can terminate the arrangement sooner under certain circumstances. These include the enactment of new laws or regulations that do not allow Contractor to write such a plan or the failure of the University or students to pay amounts owed when due, or within any applicable grace period. Termination requirements are the same regardless of whether the plan terminates on or off anniversary. Regardless this would not relieve the Contractor from its obligations for the remaining 'period' for which any premium has been paid.*

T. **TESTING AND INSPECTION**: The University reserves the right to conduct any test/inspection it may deem advisable to assure goods and services conform to the specifications.

U. **WAIVER:** No failure of the University to exercise any right or power given to it by law or by any resulting contract, or to insist upon strict compliance by Contractor with any of the provisions of any resulting contract, and no custom or practice of the parties at variance with the terms hereof, shall constitute a waiver of the University's right to demand strict compliance with the terms of any resulting contract.

VII. SPECIAL TERMS AND CONDITIONS:

A. **AUTHORIZED CONTRACT PARTICIPATION**: In accordance with the University's Rules Governing Procurement of Goods, Services, Insurance and Construction ("Rules Document"), specifically §6, Cooperative Procurement, it is the intent of this contract to allow any public body, public or private health or educational institutions, or Old Dominion University's affiliated agencies and/or corporations, access and use of any subsequent contract(s), as authorized by the Contractor(s).

Participation in this cooperative procurement is strictly voluntary. If authorized by the Contractor(s), any resultant contract(s) may be extended to the entities as indicated above to purchase at contract prices in accordance with contract terms and conditions. The Contractor(s) shall notify the University in writing of any entities accessing the contract. No modification of this contract or execution of a separate contract is required to participate. The Contractor(s) will provide semi-annual usage reports for all entities accessing the contract(s). Participating entities shall place their own orders directly with the Contractor(s), and shall fully and independently administer their use of the contract(s), including contractual disputes, invoicing and payments, without direct administration from University. University shall not be held liable for any costs or damages incurred by any other participating entity as a result of any authorization by the Contractor(s) to extend participation and use of the contract(s). It is understood and agreed that University is not responsible for the acts or omissions of any entity, and will not be considered in default of the contract(s) no matter the circumstances.

Use of this contract does not preclude any participating entity from using other contracts or competitive processes as the need may be.

B. **CONTRACT AND RENEWAL TERM:**

1. The initial term of any resulting contract shall be for a one (1) year period, commencing upon acceptance and expiring on July 31, 2025;
2. Any resulting contract may be renewed by the University for four (4) successive one-year periods under the terms and conditions of the original contract except as stated in 3a. and 3.b. below. Cost considerations may be negotiated only at the time of renewal. Written notice of the University's intention to renew shall be given approximately 90 days prior to the expiration date of each contract period.
3. a. If the University elects to exercise the option to renew the contract for an additional one-year period ***after the initial term***, the contract price(s) for the additional one year shall not exceed the contract price(s) of the initial contract term by the lesser of (1) the percentage increase/decrease of the Consumer Price Index (CPI) for All Urban Wage Earner and Clerical Workers (CPI-W), All U.S. Items, for base period 1982-84=100, for the previous twelve (12) month period, or (2) not to exceed 5%.

   b. If during any subsequent renewal periods, the University elects to exercise the option to renew the contract, the contract price(s) for the subsequent renewal period shall not exceed the contract price(s) of the previous renewal period by the lesser of (1) the percentage increase/decrease of the Consumer Price Index (CPI) for All Urban Wage Earner and Clerical Workers (CPI-W), All U.S. Items, for base period 1982-84=100, for the previous twelve (12) month period, or (2) not to exceed 5%.

C. **COMPANY PERSONNEL STANDARDS:**

1. Contractor shall provide trained personnel who shall be qualified to properly maintain/perform/test for services specified herein. If any of the Contractor's personnel are not satisfactory in the performance of services to be furnished hereunder in a proper manner and satisfactory to the University, the Contractor shall remove any such personnel and replace them with satisfactory personnel.

2. Contractor shall use all reasonable care, consistent with its rights to manage and control its operations, not to employ any persons or use any labor or have any equipment or permit any condition to exist which shall or may cause or be conducive to pose any liability to the general public as well as any activity to be construed as a nuisance.

D. **INSURANCE:** By signing and submitting this contract, the Contractor certifies that they will have the following insurance coverage during the contract period. For construction contracts, if any subcontractors are involved, the subcontractor will have workers' compensation insurance in accordance with §§ 2.2-4332 and 65.2-800 et seq. of the *Code of Virginia*. The Contractor further certifies that any subcontractors will maintain these insurance coverage's during the entire term of the contract and that all insurance coverage's will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

MINIMUM INSURANCE COVERAGES AND LIMITS REQUIRED FOR MOST CONTRACTS:

1. Workers' Compensation - Statutory requirements and benefits. Coverage is compulsory for employers of three or more employees, to include the employer. Contractors who fail to notify the Commonwealth of increases in the number of employees that change their workers' compensation requirements under the Code of Virginia during the course of the contract shall be in noncompliance with the contract.
2. Employer's Liability - $100,000.
3. Commercial General Liability - $1,000,000 per occurrence. Commercial General Liability is to include bodily injury and property damage, personal injury and advertising injury, products and completed operations coverage. The University will be included as an additional insured and so endorsed on the policy.
4. Automobile Liability - $1,000,000 per occurrence.

Profession/Service	**Limits**
Insurance/Risk Management	$1,000,000/occurrence, $3,000,000 aggregate

E. **PRIME CONTRACTOR RESPONSIBILITIES:** The Contractor shall be responsible for completely supervising and directing the work under this contract and all subcontractors that he may utilize, using his best skill and attention. Subcontractors who perform work under this contract shall be responsible to the prime Contractor. The Contractor agrees that he is as fully responsible for the acts and omissions of his subcontractors and of persons employed by them as he is for the acts and omissions of his own employees.

F. **SUBCONTRACTS:** No portion of the work shall be subcontracted without prior written consent of the University. In the event that the Contractor desires to subcontract some part of the work specified herein, the Contractor shall furnish the University the names, qualifications and experience of their proposed subcontractors. The Contractor shall, however, remain fully liable and responsible for the work to be done by its subcontractor(s) and shall assure compliance with all requirements of the contract.
The Contractor agrees only as to their subcontractors hired specially to perform services under this contract.

G. **SUPERINTENDENCE BY CONTRACTOR:**

1. The Contractor shall have a competent representative, satisfactory to the University, during the progress of the work. The Contractor shall be responsible for all methods, techniques, sequences, and procedures for coordinating all portions of the work under the contract except where otherwise specified in the contract documents, and for all

safety and worker health programs and practices. The Contractor shall notify the University, in writing, of any proposed change in superintendent including the reason therefore prior to making such change.

2. The Contractor shall, at all times, enforce strict discipline and good order among the workers on the
project, and shall not employ on the work any unfit person, anyone not skilled in the work assigned to him, or anyone who will not work in harmony with those employed by the Contractor, the subcontractors, the University or the University's separate Contractors and their subcontractors.

