Emory University Student Health Insurance Plan
Plan Design and Benefits Summary

Administrative Services by Aetna Student Health

Policy Year: 2023-2024

Policy Number: 686178

www.aetnastudenthealth.com
(877) 261-8403

This is a brief description of the Emory University Student Health Plan. The Plan is available for Emory University students and their eligible dependents. The Plan is underwritten by Emory University, with administrative services by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Policy issued to you and may be viewed online at **www.aetnastudenthealth.com.** If there is a difference between this Benefit Summary and the Master Policy, the Policy will control.

EMORY UNIVERSITY STUDENT HEALTH SERVICES

Emory University Student Health Services (EUSHS) offers responsive, convenient, confidential, high-quality primary care medical services, counseling, psychological services, health promotion and dispensary services to Emory students enrolled in the Student Health Insurance Plan. The EUSHS facilitates access to urgent and emergency services and provides referrals to specialty medical and mental health care providers. Our high standard of services has been recognized by the Accreditation Association for Ambulatory Health Care, Inc.

WEBSITE

The EUSHS website **www.studenthealth.emory.edu** provides a wealth of information about student health topics and outlines how to access the vast range of services at Emory Student Health and Counseling Services. Please use the EUSHS website as a resource throughout your time at Emory University.

PRIMARY CARE

For students and spouses/domestic partners and children (18 years or older) enrolled in the Emory University Student Health Insurance Plan (EUSHIP) and residing in the Atlanta area, EUSHS is your primary care provider under the plan. Except in an emergency, you must first seek care at the EUSHS to receive the maximum benefit for medical and mental health services. When you are away from campus, you should seek care from a participating provider in Aetna's nationwide network, "**Choice POS II**." You also have the option to seek Non-Preferred Care for standard limited coverage. A list of Aetna participating providers is available via Aetna's Docfind website at **www.aetnastudenthealth.com**.

APPOINTMENTS

Appointments are required to address most of your health care needs. Appointments can be scheduled through your Patient Portal at **www.shspnc.emory.edu/login_directory.aspx**. If you are not able to find an open appointment or need to contact a provider for an urgent matter, call the front desk at (404) 727-7551. Students have access to our medical call center after hours and weekends by calling the main appointment line at **(404) 727-7551 x 0** to speak with an AccessNurse member.

EMERGENCY CARE

Emory University Hospitals are the only Emory Core network emergency care hospitals for the Atlanta area. All non-Emory hospitals are considered Preferred Care hospitals and are covered at the in-network benefit level. If you need emergency medical care, call **911** for immediate medical assistance.

In the event of your treatment or hospitalization at an Emory Hospital for which follow up with a specialist is required, Emory Healthcare will share relevant medical information as needed for the continuity of your care.

Fees: The Emory University Student Health Insurance Plan covers most services at EUSHS (including lab tests, special procedures, and covered preventive care services). **Services that are not deemed medically necessary may not be covered.**

There are several options for payment at EUSHS: personal check or credit card (Discover, VISA, MasterCard) at the time of your visit; or the charge will be billed to your student account via Student Financial Services.

The inability to pay should never be a barrier to receiving needed health care. If you have concerns about expenses connected to medical or mental health care, discuss them with the billing office staff before or during your visit to EUSHS.

Emory Student Health Services: Is also now a member of 42 national PPO networks, including most major insurance. Effective May 18, 2020, the Student Health Services has successfully contracted with BCBS. Charges incurred at SHS, will be billed directly to BCBS and payment will be determined by your individual plan benefits.

Dispensary: A limited number of medications are available in prepackaged containers from the EUSHS. Medications at EUSHS are available for a **$10** co-pay. Also, many prescription contraception medications are available with a **$0** copayment, including oral contraceptives.

REFERRALS

Under the Emory University policy, you must seek care at the EUSHS first. If your care cannot be provided at the EUSHS, your primary care provider or mental health provider may refer you to an Emory Core provider or an Aetna Preferred Provider. To receive the maximum benefit for services, you must have a written referral to a Preferred Provider. **Outside of an emergency, services will not be covered without the proper referral.**

When you are away from campus, you do not need a referral to seek Preferred Care from Aetna's Preferred Provider Network or to seek Non-Preferred Care. For a complete list of referral requirements and exceptions, refer to the Referral Requirements on page 14 of the 2023-24 Emory University Student Health Insurance Plan Design and Summary of Benefits.

CARE IN PROGRESS

If you have recently joined the EUSHIP and are receiving care for a physical or mental health condition, you must be seen at the EUSHS to begin initial care with a primary care provider or counselor. If necessary, s/he will provide a referral to a Preferred Provider for specialty care. If you have been continuously enrolled in the EUSHIP and are receiving care from a specialist who is a Preferred Provider, you must get a new referral each Plan Year for each condition in order for on-going treatment to be covered. You should speak with your EUSHS health care provider or contact the Referral Coordinator to renew all necessary referrals.

EUSHS Hours: Visit **www.studenthealth.emory.edu** for a listing of EUSHS's hours which vary during breaks, holidays, summer and winter session. Whenever EUSHS is closed, you may consult by phone with the AccessNurse Medical Call Center who can offer advice. In an emergency, call **911** or go the nearest hospital.

Services at EUSHS

- Primary Care
- Women's Health Clinic
- Laboratory Services
- On-Site Specialty Clinics
- Prescription Medications
- Specialty Referrals
- Immunizations
- Allergy Shots:
    - At EUSHS, allergy treatment (administration of injections) is covered including sera and injections when prepared and/or administered by an allergist. The preparation of allergy sera cannot be done at EUSHS.
- Substance Abuse Consultations
- Nutrition Counseling
- Travel Clinic

Your Student Patient Portal

"Your Student Patient Portal" **www.shspnc.emory.edu/login_directory.aspx** is a secure web portal, designed to facilitate confidential communication between EUSHS staff and their patients and clients. When you visit Your Patient Portal (any time **24/7**), you may:

- Send/Receive secure messages as well as lab and X-ray results from your health care providers
- Access progress notes from recent visits
- Review billing information
- Review and print your immunization history
- Complete required visit questionnaires and surveys
- Schedule "some" healthcare appointments online (view the list on the web portal)
- View a summary of your upcoming scheduled visits
- Cancel any EUSHS appointments at any time

Graduated/Leave of Absence Students/ Continuation of Coverage

If you graduate in **December 2023** or take a leave of absence and do not return for the **2024 Spring Semester**, coverage will terminate on **December 31, 2023**. You will then be eligible to extend coverage for an additional **one month** under the continuation plan. You will have **31 days** from the termination date of your prior insurance to enroll. If you graduate in **May 2024**, coverage will remain active until the end of the policy year (**7/31/24 for all Schools).** You will also be able to extend coverage for an additional **one month** under the continuation plan once your coverage terminates. Benefits under the continuation plan remain the same as the basic student plan.

A covered student: Who has graduated or is otherwise ineligible for coverage under this Plan, and has been continuously insured under the Plan offered by the Policyholder (regular student Plan), may be covered for one month provided that: (1) **the covered student** and **covered dependent** were covered by the regular student Plan for the prior semester (2) a written request for continuation has been forwarded to Aetna within 31 days from the termination of coverage, and (3) premium payment has been made. Coverage under this provision ceases on the date this Plan terminates.

Continuation of Coverage	One month
Student	**$1,000**
Spouse/Domestic Partner	**$1,000**
Child Only	**$1,000**
Child(ren)	**$2,000**

Coverage Periods

Students: Please note that the Emory University Student Health Insurance Plan is an Annual Policy. Coverage purchased starting with the Fall 2023 Semester will continue through the following Summer 2024 Semester. Students enrolling during the Fall 2023 Semester are responsible for paying the insurance premium for the Spring/Summer Semester.

Enrollment: Only for the Spring/Summer Semester or the Summer Semester is restricted to students newly enrolled at Emory University at that time, or for students who lose their private insurance (parent's or personal insurance) due to a change of life event. Examples of "change of life events" include: exceeding the age maximum on a parent's policy, losing private insurance through loss of employment or a change in marital status, etc. Students who enroll mid-year due to a change of life event will be responsible for the full semester's premium and coverage under the EUSHIP will begin the day after the loss of coverage. The premium is not prorated.

Please Note: Students who graduate at the end of the Fall Semester, or who do not otherwise enroll in classes for the Spring/Summer Semester, will not be eligible to continue coverage under the Emory University Student Health Insurance Plan unless they purchase the Continuation Plan within 31 days of the start of the Spring Semester.

