CONTRACT MODIFICATION AGREEMENT

Date: June 30, 2026

Contract No.: 24-ODU-05-CCC – Health Insurance for International, Graduate, & Medical Students

Modification No.: 2

Issued By: OLD DOMINION UNIVERSITY
Department of Procurement Services
4401 Powhatan Avenue, Suite 111
Norfolk, VA 23529-0308

Contractor: Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

This Contract Modification Agreement is entered into pursuant to Section VI, "General Terms and Conditions", Paragraph G. "Changes to the Contract" (page 8), as follows:

DESCRIPTION OF MODIFICATION:

The parties agree to clarify the Contractor's revised Policyholder / Rate Binder, dated June 10, 2026 for academic policy year 2026/2027. The Agreement is hereby amended in accordance with the attached documents herein labeled as "Policyholder / Rate Binder", for academic policy year 2026/2027.

Enclosed
- Aetna's Policyholder / Rate Binder, policy year – 2026-2027 for Subsidized & Non-Subsidized Domestic Graduate Students, International Students, and Medical & Professional Health Students From VHS at $3,341.00/year/student;
- Aetna's Voluntary Dental PPO Max Plan at $384.00/year/student;
- Aetna's Voluntary Vision Preferred Plan at $97.00/year/student;
- Aetna's Plan Design and Benefit Summary, Policy #246802, Policy Year – '26-'27.

The parties agree to renew this agreement for the period of August 1, 2026 to July 31, 2027 subject to the prices, terms and conditions as stated in this contract.

Except for the changes provided herein, all other terms and conditions of the Agreement remain unchanged and in full force and effect, as originally submitted, negotiated and agreed.

OLD DOMINION UNIVERSITY

By: _____
(Chad A. Reed)

Title: **Vice President for Finance and Chief Financial Officer**

Date: July 16, 2026

2026-27 Student Health Insurance Program Proposal

General Information	
Aetna Student Health proposes to offer a Student Health Insurance Program to Old Dominion University ('Policyholder") for the 2026-27 policy year.	
State Approval Notice	***All insurance coverage is subject to the terms of the relevant Master Policy and applicable state filings. To the extent any term or condition described in this Proposal conflict with the relevant Master Policy, the terms and conditions of the Master Policy shall control. Aetna reserves the right to modify our 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	**8/1/2026 - 7/31/2027**
Medical plans are insured by Aetna Life Insurance Company. Aetna PPO Dental® and Aetna Vision Preferred plans are insured by Aetna Life Insurance Company. Dental and vision insurance rates are noted below.	
Benefit Changes	1) OOP Max $10,600/$21,200 2) RX Copays $30/$75/$150
Order of Benefit Determination for this policy	COB (coordination of benefits)
Medical Plan Rates*	

Population	Annual Rate
Effective Date	8/1/2026
Termination Date	7/31/2027
Student	**$3,333.00**
Spouse	**$3,333.00**
One Child	**$3,333.00**
Two or More Children	**$6,666.00**

**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.*

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	8/1/2026
Termination Date	7/31/2027
Student Only	$8.00
Spouse	$8.00
One Child	$8.00
Two or More Children	$16.00

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® PPO Max Plan

Population	Annual Rate
Effective Date	8/1/2026
Termination Date	7/31/2027
Student	$384.00
Spouse	$384.00
One Child	$384.00
Two or More Children	$768.00

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 health plan.

Enrollment in the Dental plan is available only to students enrolled in the student health plan.

Aetna Vision℠ Preferred Plan

Population	Annual Rate
Effective Date	8/1/2026
Termination Date	7/31/2027
Student	$97.00
Spouse	$97.00
One Child	$97.00
Two or More Children	$194.00

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 student health 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 09/30/2026 for Fall and 02/15/2027 for Spring (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 - all students
Effective Date	8/1/2026
Termination Date	7/31/2027
Student	**$3,341.00**
Spouse	**$3,341.00**
One Child	$3,341.00
Two or More Children	$6,682.00

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. Providers are not available in all locations, and we cannot guarantee the availability of any specific provider. The providers within 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): Tracey Rosenberry
Printed Name: Tracey Rosenberry
Title of Client Services Representative: Account Executive
Date: 6/10/2026

By (signature): Alison Dube
Printed Name: Alison Dube
Title of Underwriting Department Representative: Underwriting Manager
Date: 06/10/2026

Old Dominion University
By (signature):
Printed Name: Chad A. Reed
Title: VP for Finance and Chief Financial Officer
Date: 7/16/2026

Original or Revision? **Original**

Addendum #1

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2026-27 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 enrollee's effective date, but not more than 60 days after the enrollee'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 enrollee address.