3. The University may, in writing, require the Contractor to remove from the work any employee the University deems to be incompetent, careless, not working in harmony with others on this project, or otherwise objectionable.

VIII ADDITIONAL SPECIAL TERMS AND CONDITIONS, TECHNOLOGY REQUIREMENTS:

A. **AUDITS:**

1. The University reserves the right in its sole discretion to perform audits of the Contractor at the University's expense to ensure compliance with the terms of this Agreement. The Contractor shall reasonably cooperate in the performance of such audits. This provision applies to all agreements under which the Contractor must create, obtain, transmit, use, maintain, process, or dispose of University Data.
2. If the Contractor must under this agreement create, obtain, transmit, use, maintain, process, or dispose of the subset of the University Data known as Personally Identifiable Information or financial or business data, the Contractor will at its expense conduct or have conducted at least annually a(n):
   i. American Institute of CPAs Service Organization Controls (SOC) Type II audit, or other security audit with audit objectives deemed sufficient by the University, which attests the Contractor 's security policies, procedures and controls;
   ii. vulnerability scan, performed by a scanner approved by the University, of the Contractor 's electronic systems and facilities that are used in any way to deliver electronic services under this Agreement; and
   iii. formal penetration test, performed by a process and qualified personnel approved by the University, of the Contractor 's electronic systems and facilities that are used in any way to deliver electronic services under this Agreement.
3. Additionally, the Contractor will provide the University upon request the results of the above audits, scans and tests, and will promptly modify its security measures as needed based on those results.

B. **COMPLIANCE**:

1. The Contractor will comply with all applicable laws and industry standards in performing services under this Agreement. Any Contractor personnel visiting the University's facilities will comply with all applicable the University policies regarding access to, use of, and conduct within such facilities. The University will provide copies of such policies to the Contractor upon request.
2. The Contractor warrants that the service it will provide to the University is fully compliant with and will enable the University to be compliant with relevant requirements of all laws, regulation, and guidance applicable to the University and/or

the Contractor , including but not limited to: the Family Educational Rights and Privacy Act (FERPA), Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH), Gramm-Leach-Bliley Financial Modernization Act (GLB), Payment Card Industry Data Security Standards (PCI-DSS), Americans with Disabilities Act (ADA), and Federal Export Administration Regulations.

C. **DISCLOSURE**:

1. Unless expressly agreeing to the contrary in writing, all goods, products, materials, documents, reports, writings, video images, photographs or papers of any nature including software or computer images prepared or provided by the Contractor (or its subcontractors) for the University will not be disclosed to any other person or entity without the written permission of the University.

D. **DATA PRIVACY:**

1. The Contractor will use the University Data only for the purpose of fulfilling its duties under this Agreement and will not share such data with or disclose it to any third party without the prior written consent of the University, except as required by this Agreement or as otherwise *permitted or* required by law.
2. The University Data will not be stored outside the United States without prior written consent from the University.
3. The Contractor will provide access to the University Data only to its employees and subcontractors who need to access the data to fulfill obligations under this Agreement. The Contractor will use the Education records only for the purpose of fulfilling its duties under this Agreement for the University's and its End User's benefit, and will not share such data with or disclose it to any third party except as provided for in this Agreement, required by law, or authorized in writing by the University.

E. **DATA TRANSFER UPON TERMINATION OR EXPIRATION:**

1. The Contractor's obligations shall survive termination of this Contract until all the University Data has been returned or Securely Destroyed, meaning taking actions that render data written on media unrecoverable by both ordinary and extraordinary means. These actions must meet or exceed those sections of the National Institute of Standards and Technology (NIST) SP 800-88 guidelines relevant to data categorized as high security.
2. Upon termination or expiration of this Contract, the Contractor will ensure that all the University Data are securely transferred, returned or destroyed as directed by the University in its sole discretion within 60 days of termination of this Contract. Transfer/migration to the University or a third party designated by the University shall occur without significant interruption in service. The Contractor shall ensure that such transfer/migration uses facilities and methods that are compatible with the relevant systems of the University or its transferee, and to the extent technologically feasible, that the University will have reasonable access to the University Data during the transition.

   Should the University require participants' claim data or related information for business reasons, the Contractor will share information upon receipt of an appropriate release signed by the member. There may be an additional charge for this information transfer.

3. In the event that the University requests destruction of its data, the Contractor agrees to Securely Destroy all data in its possession and in the possession of any subcontractors or agents to which the Contractor might have transferred the University data.

Contractor will retain records in accordance with its records retention policies which are designed to comply with laws and regulations applicable to our services. Records are retained by type and not customer specific.

4. The Contractor will notify the University of impending cessation of its business and any contingency plans. This includes immediate transfer of any previously escrowed assets and data and providing the University access to the Contractor's facilities to remove and destroy the University-owned assets and data. The Contractor shall implement its exit plan and take all necessary actions to ensure a smooth transition of service with minimal disruption to the University. The Contractor will also provide a full inventory and configuration of servers, routers, other hardware, and software involved in service delivery along with supporting documentation, indicating which if any of these are owned by or dedicated to the University. The Contractor will work closely with its successor to ensure a successful transition to the new equipment, with minimal downtime and effect on the University, all such work to be coordinated and performed in advance of the formal, final transition date.

F. **DATA SECURITY:**

1. The Contractor will store and process the University Data in accordance with commercial best practices, including appropriate administrative, physical, and technical safeguards, to secure such data from unauthorized access, disclosure, alteration, and use. Such measures will be no less protective than those used to secure the Contractor 's own data of a similar type, and in no event less than reasonable in view of the type and nature of the data involved.
2. The Contractor will store and process the University Data in a secure site and will provide, *upon reasonable request,* a SAS 70, SAS 70 Type II, SSAE 16, SOC 2 or SOC 3, or other security report deemed sufficient by the University, from a third-party reviewer along with annual updated security reports.
3. The Contractor will use industry-standards and up-to-date security tools, technologies and practices such as network firewalls, anti-virus, vulnerability scans, system logging, intrusion detection, 24x7 system monitoring and third-party penetration testing in providing services under this Agreement.
4. Without limiting the foregoing, the Contractor *represents and covenants* that all electronic the University Data will be encrypted in transmission (including via web interface) and stored at no less than 128-bit level encryption.

G. **DATA AUTHENTICITY, INTEGRITY AND AVAILABILITY:**

1. The Contractor will take reasonable measures, including audit trails, to protect the University Data against deterioration or degradation of data quality and authenticity. The Contractor shall be responsible for ensuring that the University Data, per the Virginia Public Records Act, "is preserved, maintained, and accessible throughout their lifecycle, including converting and migrating electronic data as often as necessary so that information is not lost due to hardware, software, or media obsolescence or deterioration."
2. The Contractor will ensure backups are successfully completed at the agreed interval and that restoration capability is maintained for restoration to a point-in-time and\or to the most current backup available.
3. The Contractor will maintain an uptime of 99.99% or greater, as agreed to for the contracted services via the use of appropriate redundancy, continuity of operations and disaster recovery planning and implementations, excluding regularly scheduled maintenance time.