All Schools		
Annual Coverage 08/01/23 – 07/31/2024	**Spring/Summer Semester** 01/01/24 – 07/31/2024	**Summer Semester** 06/01/2024 – 07/31/2024
Waiver Deadline Date: 08/01/2023	**Waiver Deadline Date:** 01/01/2024	**Waiver Deadline Date:** 06/01/2024

Waivers must be submitted and approved by the semester deadlines. Insurance charge adjustments cannot be considered for a prior semester.

*Programs which start prior to 8/1 (two-year MBA and SOM programs) will have a supplemental option on a cost per day basis. The waiver is available on the OPUS health tile.

Rates

	Annual Term 08/01/2023 – 07/31/2024	**Spring/Summer Only *** 01/01/2024 – 07/31/2024	**Summer Semester Only*** 06/01/2024 – 07/31/2024
Student Only	**$4,762**	**$2,769**	**$793**
Spouse Only	**$5,714**	**$3,408**	**$976**
Child Only	**$5,714**	**$3,408**	**$976**
Children	**$11,428**	**$6,603**	**$1,891**

*Enrollment is only open for newly enrolled students at Emory during the Spring/Summer Semester or Summer Semester and for students who have lost their personal or private insurance due to a change of life event.

There is an "Early Start" Policy beginning 6/01/2023, for 2-year MBA/PMEL students. For additional information on this optional coverage, please contact the Goizueta Business School administration or the Emory University Student Health Insurance Office at 404-727-7560.

Student Coverage

Eligibility

Health insurance coverage is mandatory for all new and continuing students enrolled at Emory University (including Oxford College). Students are required to participate in the Emory University Student Health Insurance Plan or provide proof of other adequate health insurance as explained under the Enrollment section in this Brochure.

1. Students must be considered by their individual program to be an active and enrolled student for the current semester.
2. Students must be taking a minimum of one credit hour.
3. If the Student is not physically attending class, then the Student must be progressing appropriately in obtaining their stated degree.
4. Graduate/Doctorial students (and candidates) are eligible for one or two semesters as a *graduate in residence* or *distance learner* if specified by their program in order to complete research or independent academic work. (i.e. thesis or dissertation completion).

All degree-seeking students who do not submit proof of comparable coverage through the Online Waiver system by the deadline date and who are automatically charged for the insurance will have an effective date of coverage as indicated in "Coverage Effective Dates". If you have other coverage and wish to waive enrollment in the Emory Student Health Insurance Plan as listed above, please submit proof of comparable coverage through the Online Waiver system by the waiver deadline dates of **August 1, 2023** for Fall Semester, **January 01, 2024** for new students enrolling for the Spring Semester, and **June 01, 2024** for new students enrolling for the Summer.

To Waive Online:

- Login to OPUS (**www.opus.emory.edu**) using your Network ID and password.
- First time users should select Obtain Network ID and Password and follow the prompts.

A completed waiver must be submitted by the posted deadline date.

Dependent Coverage

Eligibility

Eligible students who do enroll may also cover their eligible **dependents. Dependent** eligibility and coverage period must be concurrent with the insured students. Eligible **dependents** are defined as, the spouse or domestic partner (as defined below) residing with the **covered student** and children under 26 years of age. To enroll your dependent, log onto the Aetna Student Health website at **www.aetnastudenthealth.com** to enroll online or submit the Dependent application which is available in the Student Health Insurance Office.

Students must enroll their eligible **dependents** and must pay the required premium as described below:

1. By the deadline date for **dependent** enrollment (by **August 01, 2023** for Fall Semester, **January 01, 2024** for the dependents of new students enrolling for the Spring/Summer Semester, and **June 01, 2024** for the **dependents** of new students enrolling for the Summer Semester.)
2. Within **31 days** after you acquire a new **dependent**.
3. Within **31 days** after a **dependent** terminates coverage under another health insurance plan. The premium rate for the late addition of **dependents** will not be pro-rated. The student must pay the full premium for the enrollment period and the **dependent** will be made effective the date the enrollment application and premium are received and approved by Aetna Student Health.

To be considered a Domestic Partner, and eligible to be covered as a dependent of an insured student under the Emory University Student Health Insurance Plan, you must meet the following criteria:

1. The Domestic Partnership must have been in existence for a period of 12 consecutive months prior to the application for coverage under this Plan.
2. The members of the Domestic Partnership are not legally married to anyone.
3. The members of the Domestic Partnership must be 18 years of age or older.
4. The members of the Domestic Partnership are not related by blood closer than would bar marriage in the State of Georgia and are mentally competent to consent to contract.
5. The members of the Domestic Partnership are each other's sole Domestic Partner and intend to remain so indefinitely and are responsible for their common welfare.

NEWBORN INFANT AND ADOPTED CHILD COVERAGE

A child born to a **Covered person** shall be covered for Accident, Sickness, premature birth, and congenital defects, for **31 days** from the date of birth. Well Baby Care coverage will not be covered unless officially added to the plan. At the end of this **31-day** period, coverage will cease under the Emory University Student Health Insurance Plan. To extend coverage for a newborn past the **31 days**, the **covered student** must: 1) enroll the child within **31 days** of birth, and 2) pay the additional pro-rated premium, starting from the date of birth. Coverage is provided for a child legally placed for adoption with a **covered student** for **31 days** from the moment of placement provided the child lives in the household of the **covered student** and is **dependent** upon the covered student for support. To extend coverage for an adopted child past the **31 days**, the **covered student** must 1) enroll the child within **31 days** of placement of such child, and 2) pay any additional premium, if necessary, starting from the date of placement.

For enrollment, please submit the Newborn application to the address on the application which is available at EUSHS. For information or general questions on dependent enrollment, contact Aetna Student Health at **(877) 261-8403.**

Medicare Eligibility

You are eligible for health coverage under this **student policy** if you have **Medicare** at the time of enrollment in this student plan.

If you obtain **Medicare** after you enrolled in this student plan, your health coverage under this plan will not end. As used here, "have **Medicare**" means that you are entitled to benefits under Premium Part A (receiving free Part A (Hospital) or enrolled in Part B (Medical), Part C (Medicare Advantage) or Part D (Prescription Drug).

The Emory University Student Health Insurance Plan will only cover your Medicare copays, deductible and coinsurance but will not cover expenses which are not covered by Medicare, including prescription medications.

Under this plan, Medicare will act as your primary insurance and all medical expenses should be submitted to Medicare first.

Continuation of Coverage

A covered student who has graduated or is otherwise ineligible for coverage under this Policy; and has been continuously insured under the plan offered by the Policyholder (regular student plan); may be covered for up to 1 month provided that: (1) a written request for continuation has been forwarded to Emory within 31 days of the termination date of your prior coverage; and (2) premium payment has been made. Coverage under this provision ceases on the date this Policy terminates.

Preferred Provider Network

Emory Student Health offers Aetna's broad network of Preferred Providers. You can save money by seeing Preferred 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 a Preferred 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 a Non- Preferred Provider. When a pre-approval is issued by Aetna, the benefit level is the same as for Preferred Providers.

Continuity of Care

Any covered person who is receiving active health care services for a chronic or terminal illness or who is an inpatient, must have the right to continue to receive health care services from that physician for up to 60 days from the date of the termination of the physician's contract. Any pregnant covered person receiving treatment in connection with such pregnancy at the time of termination of the physician's contract must have the right to continue receiving health care services from that physician throughout the remainder of the pregnancy and six weeks post-delivery care.

Pre-certification

Some services have to be pre-certified by Aetna beforehand if you want the Plan to cover them. Preferred Providers are responsible for requesting precertification for their services. You are responsible for requesting precertification if you seek care from a Non- Preferred Provider for any of the services listed in the Schedule of Benefits section of the Certificate.

If you want the Plan to cover a service from a Non- Preferred Provider that requires precertification, you must call Aetna at the number on your ID card. After Aetna receives a request for precertification, we will review the reasons for your planned treatment and determine if benefits are available.

If you do not secure pre-certification for the below listed inpatient and outpatient covered medical services and supplies obtained from a non-preferred provider your covered medical expenses will be subject to a **$500** per service, treatment, procedure, visit, or supply benefit reduction.