Student Enrollment

Student Enrollment Group (Undergraduate, Graduate, International)	Enrollment Method (Waiver, Voluntary Direct Pay, or Voluntary Bursar Billed)
Domestic Graduates	Voluntary Direct Pay
International	Mandatory
Medical, Domestic Health Professional, Nursing	Waiver

Dependent Enrollment:

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

Waiver Program Information	
Waiver Requirements	The rates for the 2026-27 policy year are explicitly conditioned on the application of the following waiver criteria: -Plan provides unlimited accident/illness coverage for each injury or sickness. -Plan provides 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. -The plan provides coverage for prescription medications. -Plan covers Hospital room, board, hospital service, physician fees (office visit or hospital care), surgeon's fees, ambulance, outpatient services and fees. -Plan provides access to primary care doctor's office visits. Policies stating coverage for emergency only and/or reimbursable expenses will not be accepted.

Addendum #2

2026-27 Student Health Insurance Program Proposal Addendum Quote Assumptions & Conditions

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Key Assumptions

Our quoted rates are proposed for the dates 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
- ***International Students: Mandatory***
- ***Medical, Domestic Health Professional, Nursing Students: Hard Waiver and Proof of Comparable Coverage***
- ***Domestic Graduate Students: Voluntary***
- A change in enrolled students of 10% or more. We have assumed 1,059 students to be enrolled for the 2026-27 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 1.0222.
- 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 specified 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 are enrolled in 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 Summary of Benefits and Coverage (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.

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

Old Dominion University

Policy Year: 2026–2027
Policy Number: 246802
https://www.aetnastudenthealth.com
(800) 954-5799

This is a brief description of the Student Health Plan. The plan is available for Old Dominion University 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.

Who is eligible?

All degree seeking graduate students enrolled at Old Dominion University's main campus, one of ODU's higher education centers, or online students within a 50-mile radius of the main campus are eligible to enroll in this insurance plan. All students who are F-1 and J-1 international students are automatically enrolled in this insurance plan at registration and the premium for coverage is added to their tuition billing. Hard waivers are approved by the Visa & Immigration Service Advising Office. J-1 Scholars and F-1s on OPT are eligible to enroll. In addition, individuals in post-doctoral positions hired by Old Dominion University are eligible to enroll in this insurance plan.

The student (Named Insured as defined in this certificate) must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study and correspondence courses do not fulfill eligibility requirements that the student actively attends classes. The Company maintains its right to investigate eligibility for student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the company discovers that the Policy availability requirements have not been met, its only obligation is a refund of premium.

Eligible students who enroll may also insure their Dependents. Eligible Dependents are the students' legal spouse and dependent children under 26 years of age. Dependent enrollment will take place via the Aetna Voluntary enrollment site https://www.aetnastudenthealth.com.

The eligibility date for Dependents of the Named Insured shall be determined in accordance with the following:

1. If a Named Insured has Dependents on the date, he or she is eligible for insurance.
2. If a Named Insured acquires a Dependents after the Effective Date, such Dependent becomes eligible:
    a. On the date the Named Insured acquires a legal spouse.
    b. On the date Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the Definitions section of the Certificate.

Dependent eligibility expires concurrently with that of the Named Insured.

All on campus Medical and Health Professional Students (EVMS) 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).

Subsidies for Graduate Assistants

Graduate assistants being paid $5,000 or more per Fall and Spring semester who enroll in this insurance plan will receive a health insurance subsidy. The subsidies are taxable and paid to graduate assistants in each fall and spring semester.

Dependent Coverage Eligibility

If your plan includes dependent coverage, you can enroll the following family members on your plan:

- Your domestic partner who meets the rules set by the policyholder and requirements under state law
- Your legal spouse that resides with you
- Your dependent children – your own or those of your spouse or domestic partner
  - The children must be under 26 years of age, and they include:
    - Biological children
    - Stepchildren
    - Legally adopted children
    - A child legally placed with you for adoption (including a foster child)
    - Foster children
    - Children you are responsible for under a qualified medical support order or court order (whether the child resides with you or not)

Coverage Dates and Rates

Coverage for all insured students (and eligible dependents) will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

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

	Annual 08/01/2026-07/31/2027	**Fall 08/01/2026-12/31/2026**	**Spring/Summer 01/01/2027-07/31/2027**	**Grad/ELC Summer 05/17/2027-07/31/2027**
Student	$3,341.00	$1,400.00	$1,941.00	$696.00
Spouse	$3,341.00	$1,400.00	$1,941.00	$696.00
Child	$3,341.00	$1,400.00	$1,941.00	$696.00
Two or more children	$6,682.00	$2,800.00	$3,882.00	$1,392.00

Waiver Deadlines for International Students: Last Day of Open Enrollment for the Semester

Rates

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

Enrollment

To enroll online or obtain an enrollment application for voluntary coverage, log on to https://www.aetnastudenthealth.com and search for your school, then click on Enroll to download the appropriate form.