H. **EMPLOYEE BACKGROUND CHECKS AND QUALIFICATIONS:**

1. The Contractor shall ensure that its employees have undergone appropriate background screening and possess all needed qualifications to comply with the terms

of this agreement including but not limited to all terms relating to data and intellectual property protection.

2. If the Contractor must under this agreement create, obtain, transmit, use, maintain, process, or dispose of the subset of the University Data known as Personally Identifiable Information or financial or business data, the Contractor shall perform the following background checks on all employees who have potential to access such data in accordance with the Fair Credit Reporting Act: Social Security Number trace; seven (7) year felony and misdemeanor criminal records check of federal, state, or local records (as applicable) for job related crimes; Office of Foreign Assets Control List (OFAC) check; Bureau of Industry and Security List (BIS) check; and Office of Defense Trade Controls Debarred Persons List (DDTC).

I. **NO END USER AGREEMENTS:**

1. This Agreement and any Contractor provided agreement(s), including but not limited to End User License Agreement(s) ("EULA's), are the entire agreement between the University (including the University employees and other End Users) and the Contractor . Should the Contractor enter into other agreements or understandings, whether electronic, click-through, verbal or in writing, with the University employees or other End Users, such agreements shall be valid except for those provisions and/or terms and conditions which may conflict with this Addendum, whereas the terms of this Agreement shall apply.

J. **REQUESTS FOR DATA, RESPONSE TO LEGAL ORDERS OR DEMANDS FOR DATA:**

1. Except as otherwise expressly prohibited by law, the Contractor will:
   i. immediately notify the University of any subpoenas, warrants, or other legal orders, demands or requests received by the Contractor seeking the University *Business Confidential* Data.; *The term "Business Confidential Data" as it relates to University means the University identifiable business proprietary data, procedures, materials, lists and systems, but does not include Protected Health Information ("PHI") as defined by HIPAA or other claims-related information;*
   ii. cooperate with the University's requests in connection with efforts by the University to intervene and quash or modify the legal order, demand or request; and
   iii. upon the University's request, provide the University with a copy of its response *as permitted by law.*
2. This shall include any data preservation or eDiscovery required by the University.

K. **RIGHTS AND LICENSE IN AND TO THE UNIVERSITY DATA:**

1. The parties agree that as between them, all rights including all intellectual property rights in and to the University *Business Confidential* data shall remain the exclusive property of the University, and the Contractor has a limited, nonexclusive license to use these data as provided in this Agreement solely for the purpose of performing its obligations hereunder. This Agreement does not give a party any rights, implied or otherwise, to the other's data, content, or intellectual property, except as expressly stated in the Agreement.

2. *Contractor agrees so long as the term "Business Confidential Data" as it relates to the University means the University identifiable business proprietary data, procedures, materials, lists and systems, but does not include Protected Health Information ("PHI") as defined by HIPAA or other claims-related information.*

L. **SECURITY BREACH:**

1. Response. *Promptly, but not more than ten (10) business days* upon becoming aware of a Security Breach, or of circumstances that resulted in unauthorized access to or

disclosure or use of the University *Business Confidential* Data, the Contractor will notify the University, fully investigate the incident, and cooperate fully with the University's investigation of and response to the incident. Except as otherwise required by law, the Contractor will not provide notice of the incident directly to individuals whose Personally Identifiable Information was involved, regulatory agencies, or other entities, without prior written permission from the University.

2. Liability. In addition to any other remedies available to the University under law or equity, when applicable to the type services being provided, the Contractor will pay for or reimburse the University in full for *that portion of* costs incurred by the University in investigation and remediation of such Security Breach, including but not limited to providing notification to regulatory agencies or other entities as required by law or contract; The Contractor agrees to indemnify, hold harmless and defend the University from and against *that portion of* claims, damages, or other harm *directly* related to such Security Breach.

IX. COMPENSATION AND METHOD OF PAYMENT:

The Contractor shall receive the premium payment directly from the University for those designated as mandatory enrollees. the University charges student accounts for the health insurance fee. Payment to the Contractor will be made mid-semester and end of semester during fall and spring. Summer enrollment is included in spring payment. Those individuals participating in the optional plan shall pay to Provider directly.

The Contractor shall have a website for students to enroll and gather other information needed such as claim forms, etc. A waiver website or portal shall be made available. The website will also have access for the University administrators to monitor payments, track payment history, etc.

X. PRICING SCHEDULE:

All Pricing shall be in accordance with the Contractor's 'Policyholder Application/Rate Proposal Binder' as detailed in Exhibit A. Summary of policy rates are shown below:

Medical Students	Annual Rate 8/01/2024 to 7/31/2025	Fall 8/01/2024 to 12/31/2024	Spring / Summer 01/01/2025 to 7/31/2025
Student Only	$3816.00	$1600.00	$2216.00
Spouse Only	$3816.00	$1600.00	$2216.00
One Child	$3816.00	$1600.00	$2216.00
Two or More Children	$7632.00	$3200.00	$4432.00

In addition, the Contractor will offer a Voluntary Vision and Dental Plans as priced below. Details of each plan coverage is summarized in Exhibit A – Aetna Vision Preferred Plan and Aetna Dental PPO Max Plan

Voluntary Vision Preferred Plan	Annual Rate 8/01/2024 to 7/31/2025
Student Only	$97.00
Spouse	$97.00
One Child	$97.00
Two or More Children	$97.00

Voluntary Dental PPO Max Plan	Annual Rate 8/01/2024 to 7/31/2025
Student Only	$474.00
Spouse	$474.00
One Child	$474.00
Two or More Children	$474.00

IN WITNESS WHEREOF, the parties have caused this Contract to be duly executed intending to be bound thereby.

CONTRACTOR: Aetna Life Insurance Company

By: Damion Ortega

Title: President, Aetna Student Health

Date: 07/30/2024

UNIVERSITY: Old Dominion University

By:

Title: Exe. Dir. of Strategic Sourcing and Payment Solutions

Date: 8/5/2024

Exhibit A

aetna

2024-25 Student Health Insurance Program Proposal

General Information

Aetna Student Health proposes to offer a Student Health Insurance Program to Virginia Health Sciences (VHS) at Old Dominion University ('Policyholder") for the 2024-25 policy year.

State Approval Notice	**All insurance coverage is subject to the terms of the relevant Master Policy and applicable state filings. In case the benefits or any terms described in this Proposal conflict with the relevant Master Policy, the benefits and terms of the Master Policy shall govern. Aetna reserves the right to modify its products, services, and/or premium rates in response to legislation, regulation or requests of government authorities which could result in material changes to enrollment/risk composition or the plan of benefits.**
Policy Effective Dates	8/1/2024 - 7/31/2025

Medical plans are insured by Aetna Life Insurance Company. Aetna PPO Dental® plans are insured by Aetna Life Insurance Company. Dental plan rates are noted below.