Pre-certification for the following inpatient and outpatient services or supplies is needed*:

- All inpatient maternity and newborn care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- Ambulance (emergency transportation by airplane);
- Autologous chondrocyte implantation, Carticel®
- Bariatric surgery (bariatric surgery is not covered under the Policy unless specifically described in the Policy);
- BRCA genetic testing;
- Cardiac rhythm implantable devices;
- Cochlear device and/or implantation;
- Dental implants and oral appliances;
- Dorsal column (lumbar) neurostimulators: trial or implantation;
- Drugs and Medical Injectables;
- Electric or motorized wheelchairs and scooters;
- Gender Reassignment (Sex Change) Treatment Expense;
- Home health care related services (i.e. private duty nursing),
- Hyperbaric oxygen therapy;

- Infertility treatment (Comprehensive and ART infertility treatment is not covered under the plan unless specifically described in the Policy.)
- Inpatient Confinements (surgical and non-surgical); hospital, skilled nursing facility, rehabilitation facility, residential treatment facility for mental disorders and substance abuse, hospice care;
- Inpatient mental disorders treatment;
- Inpatient substance abuse treatment;
- Kidney dialysis;
- Knee surgery;
- Limb Prosthetics;
- Non-Preferred Care freestanding ambulatory surgical facility services when referred by a Preferred Care Provider;
- Oncotype DX;
- Orthognatic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint;
- Osseo integrated implant;
- Osteochondral allograft/knee;
- Outpatient back surgery not performed in a physician's office;
- Pediatric Congenital Heart Surgery;
- Pre-implantation genetic testing;
- Procedures that may be considered cosmetic. Cosmetic services and supplies are not covered under the plan unless specifically described in the Policy;
- Proton beam radiotherapy;
- Referral or use of Non-Preferred Care Providers for non-emergency services, unless the covered person understands and consents to the use of a Non-Preferred Care Provider under their under Non-Preferred Care benefits when available in their plan;
- Spinal Procedures;
- Transplant Services;
- Uvulopalatopharyngoplasty, including laser-assisted procedures; and
- Ventricular assist devices.

*Your Plan may not include coverage for all of the services and supplies listed above. Please check your Master Policy for confirmation of which services and supplies are covered and which services and supplies are excluded under your Plan. If you cannot locate the benefit you are looking for in your Master Policy, contact Customer Service at the number listed on your ID card for further assistance.

Pre-certification DOES NOT guarantee the payment of benefits for your inpatient stays, certain tests, procedures, outpatient surgeries, therapies and equipment, and prescribed medications

Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Master Policy. The Master Policy also includes information regarding your eligibility criteria, notification guidelines, and benefit coverage.

Pre-certification of non-emergency admissions

Non-emergency admissions must be requested at least **fifteen (15) days** prior to the date they are scheduled to be admitted.

Pre-certification of emergency admissions

Emergency admissions must be requested within **twenty-four (24) hours** or as soon as reasonably possible after the admission.

Pre-certification of urgent admissions

Urgent admissions must be requested before you are scheduled to be admitted.

Pre-certification of outpatient non-emergency medical services

Outpatient non-emergency medical services must be requested within **fifteen (15) days** before the outpatient services, treatments, procedures, visits or supplies are provided or scheduled.

Pre-certification of prenatal care and delivery

Pre-natal care medical services must be requested as soon as possible after the attending physician confirms pregnancy. Delivery medical services, which exceed the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery, must be requested within **twenty-four (24) hours** of the birth or as soon thereafter as possible.

Please see the “Pre-certification” provision in the Master Policy for a list of services under the Plan that require pre-certification. Please see the Schedule of Benefits for any penalty or benefit reduction that may apply to your coverage when pre-certification is not obtained for the listed services or supplies when received from a non-preferred care provider.

Aetna Student Health’s liability is limited to the reimbursement level provided under the health benefit Plan for pre-certified services, where rendered within the time limits set in the pre-certification. There is no such liability if the member is no longer covered under the Plan at the time the services are received, benefits under the contract or Plan have been exhausted, or there is a substantiation of fraud by the member, provider, facility, or home health care provider.

What's New This Year!

- **Annual premium - $4,762**
- **Dependent premium - Annual premium $5,714**

Description of Benefits

The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Design and Benefits Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Policy issued to you, go to **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Master Policy, the Policy will control.

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

Care provided at Emory University Student Health Services will be covered at 100% with a $0 deductible.

DEDUCTIBLE	Core Network	Preferred Care	Non-Preferred Care
The policy year deductible is waived for designated care (Core Network) and preferred care covered medical expenses that apply to Preventive Care Expense benefits. In compliance with Georgia State mandate(s), the policy year deductible is also waived for Child Wellness Services from birth to age 5 and Pediatric Dental Services. Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible.	**Students:** **$200** per policy year **Spouse:** **$200** per policy year **Child:** **$200** per policy year	**Students:** **$500** per policy year **Spouse:** **$500** per policy year **Child:** **$500** per policy year	**Students:** **$750** per policy year **Spouse:** **$750** per policy year **Child:** **$750** per policy year
COINSURANCE			
Coinsurance is both the percentage of covered medical expenses that the plan pays, and the percentage of covered medical expenses that you pay. The percentage that the plan pays is referred to as "plan coinsurance" or the "payment percentage," and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.	Covered Medical Expenses are payable at the plan coinsurance percentage specified below, after any applicable Deductible.		

OUT-OF-POCKET MAXIMUMS	Core Network and Preferred Care	Non-Preferred Care
Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at **100%** for the remainder of the Policy Year. The following expenses do not apply toward meeting the plan's out-of-pocket limits: • Non-covered medical expenses; • Referral penalties because a required referral for the service(s) or supply was not obtained; and • Expenses that are not paid or pre-certification benefit reductions or penalties because a required pre-certification for the service(s) or supply was not obtained from Aetna.	Individual Out-of-Pocket: **$7,000** Family Out-of-Pocket: **$14,000**	Individual Out-of-Pocket: **Unlimited** Family Out-of-Pocket: **Unlimited**

REFERRAL PENALTY

PLEASE NOTE: **THERE IS A MANDATORY REFERRAL REQUIREMENT UNDER THIS PLAN**. **STUDENTS AND DEPENDENTS (AGE 18 YEARS AND OVER) ARE REQUIRED TO BE SEEN AT EMORY UNIVERSITY STUDENT HEALTH SERVICES (EUSHS) FIRST (OR AT OXFORD COLLEGE STUDENT HEALTH CENTER FOR OXFORD STUDENTS)**. **IF APPROPRIATE**, **EUSHS WILL REFER THE COVERED PERSON TO AN OUTSIDE PROVIDER FOR TREATMENT**. **THERE WILL BE NO COVERAGE FOR TREATMENT RECEIVED WITHOUT A REFERRAL FROM EUSHS**.

Emory University Student Health Services (EUSHS) offers students primary and specialty services coordinated by EUSHS. All covered students and covered dependents age 18 years or older in need of medical care should, except in the case of a medical emergency, first seek treatment and be evaluated at EUSHS. You may be referred to an outside medical provider if required medical care is unavailable at the time of service. Students on the Oxford Campus must obtain a referral from the Oxford Campus Student Health Center. If you are enrolled in the Student Health Insurance Plan, a referral is necessary to receive benefits under your Student Health Insurance Plan, except in the following circumstances:

- Treatment of an Emergency medical condition; or
- When the EUSHS (or the Oxford College Student Health Center for Oxford students) is closed; or
- When the service is rendered at another facility during breaks or vacation periods; or
- When medical care is received by a Covered person who is more than **50** miles from campus; or
- When medical care is received by a Covered person who is no longer able to use the EUSHS due to a change in student status, such as graduating or LOA/withdrawal, or
- Urgent Care/Minute Clinics when not being able to access the EUSHS
- Ob/Gyn services; or
- Dermatological services; or
- Chiropractic services, or
- All X-rays, Labs, and High Cost Procedures.
- Routine Dental services including the treatment and extraction of wisdom teeth
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness).
- Continuation Plan

A new referral must be obtained if continuous treatment is being received from one Policy Year to the next.

NOTE: Dependents under **age 18** are not permitted to use the EUSHS and do not need a referral from EUSHS in order to receive benefits for covered services.