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting https://www.aetnastudenthealth.com, selecting the school's name, and clicking on the "Plans & Products Offered to You" link on the left-hand side of the screen. 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.

Important Dates or Deadlines

Open Enrollment Dates:

Fall: July 15, 2026 – September 30, 2026

Spring: December 01, 2026 – February 15, 2027

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

Newborn child

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

Adopted child or a child legally placed with you for adoption

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

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

Dependent coverage due to a court order

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

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

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 877-626-2308.

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 covered 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 covered 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

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

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

Policy year deductibles	**In-network coverage**	**Out-of-network coverage**
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$350 per policy year	$700 per policy year
Spouse 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, Pediatric vision care services, Nutritional support, 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 covered services each policy year before the plan begins to pay for covered services. This policy year deductible applies separately to you and each of your covered dependents. After the amount you pay for covered services reaches the policy year deductible, this plan will begin to pay for covered 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 covered services each policy year before the plan begins to pay for covered services. After the amount you and your covered dependents pay for covered services reaches this family policy year deductible, this plan will begin to pay for covered 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 covered 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.		
Covered services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Covered 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	$10,600 per policy year	$21,200 per policy year
Spouse or domestic partner	$10,600 per policy year	$21,200 per policy year
Each child	$10,600 per policy year	$21,200 per policy year
Family	$21,200 per policy year	$42,400 per policy year
Covered 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 covered 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.		

Covered services	In-network coverage	Out-of-network coverage
Preventive care and wellness		
Routine physical exams performed at a physician's office	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		

Covered services	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	
Routine cancer screenings No cost share applies to PSA screenings in-network	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	

Covered services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services (continued) In figuring the maximum visits, each session of up to 60 minutes is equal to one visit		
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	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
Family planning services – female contraceptives		
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	
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)

Covered services	In-network coverage	Out-of-network coverage
Female voluntary sterilization (continued)		
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
The following are not preventive covered services: • 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's office	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Allergy sera and extracts administered via injection at a physician's or specialist's office	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Physician and specialist – inpatient 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 *Covered services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic, unless approved by the plan as medically necessary		

Covered services	In-network coverage	Out-of-network coverage
Physician and specialist – inpatient surgical services (continued)		
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 *Covered 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
The following are not covered services: • All services and supplies provided in: - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps		
Preadmission testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
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: • 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		

Covered services	In-network coverage	Out-of-network coverage
Alternatives to hospital stays (continued)		
Home health care	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Home health care maximum visits per policy year	Unlimited	
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 solely 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		
Outpatient private duty nursing	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Skilled nursing facility - Inpatient	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Emergency services and urgent care		
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
Non-emergency care in an emergency room	Not covered	Not covered
The following are not covered under this benefit: • Non-emergency services in a emergency room facility or an independent freestanding emergency department		

Covered services	In-network coverage	Out-of-network coverage
Emergency services and urgent care (continued)		
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 1-877-626-2308 and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • A separate emergency room copayment/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 services that are applied to the emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered services under the plan cannot be applied to the emergency room copayment/coinsurance. • Separate copayment/coinsurance amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These copayment/coinsurance amounts may be different from the emergency room copayment/coinsurance. They are based on the specific service given to you. • Services given to you in the emergency room that are not part of the emergency room benefit may be subject to copayment/coinsurance amounts that are different from the 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)		
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 policy year 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

Covered services	In-network coverage	Out-of-network coverage
Pediatric dental care (continued) Limited to covered persons through the end of the month in which the person turns age 19		
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 *Covered 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
- Mouth guards (not including an occlusal guard for grinding and clenching of teeth)
- Dental implants except when part of an approved treatment plan for a covered service described in *Covered services and exclusions - Reconstructive surgery and supplies*
- 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

Covered services	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	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
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.		
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants		
Jaw joint disorder 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		

Covered services	In-network coverage	Out-of-network coverage
Specific conditions (continued)		
Clinical trials - Experimental or investigational therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Clinical trials - Routine patient costs	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered services: • Services and supplies related to data collection and record-keeping needed only for the clinical trial • Services and supplies provided by the trial sponsor for free • Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis • The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)		
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		
Obesity surgery and services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Obesity surgery and services exclusions The following are not covered services: • Weight management treatment. • Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate. • Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes: - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications - Hypnosis or other forms of therapy • Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.		
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)	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		
Covered services	**In-network coverage**	**Out-of-network coverage**