Benefit Changes	No Plan Changes
Order of Benefit Determination for this policy	COB (coordination of benefits)

Medical Plan Rates*

Population	Annual Rate
Effective Date	8/1/2024
Termination Date	7/31/2025
Student	**$3,808.00**
Spouse	**$3,808.00**
One Child	**$3,808.00**
Two or More Children	**$7,616.00**

**These rates are solely for the Medical plan and do not include charges for the Travel Assistance Program or other programs purchased, nor any school health clinic or other fee charged by the school.*

Medical Plan rates charged on a per semester basis are included in the attached Medical Plan Rate Addendum.

Quote Conditions	*Please see the Quote Conditions Addendum that is incorporated into this Proposal.*

Payment and Enrollment Terms	*Please see the Payment and Enrollment Terms Addendum that is incorporated into this Proposal.*

Rescissions and Retroactive Termination of Coverage

A request to remove an eligibility record as of the plan effective date, together with documentation of a timely student waiver of coverage or cancellation request and no remittance of premium, shall not be considered a rescission, as it is proof of the member's never having enrolled in the plan. During any open enrollment period, Aetna Student Health will rely on deletion requests submitted by the school as proof of a student's waiver of coverage or cancellation request.

A request to remove an eligibility record where a student has paid the premium and/or used the plan (that is, claims were filed and paid) will generally be handled prospectively. Termination in such cases will generally be effective at the end of the month in which notice is received and premium will be pro-rated accordingly.

Ancillary Products and Programs

Travel Assistance Program (with Medical plan)

Students enrolled in the Medical plan have access to the Travel Assistance Program, which includes Accidental Death and Dismemberment coverage, Medical Evacuation and Repatriation services, Natural Disaster and Political Evacuation services, and other travel-related support. The program is provided through a relationship between Aetna Student Health and the Travel Assistance Provider, On Call International, LLC. Travel assistance services are provided by On Call and AD&D coverage under the program is provided under a blanket accident policy issued by U.S. Specialty Insurance Company dba Tokio Marine HCC.

Population	Annual Rate
Effective Date	8/1/2024
Termination Date	7/31/2025
Student Only	**$8.00**

Aetna and On Call are independent contractors and are not employees or agents of each other. Aetna is not responsible for the services or benefits provided under the Travel Assistance Program. Aetna has the right to replace the Travel Assistance Provider at any time, upon notice to Customer. Aetna receives a portion of the above fee. If you want more information about amounts retained by Aetna or the specific services, coverages and limits under the Travel Assistance Program in general, please contact your account representative.

Aetna Dental® Plan

Population	Annual Rate
Effective Date	8/1/2024
Termination Date	7/31/2025
Student	$474.00
Spouse	$474.00
One Child	$474.00
Per Child	$474.00

Aetna Dental PPO Plan - Dependents
Policyholder will offer Aetna Dental PPO Plan as an option for dependents to purchase on a voluntary basis. Students need to be enrolled in the Dental plan to enroll their dependents.

The availability of the Aetna Dental PPO Plan will be included on the Aetna Student Health/Policyholder web page. This plan can be purchased only during the open enrollment period of the student accident & sickness plan.

Aetna Dental DMO Plan - Dependents
Policyholder will offer Aetna Dental DMO Plan as an option for dependents to purchase on a voluntary basis. Students need to be enrolled in the Dental plan to enroll their dependents.

The availability of the Aetna Dental DMO Plan will be included on the Aetna Student Health/Policyholder web page. This plan can be purchased only during the open enrollment period of the student accident & sickness plan.

Aetna Vision[SM] Preferred Plan

Population	Annual Rate -
Effective Date	8/1/2024
Termination Date	7/31/2025
Student	$97.00
Spouse	$97.00
One Child	$97.00
Per Child	$97.00

Policyholder will offer the Aetna Vision Preferred Plan as an option for students to purchase on a voluntary basis. Students do not need to be enrolled in the Medical plan to enroll in Vision. The availability of the Aetna Vision Preferred Plan will be included on the Aetna Student Health/Policyholder web page. This program can be purchased through 08/14/2025 (this fee remains the same no matter when the program is purchased). Certain claims administration services under the vision plan are provided by First American Administrators, Inc., and

	certain network administration services are provided through EyeMed Vision Care, LLC.
Total Student Charges	

Population	Annual Rate -
Effective Date	8/1/2024
Termination Date	7/31/2025
Student	**$3,816.00**

**These amounts reflect the total charges for students who enroll in the Medical Plan, including optional programs purchased by the school such as the Travel Assistance Program.*

IMPORTANT INFORMATION

Except for members of the CVS Health family of companies (which includes CVS Pharmacy, CVS Caremark Mail Service Pharmacy, MinuteClinic and CVS Specialty Infusion Services), all other participating providers and vendors are independent contractors and are neither agents nor employees of Aetna or its affiliates. We cannot guarantee the availability of any particular provider outside of our corporate family and the providers in our network may change.

By signing below, Aetna agrees to issue, and Policyholder agrees to accept, the Student Health Insurance Program set forth in the foregoing Proposal, including the addenda incorporated therein.

Aetna Life Insurance Company
By (signature): Walter Jones
Printed Name: Walter M. Jones
Title of Client Services Representative: Account Manager
Date: 07/02/2024

By (signature): Alison Dube
Printed Name: Alison Dube
Title of Underwriting Department Representative: Underwriting Manager Date: 07/02/2024

Virginia Health Sciences (VHS) at Old Dominion University
By (signature): Etta Henry
Printed Name: Etta Henry
Title: Executive Director of Strategic Sourcing and Payment Solutions
Date: 8/2/2024

Original or Revision? **Original**

Addendum #1

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2024-25 Student Health Insurance Program Proposal Addendum Payment and Enrollment Terms

Payment Administration Information

Payment and Administrative Terms

1. Membership Calculations – Invoices will be generated by Aetna Student Health based on enrolled membership and information provided as of the invoice preparation date.

   a. Invoices after the initial invoice will reflect any debits or credits applicable to reflect updates to membership data received *since* the date of the *preceding* invoice.
   b. Any adjustments necessary to reflect updated membership information received *after* an invoice generation date will be reflected on the invoice for the *following* payment period.
   c. Policyholder agrees to pay the amounts indicated on each invoice in accordance with the terms of section 3, below, and without further adjustment for information received after the date of the relevant invoice. As indicated above, such information will be reflected in debits or credits applied to the invoice for the following payment period.
   d. No updates to enrollment data will be accepted more than 30 days after the end of the plan year.

2. Invoice Timing –

   a. Aetna Student Health will generate the initial invoice within 90 days of the plan effective date.
   b. Subsequent invoices will be generated at regular intervals (not less than quarterly).
   c. The final invoice will be generated 30 days after the end of the plan year.

3. Payment Terms –

   a. Invoices prior to final invoice – Payment of not less than 95% of the invoice amount within 30 calendar days of the invoice date shall be required in order keep your account current.
   b. The amount indicated on the final invoice is required to be paid in full within 30 calendar days of the invoice date.
   c. Late fees may be charged, as set forth in the Master Policy.