INPATIENT HOSPITALIZATION BENEFITS	Core Network	Preferred Care	Non-Preferred Care
Room and Board Expense The covered room and board expense does not include any charge in excess of the daily room and board maximum. Includes inpatient services following a mastectomy or lymph node dissection as advised by the attending physician in consultation with the patient.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge for a semi-private room
Intensive Care The covered room and board expense does not include any charge in excess of the daily room and board maximum.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Miscellaneous Hospital Expense Includes but not limited to: operating room, laboratory tests/X rays, oxygen tent, drugs, medicines and dressings.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Licensed Nurse Expense Includes charges incurred by a covered person who is confined in a hospital as a resident bed patient and requires the services of a registered nurse or licensed practical nurse. Not more than the Daily Maximum Benefit per shift will be paid. For purposes of determining this maximum, a shift means 8 consecutive hours.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Well Newborn Nursery Care	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Non-Surgical Physicians Expense Includes hospital charges incurred by a covered person who is confined as an inpatient in a hospital for a surgical procedure for the services of a physician who is not the physician who may have performed surgery on the covered person.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
SURGICAL EXPENSES	**Core Network**	**Preferred Care**	**Non-Preferred Care**
Surgical Expense (Inpatient) When injury or sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, covered medical expenses only include expenses incurred for the most expensive procedure.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

SURGICAL EXPENSES (continued)	Core Network	Preferred Care	Non-Preferred Care
Surgical Expense (Outpatient) When injury or sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, covered medical expenses only include expenses incurred for the most expensive procedure.	After a **$100** Copay per surgery, **90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Anesthesia Expense (Inpatient and Outpatient) If, in connection with such operation, the covered person requires the services of an anesthetist who is not employed or retained by the hospital in which the operation is performed, the expenses incurred will be Covered Medical Expenses.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Assistant Surgeon Expense (Inpatient and Outpatient)	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
OUTPATIENT EXPENSES	**Core Network**	**Preferred Care**	**Non-Preferred Care**
Physician or Specialist Office Visit Expense Includes the charges made by the physician or specialist if a covered person requires the services of a physician or specialist in the physician's or specialist's office while not confined as an inpatient in a hospital.	After a **$25** Copay per visit, **90%** of the Negotiated Charge	After a **$35** Copay per visit, **80%** of the Negotiated Charge	After a **$40** per visit Deductible, **60%** of the Recognized Charge
Laboratory Expense	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
X-ray Expense	After a **$25** Copay per visit, **90%** of the Negotiated Charge	After a **$35** Copay per visit, **80%** of the Negotiated Charge	After a **$40** per visit Deductible, **60%** of the Recognized Charge
Hospital Outpatient Department Expense	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Therapy Expense Covered medical expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis: • Radiation therapy; • Inhalation therapy; • Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy; • Kidney dialysis; and • Respiratory therapy.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

OUTPATIENT EXPENSES (continued)	Core Network	Preferred Care	Non-Preferred Care
Pre-Admission Testing Expense Includes charges incurred by a covered person for pre-admission testing charges made by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Ambulatory Surgical Expense Covered medical expenses include expenses incurred by a covered person for outpatient surgery performed in an ambulatory surgical center. Covered medical expenses must be incurred on the day of the surgery or within 24 hours after the surgery.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Emergency Room Expense Covered medical expenses incurred by a covered person for services received in the emergency room of a hospital while the covered person is not a full-time inpatient of the hospital. The treatment received must be emergency care for an emergency medical condition. There is no coverage for elective treatment, routine care or care for a non-emergency sickness. As to emergency care incurred for the treatment of an emergency medical condition or psychiatric condition, any referral requirement will not apply & any expenses incurred for non-preferred care will be paid at the same cost-sharing level as if they had been incurred for preferred care or Select Care (Emory Core). **Important Notice:** A separate hospital emergency room visit benefit deductible or copay applies for each visit to an emergency room for emergency care. If a covered person is admitted to a hospital as an inpatient immediately following a visit to an emergency room, the emergency room visit benefit deductible or copay is waived.	After a **$150** Copay per visit (waived if admitted), **90%** of the Negotiated Charge	After a **$150** Copay per visit (waived if admitted), 90**%** of the Negotiated Charge	After a **$150** per visit Deductible (waived if admitted), 90**%** of the Recognized Charge

OUTPATIENT EXPENSES (continued)	Core Network	Preferred Care	Non-Preferred Care
Emergency Room Expense (continued) Covered medical expenses that are applied to the emergency room visit benefit deductible or copay cannot be applied to any other benefit deductible or copay under the plan. Likewise, covered medical expenses that are applied to any of the plan's other benefit deductibles or copays cannot be applied to the emergency room visit benefit deductible or copay. Separate benefit deductibles or copays may apply for certain services rendered in the emergency room that are not included in the hospital emergency room visit benefit. These benefit deductibles or copays may be different from the hospital emergency room visit benefit deductible or copay and will be based on the specific service rendered. Out-of-network services needed to stabilize the individual during the emergency room visit are payable without regard to (a) whether the healthcare provider is in- or out-of-network, including cost-sharing requirements; (b) does not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers; and (c) does not impose higher cost-sharing requirements for out-of-network services. Similarly, services rendered in the emergency room that are not included in the hospital emergency room visit benefit may be subject to coinsurance rates that are different from the coinsurance rate applicable to the hospital emergency room visit benefit.	After a **$150** Copay per visit (waived if admitted), **90%** of the Negotiated Charge	After a **$150** Copay per visit (waived if admitted), 90**%** of the Negotiated Charge	After a **$150** per visit Deductible (waived if admitted), 90**%** of the Recognized Charge

OUTPATIENT EXPENSES (continued)	Core Network	Preferred Care	Non-Preferred Care
Emergency Room Expense (continued) Does not include complex imaging services, lab work and radiological services performed during a hospital emergency room visit, and any surgery which results from the hospital emergency room visit, except as required if the hospital determines that the individual has an emergency medical condition and provider services either (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility in accordance with law. **Important Note**: Please note that Non-Preferred Care Providers do not have a contract with Aetna. The provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.	After a **$150** Copay per visit (waived if admitted), **90%** of the Negotiated Charge	After a **$150** Copay per visit (waived if admitted), **90%** of the Negotiated Charge	After a **$150** per visit Deductible (waived if admitted), **90%** of the Recognized Charge
Durable Medical and Surgical Equipment Expense Durable medical and surgical equipment would include: • Artificial arms and legs; including accessories; • Arm, back, neck braces, leg braces; including attached shoes (but not corrective shoes); • Surgical supports; • Scalp hair prostheses required as the result of hair loss due to injury; sickness; or treatment of sickness; and • Head halters.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

PREVENTIVE CARE EXPENSES

Preventive Care is services provided for a reason other than to diagnose or treat a suspected or identified sickness or injury and rendered in accordance with the guidelines provided by the following agencies:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force **uspreventiveservicestaskforce.org**.
- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents **http://brightfutures.aap.org/**.
- For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration **http://www.hrsa.gov/index.html**.
- Out of pocket expenses are waived for Preventive Care Expenses performed by an in-network provider.

PREVENTIVE CARE EXPENSES	Core Network	Preferred Care	Non-Preferred Care
Routine Physical Exam Includes routine vision & hearing screenings given as part of the routine physical exam.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Immunizations Includes travel immunizations and flu shots.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Well Woman Preventive Visits Routine well woman preventive exam office visit, including Pap smears.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Sexually Transmitted Infections Includes the counseling services to help a covered person prevent or reduce sexually transmitted infections.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Mammograms (Age 35 and older) Although not included in the guidelines recommended by the United States Preventive Services Task Force or the guidelines supported by the Health Resources and Services Administration, this Plan also covers one baseline mammogram for a woman age 35 and over or when medically necessary and bone density measurement screening. For bone density testing, the policy covers the prevention, diagnosis, and treatment of osteoporosis for covered persons, who are qualified individuals. A qualified individual means a covered person, who is an: - Estrogen-deficient woman or individual at clinical risk of osteoporosis as determined directly or indirectly by a *health care practitioner*, and who is considering treatment; - Individual with osteoporotic vertebral abnormalities; - Individual with primary hyperparathyroidism;	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Core Network	Preferred Care	Non-Preferred Care
Mammograms (Age 35 and older) (continued) - Individual receiving long-term glucocorticoid therapy; or, - Individual being monitored directly or indirectly by a *health care practitioner* to assess the response to or efficacy of approved osteoporosis drug therapies.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Obesity and/or Healthy Diet Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Misuse of Alcohol and/or Drugs Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Use of Tobacco Products Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: • Cigarettes; • Cigars; • Smoking tobacco; • Snuff; • Smokeless tobacco; and • Candy-like products that contain tobacco.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Core Network	Preferred Care	Non-Preferred Care
Preventive Care Screening and Counseling Services for Depression Screening Screening or test to determine if depression is present.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Routine Cancer Screenings Covered expenses include but are not limited to: Pap smears; Mammograms; Fecal occult blood tests; Digital rectal exams; Prostate specific antigen (PSA) tests; Sigmoidoscopies; Double contrast barium enemas (DCBE); Colonoscopies (includes bowel preparation medications, anesthesia, removal of polyps performed during a screening procedure, pathology exam on any removed polyps); and lung cancer screenings.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Genetic Risk for Breast and Ovarian Cancer Covered medical expenses include the counseling and evaluation services to help assess a covered person's risk of breast and ovarian cancer susceptibility.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Prenatal Care Coverage for prenatal care under this Preventive Care Expense benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height). Refer to the Maternity Expense benefit for more information on coverage for maternity expenses under the Policy, including other prenatal care, delivery and postnatal care office visits.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Lactation Counseling Services Lactation support and lactation counseling services are covered medical expenses when provided in either a group or individual setting.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Breast Pumps and Supplies	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Core Network	Preferred Care	Non-Preferred Care
Preventive Care Female Contraceptive Counseling Services, Preventive Care Female Contraceptive Generic, Brand Name, Biosimilar Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visit, Preventive Care Female Voluntary Sterilization (Inpatient), Preventive Care Female Voluntary Sterilization (Outpatient) Includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered medical expenses when provided in either a group or individual setting. **Voluntary Sterilization** Includes charges billed separately by the provider for female voluntary sterilization procedures & related services & supplies including, but not limited to, tubal ligation and sterilization implants. Covered medical expenses under this benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement. **Contraceptives** can be paid either under this benefit or the prescribed medicines expense depending on the type of expense and how and where the expense is incurred. Benefits are paid under this benefit for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge

OTHER FAMILY PLANNING SERVICES EXPENSE	Core Network	Preferred Care	Non-Preferred Care
Voluntary Sterilization for Males (Outpatient) **Voluntary Termination of Pregnancy (Outpatient)** Covered medical expenses include charges for certain family planning services, even though not provided to treat a sickness or injury as follows. • Voluntary sterilization for males (vasectomy); • Voluntary termination of pregnancy (abortion) Benefits for Voluntary Termination of Pregnancy (abortion) are limited to **$500** per policy year. Travel and lodging expense reimbursement available through Aetna Student Health per regulation (for patient and a companion) if services are not available in Georgia due to state law **Referral not required for service**.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
AMBULANCE EXPENSE	**Core Network**	**Preferred Care**	**Non-Preferred Care**
Ground, Air, Water and Non-Emergency Ambulance Includes charges incurred by a covered person for the use of a professional ambulance in an emergency. Covered medical expenses for the service are limited to charges for ground transportation to the nearest hospital equipped to render treatment for the condition. Air transportation is covered only when medically necessary.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**80%** of the Recognized Charge

ADDITIONAL BENEFITS	Core Network	Preferred Care	Non-Preferred Care
Allergy Testing and Treatment Expense Includes charges incurred by a covered person for diagnostic testing and treatment of allergies and immunology services.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Diagnostic Testing For Learning Disabilities Expense Covered medical expenses include charges incurred by a covered person for diagnostic testing for: • Attention deficit disorder; or • Attention deficit hyperactive disorder.	Payable in accordance with the type of expense incurred and the place where service is provided.		
High Cost Procedures Expense Includes charges incurred by a covered person as a result of certain high cost procedures provided on an outpatient basis. Covered medical expenses for high cost procedures include; but are not limited to; charges for the following procedures and services: • Computerized Axial Tomography (C.A.T.) scans; • Magnetic Resonance Imaging (MRI); and • Positron Emission Tomography (PET) Scans.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Core Network	Preferred Care	Non-Preferred Care
Urgent Care Expense	After a **$25** per visit copay, **90%** of the Negotiated Charge	After a **$25** per visit copay, **80%** of the Negotiated Charge	After a **$25** per visit deductible, **60%** of the Recognized Charge
Dental Expense for Impacted Wisdom Teeth Includes charges incurred by a covered person for services of a dentist or dental surgeon for removal of one or more impacted wisdom teeth. Includes expenses for the treatment of: the mouth; teeth; and jaws; but only those for services rendered and supplies needed for the following treatment of; or related to conditions; of the: • mouth; jaws; jaw joints; or • supporting tissues; (this includes: bones; muscles; and nerves). **Referral not required.**	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**80%** of the Recognized Charge
Accidental Injury to Sound Natural Teeth Expense Covered medical expenses include charges incurred by a covered person for services of a dentist or dental surgeon as a result of an injury to sound natural teeth.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**80%** of the Recognized Charge
Non-Elective Second Surgical Opinion Expense	Payable in accordance with the type of expense incurred and the place where service is provided.		
Consultant Expense Includes the charges incurred by covered person in connection with the services of a consultant. The services must be requested by the attending physician to confirm or determine a diagnosis. Coverage may be extended to include treatment by the consultant.	After a **$25** Copay per visit, **90%** of the Negotiated Charge	After a **$35** Copay per visit, **80%** of the Negotiated Charge	After a **$40** per visit Deductible, **60%** of the Recognized Charge
Skilled Nursing Facility Expense	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Rehabilitation Facility Expense Includes charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Core Network	Preferred Care	Non-Preferred Care
Home Health Care Expense Covered medical expenses **will not** include: • Services by a person who resides in the covered person's home, or is a member of the covered person's immediate family • Homemaker or housekeeper services; • Maintenance therapy; • Dialysis treatment; • Purchase or rental of dialysis equipment; • Food or home delivered services; or • Custodial care. Benefits limited to **120** visits per policy year.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Temporomandibular Joint Dysfunction Expense Covered medical expenses include physician's charges incurred by a covered person for surgical and non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Dermatological Expense Includes physician's charges incurred by a covered person for the diagnosis and treatment of skin disorders. Related laboratory expenses are covered under the Lab and X-ray Expense benefit. Unless specified above, not covered under this benefit are charges incurred for: • Cosmetic treatment and procedures; and Laboratory fees. Referral not required.	Payable in accordance with the type of expense incurred and the place where service is provided. **NOTE: $100** outpatient surgical copay may apply to certain services.		
Prosthetic Devices Expense Includes charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by sickness, injury or congenital defect. Covered medical expenses also include instruction and incidental supplies needed to use a covered prosthetic device.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Core Network	Preferred Care	Non-Preferred Care
Prosthetic Devices Expense (continued) The plan covers the first prosthesis a covered person needs that temporarily or permanently replaces all or part of an body part lost or impaired as a result of sickness or injury or congenital defects as described in the list of covered devices below for an: • Internal body part or organ; or • External body part. Includes charges incurred by a covered person for podiatric services; provided on an outpatient basis following an injury. Unless specified above, not covered under this benefit are charges incurred for routine foot care, such as trimming of corns, calluses, and nails.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Hypodermic Needles Expense Includes expenses incurred by a covered person for hypodermic needles and syringes.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Convalescent Facility Expense	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Maternity Expense Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person, and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother and done in accordance with the rules and regulations promulgated by State Mandate. Covered medical expenses may include home visits, parent education, and assistance and training in breast or bottle-feeding.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Core Network	Preferred Care	Non-Preferred Care
Non-Prescription Enteral Formula Expense Includes charges incurred by a covered person, for non-prescription enteral formulas for which a physician has issued a written order, and are for the treatment of malabsorption caused by: • Crohn's Disease; • Ulcerative colitis; • Gastroesophageal reflux; • Gastrointestinal motility; • Chronic intestinal pseudo obstruction; and • Inherited diseases of amino acids and organic acids. Covered medical expenses for inherited diseases of amino acids; and organic acids; will also include food products modified to be low protein.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Acupuncture in Lieu of Anesthesia Expense Includes charges incurred by a covered person for acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician; practicing within the scope of their license.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Transfusion or Kidney Dialysis of Blood Expense Includes charges incurred by a covered person for the transfusion or kidney dialysis of blood, including the cost of: Whole blood; blood components; and the administration of whole blood and blood components.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Hospice Expense	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Blood and Body Fluid Exposure/ Needle Stick Coverage Expense Limited to those charges related to a clinical related injury and the immediate blood or body fluid exposure or needlestick event. Services may also be covered under the base plan the same as any other service.	Payable in accordance with the type of expense incurred and the place where service is provided.		

ADDITIONAL BENEFITS (continued)	Core Network	Preferred Care	Non-Preferred Care
Private Duty Nursing Includes private duty nursing services provided by an R.N. or L.P.N. if the covered person's condition requires skilled nursing care and visiting nursing care is not adequate	Payable in accordance with the type of expense incurred and the place where service is provided.		
Diabetes Benefit Expense Includes charges for services, supplies, equipment, & training for the treatment of insulin and non-insulin dependent diabetes &elevated blood glucose levels during pregnancy. Self-management training provided by a licensed health care provider certified in diabetes self-management training.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Autism Spectrum Disorder Expense Includes charges incurred for services and supplies required for the diagnosis & treatment of autism spectrum disorder when ordered by a physician or behavioral health provider as part of a treatment plan.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Basic Infertility Expense Covered medical expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Comprehensive Infertility Expenses Comprehensive Infertility Services Benefits • Ovulation induction with menotropins is subject to the maximum benefit of **6** cycles per lifetime. • Intrauterine insemination is subject to the maximum benefit of **6** cycles per lifetime.	Payable in accordance with the type of expense incurred and the place where service is provided.		