Specific conditions (continued)		
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
Voluntary sterilization for males		
Inpatient physician or specialist surgical services	80% (of the negotiated charge)	50% (of the recognized charge)
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		
Abortion		
Inpatient physician or specialist surgical services	80% (of the negotiated charge)	50% (of the recognized charge)
Outpatient physician or specialist surgical services	80% (of the negotiated charge)	50% (of the recognized charge)
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered services under this benefit: • Any treatment, surgery, service or supply that is not in the list above of covered services		
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing. Includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	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

Covered services	In-network coverage	Out-of-network coverage
Mental health and substance use disorder treatment Coverage is provided under the same terms and conditions as any other illness.		
Inpatient hospital mental health disorders treatment (room and board) Inpatient residential treatment facility mental health disorders treatment (room and board)	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Other inpatient mental disorders treatment services and supplies (other than room and board) Other inpatient residential treatment facility services and supplies (other than room and board)	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
Transplant services		
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Transplant services – travel and lodging	Covered	
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		

Covered services	In-network coverage	Out-of-network coverage
Infertility services		
Treatment of basic infertility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Infertility services exclusions The following are not covered under the infertility services benefit: • All infertility services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services. • Infertility medication. • 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).		
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

Covered services	In-network coverage	Out-of-network coverage
Specific therapies and tests (continued)		
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
Maximum visits per policy year for habilitation services - physical and occupational therapies combined	Unlimited	
Maximum visits per policy year for rehabilitation services - physical and occupational therapies combined	Unlimited	
Maximum visits per policy year for habilitation services - speech therapy	Unlimited	
Maximum visits per policy year for rehabilitation services - speech therapy	Unlimited	
The following are not covered services: • Home programs, other than home health care services, on-going conditioning, or maintenance care.		
Early intervention services No visit limit applies for physical, occupational, or speech therapy services.		
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	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 therapy services Rehabilitation services must involve goals you can reach in a reasonable period. Benefits end when progress toward the goal ends.		
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 or the place where the service is received	Covered according to the type of benefit or the place where the service is received

Covered services	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	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 services		
Breast Examinations -Diagnostic and supplemental breast examinations	100% per visit	100% per visit
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	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 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
Prosthetic Devices	80% (of the negotiated charge) per item	50% (of the recognized charge) per item

Covered services	In-network coverage	Out-of-network coverage
Other services (continued)		
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 item 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	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
Low vision Maximum	One comprehensive low vision evaluation every policy year	
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Maximum contact lens fitting visits per policy year	1 visit	

Covered services	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 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
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 • Non-elective contact lenses if you have undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK		

Covered services	In-network coverage	Out-of-network coverage
Adult vision care Limited to covered persons age 19 and over		
Adult routine vision exams (including refraction) performed by a legally qualified ophthalmologist or optometrist	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
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, except as covered in the Vision correction after surgery or accident section • 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		
Adult 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		

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.		
Covered services	**In-network coverage**	**Out-of-network coverage**
Preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$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	$75 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	$225 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered

Covered services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Non-preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$150 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	$450 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	$150 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	$450 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Diabetic supplies, drugs, and insulin		
For each fill up to a 30-day supply filled at a retail pharmacy	Paid according to the type of drug per the schedule of benefits, above	Not covered
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Not covered
Diabetic insulin important note: Your cost share per 30-day supply of a covered diabetic prescription filled at an in-network pharmacy will not exceed $25 for prescription insulin. No policy year deductible applies for insulin.		

Covered services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Anti-cancer drugs taken by mouth For each fill up to a 30-day supply	100% (of the negotiated charge) No policy year deductible applies	Not covered
Preventive care drugs and supplements filled at a retail pharmacy or mail order pharmacy For each 30–day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Not covered
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	Not covered
Risk reducing breast cancer prescription drugs maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	

Covered services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
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	Not covered
Tobacco cessation prescription drugs and OTC drugs maximums	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Contraceptives (birth control) Brand-name prescription drugs and devices are covered at 100% at an in-network pharmacy when a generic is not available		
For each fill up to 12-month supply of generic and OTC drugs and devices filled at a retail pharmacy or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	Not covered
For each fill up to 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 provider prescribes a covered brand-name prescription drug when a generic prescription drug equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost share for the brand-name drug. If a provider does not specify DAW and you request a covered brand-name prescription drug, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug. The cost difference related to a prescription not specified as DAW does not apply toward your policy year deductible or maximum out-of-pocket limit.		
Outpatient prescription drug exclusions The following are not covered 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 ***(continued on next page)***		