	4. Voluntary Members – No voluntary members will be enrolled in the Plan until Aetna Student Health has received the full applicable premium amount for such student.

Enrollment Information and Requirements

Enrollment and Student Address Information

Policyholder specifically understands and acknowledges that the timely receipt of accurate enrollment information, including, but not limited to, a current U.S. address for each student, is necessary for the proper and timely payment of claims and the distribution of explanations of benefits, appeals and other important plan information. Policyholder agrees that current enrollment and address information for each covered student/dependent will be provided to Aetna Student Health by the student's effective date, but not more than 60 days after the student's effective date. School specifically agrees to be responsible for, and to hold Aetna Student Health and its affiliates harmless from, any and all claims and causes of action arising out of Policyholder's failure to provide this information in a timely manner.

NOTE: A general school address (such as the address of the student health center) is NOT an acceptable substitute for a current student address.

Student Enrollment

Student Enrollment Group (Undergraduate, Graduate, International)	Enrollment Method (Waiver, Voluntary Direct Pay, or Voluntary Bursar Billed)
All Medical Student s	Hardwaiver

Dependent Enrollment:

Student Enrollment Group (Undergraduate, Graduate, International)	Enrollment Method (Waiver, Voluntary Direct Pay, or Voluntary Bursar Billed)
All Dependents	Voluntary

Waiver Program Information

Waiver Requirements

The rates for the 2024-25 policy year are explicitly conditioned on the application of the following waiver criteria:

- Does your insurance provide unlimited accident/illness coverage for each injury or sickness?
- Does your insurance provide accident/illness coverage of at least $500,000 for each injury or sickness?
- The plan provides both emergency and non-emergency health care and mental health care benefits in the Hampton Roads area.
- The plan has participating hospitals, physicians, pharmacies, and mental health care providers in the Hampton Roads area.

- Your plan has local participating hospitals, physicians, pharmacies and mental health care providers within a 50 mile radius of campus.
- Does your plan cover Hospital room, board, hospital service, physician fees (office visit or hospital care), surgeon's fees, ambulance, outpatient services and fees?
- Does your plan provide access to primary care doctor's office visits? Policies stating coverage for emergency only and/or reimbursable expenses will not be accepted.
- Does your plan provide access to primary care doctor's office visits? Policies stating coverage for emergency only and/or reimbursable expenses will not be accepted.

Addendum #2

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2024-25 Student Health Insurance Program Proposal Addendum Quote Assumptions & Conditions

Key Assumptions

Our quoted rates are proposed for the first 12 months of the policy period and are valid as of the policy effective date. The quoted rates apply only to the benefit levels and conditions specified in the proposal and any variations in benefit level or quotation conditions may require a rate change.

We have the right to change our rates if certain key assumptions used in the rating process materially change even after final rates are released. While this is not a comprehensive list of financial conditions that could result in a change in or proposal, the following are the key factors that could require Aetna to adjust or terminate this proposal:

- A change in eligible students of 10% or more.
- Enrollment Process Assumptions
- *Medical School Students: Hard Waiver and Proof of Comparable Coverage*
- A change in enrolled students of 10% or more. We have assumed 394 students to be enrolled for the 2024-25 policy period.
- Failure to enforce hard waiver requirements.
- A change in the enrolled member to student ratio of 3% as of this renewal the ratio is 1.0207.
- An actual or expected change in the demographic or other mix of students (domestic, international, graduate, undergraduate, full-time, dependent enrollment, etc.) from that assumed at the

	time rates are established that could materially impact per capita claim costs by 3% or more. • Any change in the school's eligibility requirement for minimum number of credit hours from the previous policy year. Also, any change in the requirement that eligible students must be matriculated at the school or university. • A change in the graduate assistant contribution strategy that could materially impact participation or adverse selection. • A change in the policy situs state. • The school's financial condition is unsound and, in our judgement, puts the school at risk of default on its obligations under the policy.
Enrollment Period	Our rates assume one Fall open enrollment for a twelve-month coverage period, that students planning a December graduation may enroll for the Fall semester only and new students starting in the Spring semester may enroll for the Spring semester only. Otherwise, students may enroll outside of open enrollment only if they experience a qualifying life event.
Medicare Eligibility	Federal law prohibits us from enrolling students who are entitled to benefits under Part A (having qualified for Part A with no additional premiums necessary) or enrolled in Part B or Premium Part A upon the policy effective date. These individuals are not eligible to enroll in the Student Health plan. This Student Health Plan is not a Medicare replacement plan nor a Medicare supplement plan. Students who have Medicare at the policy effective date are not allowed to enroll in this plan.
Plan Offering	Our quote assumes that that Aetna will be the sole vendor for all types of student medical coverage offered during the twelve-month school year.
Student Health Center Services	The enclosed premium rates assume the scope, cost, and utilization of health center services will not change materially for the current school year from that of the previous school year (the experience year primarily used to develop the enclosed premiums) unless mutually agreed upon in specific, documented terms by Policyholder and Aetna. The enclosed premium rates assume the Student Health Center Provider Fee Schedule and Billing Terms will not increase by more than a 5% annual average compared to the previous school year.
Summaries of benefits and coverage (SBC)	Federal law requires the SBC to include statements about whether the plan or coverage provides minimum essential coverage and the plan's actuarial value. The quoted Medical plan has a Minimum Value that is greater than 60%.
Massachusetts Minimum Creditable Coverage	Under the Massachusetts Health Care Reform Act, most Massachusetts residents 18 years or older must carry health insurance that meets specific standards called Minimum Creditable Coverage (MCC). MCC establishes the lowest health plan benefit threshold an individual must have in order to meet the requirement for Massachusetts residents to have health insurance. Regulations defining minimum creditable coverage have been established by the Commonwealth Health Insurance Connector Authority Board effective

	January 1, 2009. Specific additions were added to the MCC standards for 2014. Members will get a MA 1099-HC form from Aetna stating if the plan meets these standards. If the plan does not meet the standards, the members will have to pay a penalty tax.
Contraceptive Coverage	Certain schools may be eligible for an exemption from the federal requirement to cover contraceptive services, without cost sharing, as an essential health benefit (Some state mandated benefit laws, however, might not permit an exemption.) If you qualify and want to be treated as exempt, please work with your Account Executive to provide the required documentation to us. We have the right to treat fully insured plans as subject to the ACA contraceptive services coverage requirements without an executed exemption certification document.
Quote Conditions	This quote is intended to comply with applicable state and federal law. If, however, there is a conflict, then state and federal laws and regulations take precedence over the quote conditions. Aetna reserves the right to modify products, services, rates, and fees in response to legislation, regulation or requests of government authorities resulting in changes to plan benefits, claim payment requirements, or any other changes affecting the manner or cost of paying benefits, even if no benefit or plan changes are mandated. We reserve the right to recoup any material fees, costs, assessments, or taxes due to changes in the law or regulatory action. If any of the above conditions are not met and maintained, we may, in accordance with applicable federal and state law, decline not to renew coverage after this proposal year. By accepting and signing the final Proposal, you (the school) stipulate that you have read, understand, and agree with each and every condition associated with this quote.