ADDITIONAL BENEFITS (continued)	Core Network	Preferred Care	Non-Preferred Care
Advanced Reproductive Technology (ART) Expenses Advanced Reproductive Technology is defined as: • In vitro fertilization (IVF); • Zygote intrafallopian transfer (ZIFT); • Gamete intra-fallopian transfer (GIFT); • Cryopreserved embryo transfers; and • Intracytoplasmic sperm injection (ICSI); or ovum microsurgery. **Maximum:** • Up to **3** cycles of any combination of the following ART services per lifetime which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers; • IVF; GIFT; ZIFT; or cryopreserved embryo transfers subject to the maximum benefit, if any shown on the Schedule of Benefits while covered under an Aetna plan; • ICSI or ovum microsurgery; • Payment for charges associated with the care of the eligible covered person under this Plan who is participating in a donor IVF program, including fertilization and culture; and • Charges associated with obtaining the spouse's sperm for ART, when the spouse is also covered under the Policy. **Limitations:** Unless otherwise specified above, the following charges will not be payable as covered medical expenses under the Policy: ART services for a female attempting to become pregnant who has not had at least **1** year or more of timed, unprotected coitus, or **12** cycles of artificial insemination (for covered persons under **35** years of age), or **6** months or more of timed, unprotected coitus, or **6** cycles of artificial insemination (for covered persons **35** years of age or older) prior to enrolling in the infertility program; • ART services for couples in which **1** of the partners has had a previous sterilization procedure, with or without surgical reversal; • Reversal of sterilization surgery;	Payable in accordance with the type of expense incurred and the place where service is provided.		

ADDITIONAL BENEFITS (continued)	Core Network	Preferred Care	Non-Preferred Care
Advanced Reproductive Technology (ART) Expenses (continued) **Limitations (continued):** • Infertility Services for females with FSH levels **19** or greater mIU/ml on day **3** of the menstrual cycle; • The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier; • Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); • Home ovulation prediction kits; • Drugs related to the treatment of non-covered medical expenses or related to the treatment of infertility that are not medically necessary; • Injectable infertility medications, including but not limited to, menotropins, and hCG, GnRH agonists; • Any service or supply provided without precertification from Aetna's infertility case management unit; • Infertility Services that are not reasonably likely to result in success; • Ovulation induction and intrauterine insemination services if a covered person is not infertile; • Any ART procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); Any charges associated with care required to obtain ART services (e.g., office, hospital, ultrasounds, laboratory tests, etc.); and any charges associated with obtaining sperm for any ART procedures.	Payable in accordance with the type of expense incurred and the place where service is provided.		

ADDITIONAL BENEFITS (continued)	Core Network	Preferred Care	Non-Preferred Care
Bariatric Surgery Expense Covered medical expenses for the treatment of morbid obesity include one bariatric surgical procedure including related outpatient services, within a two-year period, beginning with the date of the first bariatric surgical procedure, unless a multi-stage procedure is planned.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Clinical Trials Expense (Experimental or Investigational Treatment) Includes charges made by a provider for experimental or investigational drugs, devices, treatments or procedures “under an approved clinical trial” only when a covered person has cancer or a terminal illness.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Clinical Trials Expense Routine Patient Costs Covered Percentage Includes charges made by a provider for "routine patient costs" furnished in connection with a covered person’s participation in an "approved clinical trial” for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.	Payable in accordance with the type of expense incurred and the place where service is provided.		

Gender-Affirming Treatment Expense
Includes charges made in connection with a medically necessary gender affirming surgery as long as the covered student or their covered dependent has obtained pre-certification from Aetna.
 	
Covered medical expenses include:
• Charges made by a physician for:
  ○ Performing the gender affirming surgical procedure (bottom or top surgery); and
  ○ Pre-operative and post-operative hospital and office visits.
• Charges made by a hospital for inpatient and outpatient services (including outpatient surgery).
• Charges made by a Skilled Nursing Facility for inpatient services and supplies.
• Charges made for the administration of anesthetics.
• Charges for outpatient diagnostic laboratory and x-rays.
	Payable in accordance with the type of expense incurred and the place where service is provided.		

ADDITIONAL BENEFITS (continued)	Core Network	Preferred Care	Non-Preferred Care
Gender-Affirming Treatment Expense (continued) • Charges for blood transfusion and the cost of unreplaced blood and blood products. • Charges made by a behavioral health provider for gender affirming-counseling • Mammoplasty • Thyroid Chondroplasty • Facial Feminization Surgery • Vocal Folds Shortening • Retro displacement of Anterior Commissure (VFSRAC) • Follicular Unit Extraction (FUE) • Follicular Unit Transplant (FUT) • Speech Therapy • Tracheal Shave (Adam's Apple) • Removal of Hair for Male to Female patients (Electrolysis and Laser) No benefits will be paid for covered medical expenses under this benefit unless they have been pre-certified by Aetna. Refer to the Pre-certification section for more information.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Chiropractic Treatment Expense Includes charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine. **Referral not required**	After a **$25** Copay per visit, **90%** of the Negotiated Charge	After a **$35** Copay per visit, **80%** of the Negotiated Charge	After a **$40** per visit Deductible, **60%** of the Recognized Charge
In-Hospital Dental Procedure Expense Covered expenses include charges for general anesthesia and associated hospital or ambulatory surgical facility charges for dental care provided if the covered person is: • 7 years of age or younger or is developmentally disabled; • an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition; or • an individual who has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation.	Payable in accordance with the type of expense incurred and the place where service is provided.		

Telemedicine Expense Telemedicine: The practice of health care delivery, diagnosis, consultation, and treatment of a covered illness or injury by way of the transfer of medical data by electronic means including audio, video, or data communications.	Payable in accordance with the type of expense incurred and the place where service is provided.

SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE

Inpatient rehabilitation benefits for the services listed will be paid as part of the Hospital Expense and Skilled Nursing Facility Expense benefits.

Cardiac Rehabilitation Benefits

Cardiac rehabilitation benefits received at a hospital, skilled nursing facility, or physician's office. This Plan will cover charges in accordance with a treatment plan as determined by a covered person's risk level when recommended by a physician.

Pulmonary Rehabilitation Benefits

Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.

SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE	Core Network	Preferred Care	Non-Preferred Care
Cardiac Rehabilitation	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Pulmonary Rehabilitation	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

SHORT-TERM REHABILITATION EXPENSE

Includes charges for short-term rehabilitation services, as described below, when prescribed by a physician. Short-term rehabilitation services must follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration;
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- Allows therapy services, provided in a covered person's home, if the covered person is homebound.

Inpatient rehabilitation benefits for the services listed will be paid as part of the inpatient hospital and skilled nursing facility benefits.

Short-Term Rehabilitation Expense Outpatient Cognitive, Physical, Occupational and Speech Rehabilitation and Habilitation Therapy Services (combined)	After a **$35** Copay per visit, **90%** of the Negotiated Charge	After a **$35** Copay per visit, **80%** of the Negotiated Charge	After a **$40** per visit Deductible, **60%** of the Recognized Charge
TREATMENT OF MENTAL DISORDER EXPENSE	**Core Network**	**Preferred Care**	**Non-Preferred Care**
Inpatient Mental Health & Residential Mental Health Treatment Facility Expense Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

TREATMENT OF MENTAL DISORDER EXPENSE (continued)	Core Network	Preferred Care	Non-Preferred Care
Inpatient Mental Health Physician Services per Admission & Residential Mental Health Treatment Physician Services Expense	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Outpatient Mental Health Expense: Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine consultations)	After a **$10** Copay per visit, **90%** of the Negotiated Charge	After a **$10** Copay per visit, **80%** of the Negotiated Charge	After a **$10** per visit Deductible, **80%** of the Recognized Charge
All Other Outpatient Mental Health Expenses including: Partial Hospitalization Expense; Intensive Outpatient Program provided in a facility or program for mental health or substance abuse treatment provided under the direction of a physician; Other outpatient mental health treatment such as: Electro-convulsive therapy (ECT); Mental disorder injectables and; Transcranial magnetic stimulation (TMS).	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
ALCOHOLISM AND DRUG ADDICTION TREATMENT	**Core Network**	**Preferred Care**	**Non-Preferred Care**
Inpatient Substance Abuse & Residential Substance Abuse Treatment Facility Expense Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Inpatient Substance Abuse Physician Services per Admission & Residential Substance Abuse Treatment Physician Services Expense	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Outpatient Substance Abuse Treatment	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