Outpatient prescription drug exclusions (continued)

The following are not covered services:

- Any treatment, device, drug, service, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes unless listed as a covered service
- 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, unless we have approved a medical exception
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a covered 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 unless listed in the drug guide or we have approved a medical exception
  - Which do not require a prescription by law, even if a prescription is written, unless listed as a covered service or we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - 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 a covered service
  - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications unless listed as a covered service
  - That are drugs or growth hormones used to stimulate growth and prescribed only to treat idiopathic short stature
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Immunizations related to travel or work
- Immunization or immunological agents unless listed as a covered service
- Implantable drugs and associated devices unless listed as a covered service
- 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 unless listed in the drug guide or we have approved a medical exception
- Off-label drug use except as specifically provided for in the *Off-label use* section

(continued on next page)

Outpatient prescription drug exclusions (continued)

The following are not covered services:

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

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug. The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:
CVS Health
ATTN: Aetna PA
1300 E Campbell Road
Richardson, TX 75081

Out of Country claims

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

General Exclusions

Abortion drugs

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

Blood and blood products

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

Cosmetic services and plastic surgery

• Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, including cosmetic drugs, medications, and preparations used for cosmetic purposes, except where described in the *Covered services and exclusions* section

Court-ordered services and supplies

• This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a covered service under your plan

Custodial care

Except as described in the *Hospice care section*, services and supplies meant to help you with activities of daily living or other personal needs.

Examples of these are:

• Routine patient care such as changing dressings, periodic turning and positioning in bed
• Administering oral medications
• Care of a stable tracheostomy (including intermittent suctioning)
• Care of a stable colostomy/ileostomy
• Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
• Care of a bladder catheter, including emptying or changing containers and clamping tubing
• Watching or protecting you
• Respite care except in connection with hospice care, adult or child day care, or convalescent care
• Institutional care, including room and board for rest cures, adult day care and convalescent care
• Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
• Any other services that a person without medical or paramedical training could be trained to perform
• For behavioral health (mental health treatment and substance use disorder 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

Dental care for adults

• Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions

- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants except when part of an approved treatment plan for a covered service described in the *Covered services and exclusions – Reconstructive surgery and supplies* section.

This exclusion 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 are:
- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs, whether or not the program is part of a residential treatment facility or otherwise licensed institution
  - Job training
  - Job hardening programs
- Any services that are schooling related or similar programs
- Therapeutic programs within a school, vocational, work, or recreational setting.

This exclusion does not include educational services as described under the *Behavioral health*, *Diabetic services, supplies, equipment, and self-care programs*, and *Lymphedema* provisions.

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

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

Gene-based, cellular and other innovative therapies (GCIT)
All services and supplies associated with GCIT including, but not limited to:
- The cost of the GCIT product.
- Any medical, surgical, professional, and facility charges directly related to GCIT. Examples include:
  - Anesthesia
  - Infusion
  - Lab and radiology
  - Nursing
  - Physician or specialist services

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 loss

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
- Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Compresses
  - Over the counter convenience and hygienic items
  - Other devices not intended for reuse by another patient

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

Other primary payer
- Payment for a portion of the 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.

Prescription or non-prescription drugs and medicines
- 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 compound, unless we have approved a medical exception
- Specialty prescription drugs except as stated in the *Covered services and exclusions* section

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

Private duty nursing in an inpatient setting

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

School health services
- Services and supplies normally provided by the policyholder's:
  - School health services
  - Infirmary
  - Hospital
  - Pharmacy
- Services and supplies provided by health professionals who the policyholder:
  - Employs
  - Is affiliated with
  - Has an agreement or arrangement with
  - Otherwise designates

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

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

Sexual dysfunction and enhancement
- Except where described in the *Covered services and exclusions* section, any treatment, prescription drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape of a sex organ
  - Sex therapy, sex counseling, or other counseling or advisory services

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.

Telemedicine
- Services including:
  - Telephone calls
  - Telemedicine kiosks

Therapies and tests
- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

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

Treatment in a federal, state, or governmental entity
- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, unless coverage is required by applicable laws

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

Wilderness treatment programs
- Wilderness treatment programs, whether or not the program is part of a residential treatment facility or otherwise licensed institution

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

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

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

Sanctioned Countries

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

For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Discrimination is Against the Law

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

Aetna Inc.:

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

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

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

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

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

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

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

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

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