Exhibit B

Aetna Student Health
Plan Design and Benefits Summary

Preferred Provider Organization (PPO)

Eastern Virginia Medical School

Policy Year: 2024–2025
Policy Number: 686196
https://www.aetnastudenthealth.com
(800) 954-5799

This is a brief description of the Student Health Plan. The plan is available for Eastern Virginia Medical School students and their eligible dependents. The plan is insured by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at https://www.aetnastudenthealth.com. If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

EVMS Student Site

The EVMS Student Wellness Program is made up of four separate parts consisting of the primary healthcare, student mental health, occupational health and voluntary health insurance offered through Aetna Student Health. Primary healthcare, which is covered by your student fees and is offered independently from your health insurance, is supported by the EVMS Student Site.

The EVMS Student Health Insurance plan is offered by Aetna Student Health, underwritten by Aetna Life Insurance Company (Aetna).

Coverage is effective August 1 of each academic year and continues through July 31.

Each year, all full-time registered students are automatically enrolled in the EVMS Student Health Insurance Plan, and their student accounts are charged for the premiums unless the online waiver is completed attesting that comparable coverage is in place.

Those students who wish to waive the Student Health Insurance must do so by completing the online Student Health Insurance Waiver at https://www.aetnastudenthealth.com. An online waiver must be completed each academic year.

Student Health Insurance Waiver Information

Students that wait until the end of the waiver period to be default-enrolled will not be able to create an account with Aetna Student Health or print an insurance card until the end of the waiver period. At the close of the waiver period, a report will be provided to Financial Services, and student accounts will be adjusted accordingly.

If a student fails to complete the waiver or is denied due to inadequate existing coverage, the fee will stand, and the student will be covered by the Aetna Student Health Insurance plan.

Who is eligible?

All on campus Eastern Virginia Medical School Students who are registered and taking full-time credit hours are automatically enrolled in this insurance plan at registration, unless proof of comparable coverage is furnished.

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective. You cannot meet this eligibility requirement if you take courses through:

- Home study
- Correspondence
- The internet
- Television (TV).

Dependent Coverage Eligibility

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

Coverage Periods

Students: Coverage for all insured students enrolled for the Annual Coverage Period, will become effective at 12:00 AM on **August 1, 2024,** and will terminate at 11:59 PM on **July 31, 2025**.

New Spring Semester students: Coverage for all insured students enrolled for the Spring Semester, will become effective at 12:00 AM on **January 1, 2025,** and will terminate at 11:59 PM on **July 31, 2025**.

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

Eligible Dependents: Coverage for dependents eligible under the Plan for the following Coverage Periods. Coverage will, will become effective at 12:00 AM on the Coverage Start Date indicated below **August 1, 2024**, and will terminate at 11:59 PM on the Coverage End Date indicated **July 31, 2025**. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as a Brokers fee.

2024-2025 Rates

	Annual	New Spring Student only
Student	$3,816.00	$2,216.00
Spouse	$3,816.00	$2,216.00
One Child	$3,816.00	$2,216.00
Two or More Children	$7,632.00	$4,432.00

*This premium includes the travel assistance program

Dependent Enrollment

Dependent coverage is purchased directly through Aetna Student Health and is not billed thru the Student Disbursement Account.

To enroll online, log on to https://www.aetnastudenthealth.com and search for your school, then click on the Enroll link to enroll your dependent(s).

To enroll the dependent(s) of a covered student using a paper application, please contact customer service at 1-800-954-5799 to request an Enrollment Form to be sent by email, fax or in the mail. Payment and completed application must be sent to the address on the form. Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. An example of a significant life change would be loss of health coverage under another health plan. The completed Enrollment Form and premium must be sent to Aetna Student Health.

In addition, Aetna Student Health offers a dental plan that can be purchased separately through Aetna Student Health. To enroll in the dental plan online, log on to https://www.aetnastudenthealth.com and search for your school, then click on the Enroll link and select the dental plan option to enroll in the dental plan.

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

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

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

- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - To keep your stepchild covered, we must receive your completed enrollment information within 31 days after the date of your marriage or your Declaration of Domestic Partnership.
  - You must still enroll the stepchild within 31 days after the date of your marriage or your Declaration of Domestic Partnership even when coverage does not require payment of an additional premium contribution for the stepchild.
  - If you miss this deadline, your stepchild will not have health benefits after the first 31 days.
  - If your coverage ends during this 31-day period, then your stepchild's coverage will end on the same date as your coverage. This applies even if the 31-day period has not ended.

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

- A foster child – A foster child is covered on your plan for the first 31-day period after obtaining legal responsibility as a foster parent. A foster child is a child whose care, comfort, education and upbringing are left to persons other than the natural parents.
  - To keep your foster child covered, we must receive your completed enrollment information within 60 days after the date the child is placed with you.
  - If you miss this deadline, your foster child will not have health benefits after the first 31-day period.
  - If your coverage ends during this 31-day period, then your foster child's coverage will end on the same date as your coverage. This applies even if the 31-day period has not ended.

If you need information or have general questions on dependent enrollment, call Member Services at 1-800-954-5799.

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. 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. For emergency services, precertification is not required, but you should still notify us within the timeframes listed below. That includes an emergency interhospital transfer for a life-threatening condition for a newborn and for the mother to accompany the newborn.

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 admission	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

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

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 Virginia 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	$350 per policy year	$700 per policy year
Spouse or domestic partner	$350 per policy year	$700 per policy year
Each child	$350 per policy year	$700 per policy year
Family	$700 per policy year	$1,400 per policy year
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network care for Preventive care and wellness, Pediatric dental Type A services, and Pediatric vision care services, and outpatient prescription drugs • In-network care and out-of-network care for Well newborn nursery care and Hearing aids for minors		
Individual deductible 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. This policy year deductible applies separately to you and each of your covered dependents. 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.		
Family deductible This is the amount you and your covered dependents 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 and your covered dependents pay for eligible health services reaches this family policy year deductible, this plan will begin to pay for eligible health services that you and your covered dependents incur for the rest of the policy year. To satisfy this family policy year deductible limit for the rest of the policy year, the following must happen: • The combined eligible health services that you and each of your covered dependents incur towards the individual policy year deductibles must reach this family policy year deductible limit in a policy year. When this occurs in a policy year, the individual policy year deductibles for you and your covered dependents will be considered to be met 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	$6,250 per policy year	$10,000 per policy year
Spouse or domestic partner	$6,250 per policy year	$10,000 per policy year
Each child	$6,250 per policy year	$10,000 per policy year
Family	$12,500 per policy year	$15,000 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.		

Description	**In-network coverage**	**Out-of-network coverage**
Preventive care and wellness		
Routine physical exam	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Routine physical exam limits for covered persons through age 21: maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Routine physical exam limits for covered persons age 22 and over: maximum visits per policy year	1 visit	
Preventive care immunizations		
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	Not covered
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.		