TRANSPLANT SERVICES EXPENSE	Core Network	Preferred Care	Non-Preferred Care
Transplant Services Expense Benefits may vary if an Institute of Excellence™ (IOE) facility or non-IOE or non-preferred care provider is used. Through the IOE network, the covered person will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure the covered person requires. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Transplant Travel and Lodging Expense The plan will reimburse a covered person for some of the cost of their travel and lodging expenses. Benefits are limited to **$10,000** per transplant.	**100%** of Actual up to **$50** per night per companion and IOE patient.		
PEDIATRIC DENTAL SERVICES EXPENSE (Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	**Core Network**	**Preferred Care**	**Non -Preferred Care**
Type A Expense (Pediatric Routine Dental Exam Expense)	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**100%** of the Recognized Charge*
Type B Expense (Pediatric Basic Dental Care Expense)	**70%** of the Negotiated Charge*	**70%** of the Negotiated Charge*	**70%** of the Recognized Charge*
Type C Expense (Pediatric Major Dental Care Expense)	**60%** of the Negotiated Charge*	**60%** of the Negotiated Charge*	**60%** of the Recognized Charge*
Pediatric Orthodontia Expense • Orthodontics • Medically necessary comprehensive treatment • Replacement of retainer (limit one per lifetime).	**60%** of the Negotiated Charge*	**60%** of the Negotiated Charge*	**60%** of the Recognized Charge*

PEDIATRIC ROUTINE VISION (Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	Core Network	Preferred Care	Non -Preferred Care
Pediatric Routine Vision Exams (including refractions) Includes charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction & glaucoma testing. Benefits are limited to 1 visit per policy year.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge*
Pediatric Visit for the fitting of prescription contact lenses, Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses Includes charges for the following vision care services and supplies: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a preferred care provider. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a non-preferred care provider. Coverage includes charges incurred for: • Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses. Aphakic prescription lenses prescribed after cataract surgery has been performed. 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.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge*

***Annual Deductible does not apply to these services**

PRESCRIBED MEDICINES EXPENSE

COVERED PERCENTAGE*	Preferred Care	Non-Preferred Care
Preventive Care Drugs and Supplements **Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.** HPV vaccination is approved for members between 26-45 years of age who are starting a new series.		
Risk Reducing Breast Cancer Prescription Drugs For each **30**-day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	**100%** of the Recognized Charge
Other preventive care drugs and supplements For each **30**-day supply filled at a retail pharmacy.	**100%** per supply	**100%** of the Recognized Charge
CONTRACEPTIVES	**Preferred Care**	**Non-Preferred Care**
For each **30**-day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	**100%** of the Recognized Charge
ALL OTHER PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each **30**-day supply filled at a retail pharmacy.	**100%** of the Negotiated Charge	**100%** of the Recognized Charge

*The prescription drug plan covered percentage is the percentage of prescription drug covered medical expenses that the plan pays after any applicable deductibles and copays have been met.

PER PRESCRIPTION COPAY/DEDUCTIBLE

	Preferred Care	Non-Preferred Care
Generic Prescription Drugs For each **30**-day supply filled at a retail pharmacy.	**$15** Copay per supply	**$15** Deductible per supply
Preferred Brand-Name Prescription Drugs For each **30**-day supply filled at a retail pharmacy.	**$35** Copay per supply	**$35** Deductible per supply
Non-Preferred Brand-Name Prescription Drugs For each **30**-day supply filled at a retail pharmacy.	**$65** Copay per supply	**$65** Deductible per supply
Specialty Drugs For each **30**-day supply filled at a retail pharmacy.	**$150** Copay per supply**;** **$0** copay per supply if enrolled in Prudent RX	**Not applicable**
Orally Administered Anti-Cancer Prescription Drugs (including Chemotherapy Drugs)	Payable on the same basis as covered cancer chemotherapy medications that are administered intravenously or by injection.	

A 90 day supply option is available. The applicable copay per prescription will apply.

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

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

The per prescription copay/deductible and policy year deductible will not apply to risk-reducing breast cancer generic, prescription drugs when obtained at a preferred care pharmacy. This means that such risk-reducing breast cancer generic prescription drugs will be paid at 100%.

Waiver for Prescription Drug Contraceptives

The per prescription copay/deductible and policy year deductible will not apply to:

- Female contraceptives that are:
    - Oral prescription drugs that are generic prescription drugs.
    - Injectable prescription drugs that are generic prescription drugs.
    - Vaginal ring prescription drugs that are generic prescription drugs, brand-name prescription drugs and biosimilar prescription drugs.
    - Transdermal contraceptive patch prescription drugs that are generic prescription drugs, brand-name prescription drugs, and biosimilar prescription drugs.
- Female contraceptive devices.
- FDA-approved female:
    - generic emergency contraceptives; and
    - generic over-the-counter (OTC) emergency contraceptives.

when obtained at a preferred care pharmacy. This means that such contraceptive methods will be paid at 100%.

The per prescription copay/deductible and policy year deductible continue to apply:

- When the contraceptive methods listed above are obtained at a non-preferred pharmacy.
- To female contraceptives that are:
    - Oral prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
    - Injectable prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
- To female contraceptive devices that are brand-name devices.
- To FDA-approved female:
    - brand-name and biosimilar emergency contraceptives; and
    - brand-name over-the-counter (OTC) emergency contraceptives.
- To FDA-approved female brand-name over-the-counter (OTC) contraceptives.
- To FDA-approved male brand-name over-the-counter (OTC) contraceptives.

However, the per prescription copay/deductible and policy year deductible will not apply to such contraceptive methods if:

- A generic equivalent, biosimilar or generic alternative, within the same therapeutic drug class is not available; or
- A covered person is granted a medical exception; or
- A physician specifies “Dispense as Written” (DAW).

A covered person's prescriber may seek a medical exception by submitting a request to Aetna's Pre-certification Department. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case medically necessary determination and coverage will not apply or extend to other covered persons.

Exclusions

This Plan does not cover nor provide benefits for:

1. Expense incurred for dental treatment, services and supplies except for those resulting from injury to sound natural teeth or for extraction of impacted wisdom teeth and those as specially covered under the Policy.

2. Expense incurred for services normally provided without charge by the Policyholder's school health services; infirmary or hospital; or by health care providers employed by the Policyholder.

3. Expense incurred as a result of injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense so long as they are not taken against persons who are trying to restore law and order.

4. Expense incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.

5. Expense incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.

6. Expense incurred as a result of an injury sustained or sickness contracted while in the service of the Armed Forces of any country. Upon the covered person entering the Armed Forces of any country, the unearned pro rata premium will be refunded to the Policyholder.

7. Expense incurred for treatment provided in a governmental hospital unless there is a legal or regulatory obligation to pay such charges in the absence of insurance.

8. Expense incurred for elective treatment or elective surgery except as specifically covered under the Policy and provided while the Policy is in effect.

9. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance whether or not for psychological or emotional reasons except to the extent needed to:
   - Improve the function of a part of the body that is not a tooth or structure that supports the teeth and is malformed as a result of a severe birth defect including harelip, webbed fingers or toes, or as direct result of disease or surgery performed to treat a disease or injury.
   - Repair an injury (including reconstructive surgery for prosthetic device for a covered person who has undergone a mastectomy) which occurs while the covered person is covered under the Policy. Surgery must be performed in the policy year of the accident which causes the injury or in the next policy year.

10. Expense incurred as a result of commission of a felony.

11. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits provision.

12. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.

13. Expense incurred for any services rendered by a member of the covered person's immediate family or a person who lives in the covered person's home.

14. Expense incurred for the male or female reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.

15. Expenses for treatment of injury or sickness to the extent that payment is made as a judgment or settlement by any person deemed responsible for the injury or sickness (or their insurers).

16. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.

17. Expense incurred for custodial care.

18. Expense incurred for the removal of an organ from a covered person for the purpose of donating or selling the organ to any person or organization except as specifically covered in the Policy. This limitation does not apply to a donation by a covered person to a spouse, child, brother, sister, or parent.

19. Expenses incurred for blood or blood plasma except charges made by a hospital for the processing or administration of blood.

20. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices except as specifically covered in the Policy.

21. Expense incurred for, or in connection with, drugs, devices, procedures, or treatments that are, as determined by Aetna to be, experimental or investigational except as specifically covered under the Policy.

22. Expenses incurred for breast reduction/mammoplasty.

23. Expenses incurred for gynecomastia (male breasts).

24. Expense incurred by a covered person not a United States citizen for services performed within the covered person’s home country if the covered person’s home country has a socialized medicine program.

25. Expense incurred for acupuncture except as specifically covered under the Policy.

26. Expense incurred for alternative holistic medicine and/or therapy including, but not limited to, yoga and hypnotherapy unless specifically covered under the Policy.

27. Expense for injuries sustained as the result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not claim is made for such benefits. The Policy will only pay for those losses which are not payable under the automobile medical payment insurance Policy.

28. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.

29. Expense incurred for hearing exams, hearing aids; the fitting; or prescription of hearing aids except as specifically covered under the Policy. Not covered are:
    - Any hearing service or supply that does not meet professionally accepted standards;
    - Hearing exams given during a stay in a hospital or other facility;
    - Any tests, appliances, and devices for the improvement of hearing, including aids, hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech; and
    - Routine hearing exams, except for routine hearing screenings as specifically described under Preventive Care Benefits.

30. Expense for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.

31. Expense for personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment even if such items are prescribed by a physician.

32. Expense incurred for any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Policy, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal.

33. Expense for incidental surgeries and standby charges of a physician.

34. Expense for services and supplies for or related to gamete intrafallopian transfer, artificial insemination, in-vitro fertilization (except as required by the state law) or embryo transfer procedures, male elective sterilization, male or female elective sterilization reversal, or elective termination, unless specifically covered in the Policy.

35. Expense incurred for non-preferred care charges that are not recognized charges.

36. Expense for treatment of covered students who specialize in the mental health care field and who receive treatment as a part of their training in that field.

37. Expense incurred for routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically covered in the Policy.

38. Expense incurred for a treatment, service, prescription drug, or supply which is not medically necessary as determined by Aetna for the diagnosis, care, or treatment of the sickness or injury involved, the restoration of physiological functions, or covered preventive services. This includes behavioral health services that are not primarily aimed at treatment of sickness, injury, restoration of physiological functions or that do not have a physiological or organic basis. This applies even if they are prescribed, recommended, or approved by the person's attending physician, dentist, or vision provider.

39. Expenses incurred for vision-related services and supplies, except as specifically covered in the Policy. In addition, the plan does not cover:
    - Special supplies such as non-prescription sunglasses;
    - Vision service or supply which does not meet professionally accepted standards;
    - Special vision procedures, such as orthoptics or vision training;
    - Eye exams during a 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; and
    - Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
    - Services to treat errors of refraction.

40. Expense incurred for private duty nursing services during a stay in a hospital, and outpatient private duty nursing services. Skilled nursing services are covered as specifically described in the Policy in accordance with a home health care plan approved by Aetna.

41. Expense incurred for designated care and preferred care charges in excess of the negotiated charge.

42. Expense incurred for behavioral health services for the following categories (or equivalent terms as listed in the most recent version of the International Classification of Diseases (ICD)) except as specifically covered in the Policy:
    - Dementias and amnesias without behavioral disturbances;
    - Sexual deviations and disorders except for gender identity disorders;
    - Tobacco use disorders;
    - Specific disorders of sleep;
    - Antisocial or dissocial personality disorder;
    - Pathological gambling, kleptomania, pyromania;
    - Specific delays in development (learning disorders, academic underachievement); and
    - Mental retardation.

43. Expense incurred in a facility for care, services or supplies provided in:
    - Rest homes;
    - Assisted living facilities;
    - Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
    - Health resorts;
    - Spas, sanitariums;

- Infirmaries at schools, colleges or camps; and
- Wilderness Treatment Programs or any such related or similar program, school and/or education service.

44. Expense incurred for early intensive behavioral interventions (including Applied Behavior Analysis, Denver, LEAP, TEACHH, Rutgers, floor time, Lovaas and similar programs) except as specifically covered in the Policy.

45. 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).

46. Expense incurred for drugs, medications and supplies, except as specifically covered in the Policy. Not covered are:
    - Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
    - Services related to the dispensing, injection or application of a drug;
    - A prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
    - Immunizations related to work;
    - Needles, syringes and other injectable aids, except as covered for diabetic supplies, and for a covered drug;
    - Drugs related to the treatment of non-covered medical expenses;
    - Performance enhancing steroids;
    - Implantable drugs and associated devices;
    - Injectable drugs if an alternative oral drug is available, unless medically necessary;
    - Any expenses for prescription drugs, and supplies covered under the Pharmacy Plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage; and
    - Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy whether functional or organic.

47. Expense incurred for educational services:
    - Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
    - Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills
    - Services eligible under the Individuals with Disabilities in Education Act (IDEA).

48. Expenses incurred for food items except as specifically covered under the Policy: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

49. Expense incurred in relation to genetics: Except as specifically covered in the Policy, the plan does not cover any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

50. Expense incurred for any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones except as specifically covered in the Policy.

51. Expense incurred for outpatient cognitive therapy, physical therapy, and occupational therapy, except as specifically covered in the Policy. Not covered under the Policy are charges for:
    - Educational services;
    - Any services unless provided in accordance with a specific treatment plan;
    - Any services which are covered medical expenses in whole or in part under any other group plan sponsored by an employer;
    - Services provided during a stay in a hospital, skilled nursing facility or hospice facility except as specifically covered in Policy section;
    - Services provided by a home health care agency;
    - Services provided by a physician or treatment covered as part of Chiropractic Treatment. This applies whether or not benefits have been paid under the Chiropractic Treatment benefit;
    - Services not performed by a physician, occupational or physical therapist or under the direct supervision of a physician;
    - Services provided by a physician or physical or occupational therapist who resides in your home; or who is a member of your family, or a member of your spouse's or your domestic partner's family; and
    - Special education to instruct a person to function. This includes lessons in sign language.

52. Expense incurred for outpatient speech therapy. Except as specifically covered in the Policy, not covered are charges for:
    - Any services unless provided in accordance with a specific treatment plan;
    - Services provided during a stay in a hospital, skilled nursing facility or hospice facility except as specifically covered in the Policy;
    - Services provided by a home health care agency;
    - Services not performed by a physician, or speech therapist or under the direct supervision of a physician;
    - Services provided by a physician or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's or your domestic partner's family; and
    - Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

53. Expense incurred for therapies and tests: Any of the following treatments or procedures including but not limited to:
    - Aromatherapy;
    - Bio-feedback and bioenergetic therapy;
    - Carbon dioxide therapy;
    - Chelation therapy (except for heavy metal poisoning);
    - Computer-aided tomography (CAT) scanning of the entire body;

- Early intensive behavioral interventions (including Applied Behavior Analysis, Denver, LEAP, TEACHH, Rutgers programs) except as specifically covered in the What the Medical Plan Covers Section;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Additional Pediatric Dental Services Exclusions and Limitations
The Pediatric Dental Services benefit is subject to the following additional exclusions and limitations:

54. Expenses incurred for any instruction for diet, plaque control and oral hygiene.

55. Expenses incurred for 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 covered in the Policy. Facings on molar crowns and pontics will always be considered cosmetic.

56. Expenses incurred for crown, inlays and onlays, and veneers unless:
    - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
    - The tooth is an abutment to a covered partial denture or fixed bridge.

57. Expenses incurred for dental examinations that are:
    - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
    - Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
    - Required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and

- Any special medical reports not directly related to treatment except when provided as part of a covered service.

58. Expenses incurred for dental implants, braces (that are not determined to be a dental necessity), mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

59. Expenses incurred for dental services and supplies that are covered in whole or in part under any other part of this plan.

60. Expenses incurred for dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, abfraction or erosion.

61. Expenses incurred for general anesthesia and intravenous sedation, except as specifically covered in the Policy and only when done in connection with another medically necessary covered service or supply.

62. Expenses incurred for orthodontic treatment except as specifically covered in the Policy.

63. Expenses incurred for pontics, crowns, cast or processed restorations made with high noble metals (gold).

64. Expenses incurred for replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

65. Expenses incurred for replacement of teeth beyond the normal complement of 32.

66. Expenses incurred for routine dental exams and other preventive services and supplies, except as specifically covered in the Policy.

67. Expenses incurred for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

68. Expenses incurred for the surgical removal of impacted wisdom teeth only for orthodontic reasons.

69. Expenses incurred for treatment by other than a dentist or dental provider that is legally qualified to furnish dental services or supplies.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

The Emory University Student Health Insurance Plan is self-funded by Emory University, with claim administration services provided by Aetna Life Insurance Company. Aetna Student Health^{SM} is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

IMPORTANT NOTICES:

The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

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**.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-877-261-8403.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), **CRCoordinator@aetna.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

To access language services at no cost to you, call 1-877-261-8403.

Para acceder a los servicios de idiomas sin costo, llame al 1-877-261-8403. (Spanish)

如欲使用免費語言服務，請致電 1-877-261-8403。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-877-261-8403. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-261-8403. (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-261-8403 an. (German)

(Arabic) .1-877-261-8403 لوصحلل ىلع تامدخلا ةيوغللا نود أي ةفلكت، ءاجرلا ،لاصتلاا ىلع مقرلا

Pou jwenn sèvis lang gratis, rele 1-877-261-8403. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-261-8403. (Italian)

言語サービスを無料でご利用いただくには、1-877-261-8403 までお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 1-877-261-8403 번으로 전화해 주십시오. (Korean)

(Persian-Farsi) .یارب یسرتسد هب تامدخ نابز روط رایگان، با هرامش 8403-261-877-1 تماس یگیرید

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-261-8403. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-261-8403. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-261-8403. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-261-8403. (Vietnamese)