Description	In-network coverage	Out-of-network coverage
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	Not covered
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	Not covered
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	

Description	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	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Routine cancer screening maximums	Subject to any age, family history and frequency guidelines as set forth in the most current: • Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF • 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 maximums	1 screening every 12 months	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Lactation counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
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	Not covered
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	

Description	In-network coverage	Out-of-network coverage
Family planning services – female contraceptives (continued)		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit (a 12-month supply of hormonal contraceptives will be covered under the plan when dispensed or furnished at one time)	100% (of the negotiated charge) per item No copayment or policy year deductible applies	Not covered
Female voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	50% (of the recognized charge)
Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	50% (of the recognized charge)
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)	$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	50% (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	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 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

Description	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 anesthesiologist, anesthetist and surgical assistant expenses)	80% (of the negotiated charge)	50% (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 anesthetic unless approved by the plan as medically necessary		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthesiologist, anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	50% (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 unless approved by the plan as medically necessary		
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	50% (of the recognized charge) per visit
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Preadmission testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit

Description	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)	50% (of the recognized charge)
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • 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 unless approved by the plan as medically necessary		
Home Health Care	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
The following are not covered under this benefit: • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities) • Transportation • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy		
Hospice - Inpatient	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Hospice - Outpatient	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
The following are not covered under this benefit: • Funeral arrangements • Pastoral counseling • Financial or legal counseling which includes estate planning and the drafting of a will • Services which are not related to your care and may include: - Sitter or companion services for either you or other family members except for respite care - Transportation - Maintenance of the house		
Skilled nursing facility - Inpatient	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission

Description	In-network coverage	Out-of-network coverage
Emergency services and urgent care		
Hospital emergency room	$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
The following are not covered under this benefit: • Non-emergency services in a hospital emergency room facility		
Hospital Emergency Room - 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 or call Member Services for an address at 1-800-954-5799 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.		
Urgent care	$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	$50 copayment then the plan pays 50% (of the balance of the recognized charge) per visit
Non-urgent use of an urgent care provider	Not covered	Not covered
The following is not covered under this benefit: • Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)		

Description	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	50% (of the recognized charge) per visit
Type B services	80% (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
- 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
- Crowns to alter vertical dimension
- Dental implants and braces (that are determined not to be medically necessary) and mouth guards (not including an occlusal guard for grinding and clenching of teeth)
- 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 or pre-medication
- 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, except when medically necessary
- Treatment by other than a dental provider

Description	In-network coverage	Out-of-network coverage
Specific conditions		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Podiatric (foot care) treatment Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Services and supplies for: - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet		
Impacted wisdom teeth	80% (of the negotiated charge)	50% (of the recognized charge)
Adult dental care for cancer treatments	80% (of the negotiated charge)	50% (of the recognized charge)
Accidental injury to sound natural teeth	80% (of the negotiated charge)	50% (of the recognized charge)
Covered services do not include an injury that results from chewing or biting.		
Bones or joints of the head, neck, face, or jaw treatment-Jaw joint disorder, 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		
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Services and supplies related to data collection and record-keeping that is not used in the direct clinical management of the patient • Services and supplies provided by the trial sponsor without charge to you • Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis • 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)		
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		

Description	In-network coverage	Out-of-network coverage
Specific conditions (continued)		
Obesity (Bariatric) Surgery and services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Obesity (Bariatric) Surgery and services – Exclusions: Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Eligible health services and exclusions – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are: • Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications • Hypnosis or other forms of therapy • Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement		
Oral 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
Maternity care (includes delivery and postpartum care services) Coverage is provided under the same terms, conditions as any other illness.	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, except for home delivery by a certified nurse midwife, or in any other place not licensed to perform deliveries		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	50% (of the recognized charge) No policy year deductible applies
Care and treatment for the Newborn to correct functional impairment caused by congenital defects and birth abnormalities (including inpatient and outpatient dental services, dental appliances, oral surgical, and orthodontic services that are medically necessary for the treatment of cleft lip, cleft palate or ectodermal dysplasia)	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	80% (of the negotiated charge)	50% (of the recognized charge)
Voluntary sterilization for males - Outpatient physician or specialist surgical services	80% (of the negotiated charge)	50% (of the recognized charge)
The following are not covered services: • Reversal of voluntary sterilization procedures, including related follow-up care		

Description	In-network coverage	Out-of-network coverage
Family planning services – other (continued)		
Abortion - Inpatient physician or specialist surgical services	80% (of the negotiated charge)	50% (of the recognized charge)
Abortion - Outpatient physician or specialist surgical services	80% (of the negotiated charge)	50% (of the recognized 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		
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 There are no visit limits for any eligible health services to diagnose or treat autism spectrum disorder.		
Autism spectrum disorder treatment, diagnosis, and testing. Includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Behavioral Health & Substance related disorders treatment		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies Coverage is provided under the same terms, conditions as any other illness	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Outpatient office visits (includes telemedicine consultations)	$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	50% (of the recognized charge) per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program) (includes skilled behavioral health services in the home)	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit

Description	In-network coverage (IOE facility)	Out-of-network coverage (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Transplant services		
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received	
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received	
Transplant services – travel and lodging	Covered	

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

Description	In-network coverage	Out-of-network coverage
Infertility services		
Treatment of basic infertility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Infertility services exclusions

The following are not covered under the infertility services benefit:

- All infertility services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
- Intrauterine (IUI)/intracervical insemination (ICI) services.
- 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 when the surrogate is not a covered person under your plan. 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.

Description	In-network coverage	Out-of-network coverage
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge)	50% (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)	50% (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)	50% (of the recognized charge)
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Outpatient infusion therapy (including medical formulas) 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		
Outpatient physical, occupational, speech (including speech language therapies) and cognitive therapies (including Cardiac and Pulmonary Therapy)	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Early intervention services include speech and language therapy, physical and occupational therapies and assistive technology services and devices Limited to covered dependents to age 3 No visit limit applies for physical, occupational or speech therapy 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
Spinal manipulation chiropractic, osteopathic, and manipulation services Includes rehabilitation and habilitation services	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	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

Description	In-network coverage	Out-of-network coverage
Other services		
Acupuncture	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
The following is not covered under this benefit: • Acupressure		
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient care		
Durable medical and surgical equipment including supplies and equipment needed for the use of DME	80% (of the negotiated charge) per item	50% (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		
Lymphedema	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Nutritional support	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
The following are not covered under this benefit: • Any other 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, if the item can be obtained over-the-counter and without a written prescription		
Orthotics	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
Cochlear implants	80% (of the negotiated charge) per item	50% (of the recognized charge) per item

Description	In-network coverage	Out-of-network coverage
Other services (continued)		
Prosthetic Devices & Cranial prosthetics *(Medical wigs)* after cancer treatment	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
Cranial prosthetics *(Medical wigs)* maximum per policy year	1 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 for minors		
Hearing aids for minors	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per item No policy year deductible applies
Hearing aids for minors maximum	Coverage is limited to 1 hearing aid per hearing-impaired ear every 24 months up to $1,500 per hearing aid. Covered services are for children 18 years of age or younger.	
The following are not covered services: • Replacement of a hearing aid that is lost, stolen, or damaged through neglect • Replacement parts or repairs for a hearing aid • Batteries after the initial is provided or cords • A hearing aid that does not meet the specifications prescribed for correction of hearing loss		
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 & fitting of contact exam)	100% (of the negotiated charge) per visit No policy year deductible applies	50% (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	
Vision correction after surgery or accident	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: • Eyeglass frames, prescription lenses or prescription contact lenses that are not related to a surgery or accidental injury		

Description	In-network coverage	Out-of-network coverage
Pediatric vision care (continued) **(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	50% (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 standard single vision, bifocal, trifocal, or progressive prescription lenses Daily disposables: up to 3-month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maximum number of optical devices per policy year	One optical device	
***Important note:** Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.		
The following are not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		
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	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	

Description	In-network coverage	Out-of-network coverage
Adult vision care (continued) **Limited to covered persons age 19 and over**		
Vision correction after surgery or accident includes eyeglasses or contact lenses and fitting	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: • Eyeglass frames, prescription lenses or prescription contact lenses that are not related to a surgery or accidental injury		
The following are not covered under this benefit: Adult vision care • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes 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 • Eye exams for contact lenses or their fitting • Eyeglasses or duplicate or spare eyeglasses or lenses or frames • 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		

Outpatient prescription drugs
Outpatient prescription drug 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 and out-of-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.
Outpatient prescription drug 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 drug 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.

Description	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	$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	$90 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	$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered

Description	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	$65 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	$195 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	$65 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	$195 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Diabetic insulin		
30-day supply filled 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 filled 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
Important note: Your cost share will not exceed $50 per 30-day supply of a covered prescription insulin drug filled at a network pharmacy. No deductible applies for insulin.		
Orally administered anti-cancer prescription drugs For each fill up to a 30-day supply filled at a specialty pharmacy or retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies

Description	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
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
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.	

Description	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Contraceptives (birth control)		
For each fill up to a 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	Not covered
For each fill up to a 12-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	Not covered

Outpatient prescription drugs important note:

If a prescriber prescribes a covered brand-name prescription drug where a generic prescription drug equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost sharing for the brand-name prescription drug. If a prescriber does not specify DAW and you request a covered brand-name prescription drug where a generic prescription drug equivalent is available, you will be responsible for the cost difference between the brand-name prescription drug and the generic prescription drug, plus the cost sharing that applies to the brand-name prescription drug. The cost difference related to a prescription drug that is not specified as DAW is not applied towards your policy year deductible or maximum out-of-pocket limit.

Outpatient prescription 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, except as covered in the Physician services section
- Any services related to providing, injecting or application of a drug
- Compounded prescriptions when there is not at least one ingredient for which a prescription is needed, when there is a copy of a commercially available drug product and compounds
- 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 where described in the 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, except where stated above
  - 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
  - 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

(continued on next page)

Outpatient prescription drug exclusions (continued)

The following are not eligible health services:

- Drugs or 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
- 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 as specifically provided for in the Off-label use section
- 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.

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

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

This exclusion does not apply when services are medically necessary and you incur a charge for the expense or to blood products for treatment of hemophilia and congenital bleeding disorders including, but not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.

Cardiac rehabilitation
- Services for home programs, on-going conditioning, and maintenance care

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

Cornea or cartilage transplants
- Cornea (corneal graft with amniotic membrane)
- Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

Cosmetic services and plastic surgery
- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body.

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

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

Custodial care

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

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care except in connection with hospice care, adult (or child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training
- For behavioral health (mental health treatment and substance use disorders treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care
  - Services given mainly to:
    - o Provide a place free from conditions that could make your physical or mental state worse

This exclusion does not apply to services covered in the *Hospice care* section.

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 apply to services under the *Adult dental care, Oral surgery,* and *Additional dental care for children and adults* sections.

Educational services

Examples of these services are:

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

Examinations

Except as covered under the *Preventive care and wellness* section, health or dental examinations needed:

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

Experimental or investigational

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

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 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
Unless there is evidence that the member meets one or more clinical criteria detailed in our precertification and clinical policies:
- 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

Hearing aids
Except as covered in the *Durable medical equipment (DME)* and *Hearing aids for minors* sections, any tests, appliances and devices to:
- Improve your hearing
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Hearing exams
- Hearing exams performed for the evaluation and treatment of illness, injury, or hearing

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.

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 and services for the treatment of autism spectrum disorder

Medical supplies – outpatient disposable over-the-counter items
- Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Other home test kits
  - Compresses

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, terminated it or did not make a proper request for it

Non-medically necessary services
- Services we determine are not medically necessary. This includes services that do not meet our clinical policy bulletin guidelines.

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

Other primary payer
- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer This exclusion does not apply to laws that make the government program the secondary payer after benefits under this policy have been paid. See the *Coordination of benefits (COB)* section for details.

Outpatient prescription or non-prescription drugs and medicines
- Outpatient prescription drugs or non-prescription drugs and medicines provided by the policyholder

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

Private duty nursing in an inpatient setting

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

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

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

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

the policyholder.

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

Services provided by a family member
- Services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, or in-law.

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

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
Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, services, devices, supplies or facilities used for physical fitness, even if ordered by a physician.

Therapies and tests
- Full body CT scans unless 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, 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 as part of your training
- Any services and supplies provided to a covered student who receives treatment from a provider as part of their training

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 Eastern Virginia Medical School 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 1-800-954-5799.

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 1-800-954-5799.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-800-954-5799.

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 **1-800-954-5799** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-954-5799** (TTY: **711**).

አማርኛ/Amharic

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-800-954-5799** (መስማት ለተሳናቸው: **711**).

العربية/Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-954-5799** (رقم الهاتف النصي: **711**).

Bàsɔ̀ɔ̀ Wùqù/Bassa

Dè dɛ nìà kɛ dyeɖeˈ gbo: ɔ juˇ keˈ m̀ dyi Bàsɔ̀ɔ̀-wùqù-po-nyɔ̀ juˇ niˇ, nìiˇ à wuqu kà kò qò po-poɔ̀ bɛ́ m̀ gbo kpaˈa. Ɓaˈ **1-800-954-5799** (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 **1-800-954-5799** (TTY: **711**)。

فارسی/Farsi

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-800-954-5799** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d'une assistance gratuite dans votre langue en composant le **1-800-954-5799** (TTY: **711**).

ગુજરાતી/Gujarati

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે. કૉલ કરો **1-800-954-5799** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-954-5799** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-954-5799** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-800-954-5799** (TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-800-954-5799** (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 **1-800-954-5799** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-954-5799** (TTY: **711**).

اردو/Urdu

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں - **1-800-954-5799** (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 **1-800-954-5799** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-800-954-5799** (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).