Aetna Student Health
Major Medical Outline of Coverage

Preferred Provider Organization (PPO)

Dickinson College

Policy Year: 2024 – 2025
Policy Number: 198841
https://www.aetnastudenthealth.com
(877) 626-2308

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

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

Notice:
This health insurance policy may not cover all your health care expenses. Read your member certificate carefully to determine which health care services are covered.

STUDENT HEALTH SERVICES

The Wellness Center offers health services to currently enrolled students and serves as their primary-care provider while you are away from home. The Center is staffed with nurse practitioners and offers multiple services, including treatment for common illnesses and injuries, preventive sexual-health services, immunizations, and physical exams. All students are eligible to be seen regardless of health insurance type.

Appointments are required and can usually be made for the same day or the following day. To make an appointment, call **(717) 245-1663**.

Who is eligible?

All Full-Time Domestic Undergraduate students are required to purchase this insurance plan unless proof of comparable coverage is furnished. Students must enroll or waive the school-sponsored insurance plan each academic year.

All **International** students and **Visiting Scholars** are automatically enrolled in this insurance plan at registration.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence and online courses do not fulfill the Eligibility requirements that the student actively attend classes.

It is important for you to make an informed health assessment each year. Make sure you are not left without appropriate health coverage – it could hinder your academic progress.

Coverage Dates and Rates

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

	Annual **08/01/2024 – 07/31/2025**	**Spring** **01/01/2025 – 07/31/2025**
Student	$2,211	$1,284
Spouse	$2,211	$1,284
One Child	$2,211	$1,284
Two or More Children	$4,422	$2,568

Enrollment

To complete the Enrollment or Waiver process, please go to **www.RCMDstudentbenefits.com,** select your school, select "**Enroll/Waive**" and follow instructions. You will need to enter your date of birth and student ID number.
Once you are enrolled in the plan, there are no refunds or cancelations after the deadline date of **Annual 8/30/2024**, **Spring 1/31/2025** ***(for new incoming students)***, except for ineligibility or entry to the armed forces. The Policy is a Non-Renewable One-Year Term Policy and does not guarantee enrollment in the next policy year.

Students who fail to waive coverage before the deadline dates: **Annual 8/30/2024**, **Spring 1/31/2025** ***(for new incoming students)*** you will be enrolled automatically and responsible to pay for this coverage that was purchased on your behalf. If you have any questions, please email **dickinson@rcmd.com**.

Dependent Coverage Eligibility

Covered students may also enroll their lawful spouse, and dependent children up to the age of 26.

To complete a Dependent Enrollment, please go to **www.RCMDstudentbenefits.com**, select your school, select "**Enroll/Waive**" and follow instructions. You will need to enter the student's date of birth and student ID number. Dependent enrollment will not be accepted after the enrollment deadlines stated above, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.)

If you need information or have general questions on dependent enrollment, call Member Services at **877-626-2308**.

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

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

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

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

Medicare Eligibility Notice

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

Termination and Refunds

Withdrawal from Classes – Leave of Absence: If you withdraw from classes under a school-approved leave of absence, your coverage will remain in force through the end of the period for which premium payment has been received. No premiums will be refunded.

Withdrawal from Classes – Other than Leave of Absence: If you withdraw from classes within 31 days after the policy effective date, you will be considered ineligible for coverage. Your coverage will be terminated retroactively, and any premium paid will be refunded. If you withdraw from classes more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which premium payment has been received. No premium will be refunded. If you withdraw from classes to enter the armed forces of any country, your coverage will end as of the date of such entry. We will refund your premium, on a pro-rata basis, if you submit a written request within 90 days from the date you withdraw.

In-network Provider Network

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

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

Access our provider directory to find in-network providers for your plan at https://www.aetnastudenthealth.com.

Precertification

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

Precertification Call

Precertification should be secured within the timeframes specified below. To obtain precertification, call Member Services at the toll-free number on your ID card. You, your physician or the facility must call us within these timelines:

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

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

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

Coordination of Benefits (COB)

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

Description of Benefits

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

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

Policy year deductible	**In-network coverage**	**Out-of-network coverage**
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$100 per policy year	$350 per policy year
Spouse	$100 per policy year	$350 per policy year
Child	$100 per policy year	$350 per policy year
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network care for Preventive care and wellness; Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist); Walk-in clinic visits (non-emergency visit); Mental Health & Substance Abuse Treatment Outpatient office visits; Pediatric Dental Type A services; and Pediatric Vision Care Services • In-network care and out-of-network care for Pediatric preventive care immunizations; Hospital emergency room; Ambulance; Urgent care; Well newborn nursery care; Outpatient prescription drugs; and Nutritional supplements		
Eligible health services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Eligible health services applied to the in-network policy year deductibles will not be applied to satisfy the out-of-network policy year deductibles.		
Maximum out-of-pocket limit per policy year		
Student	$2,000 per policy year	$6,000 per policy year
Spouse	$2,000 per policy year	$6,000 per policy year
Child	$2,000 per policy year	$6,000 per policy year
Family	$4,000 per policy year	Unlimited
Eligible health services applied to the out-of-network maximum out-of-pocket limit will not be applied to satisfy the in-network maximum out-of-pocket limit and eligible health services applied to the in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.		

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care and wellness		
Routine physical exams	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Covered persons through age 21: Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.	
Covered persons age 22 and over: Maximum visits per policy year	1 visit	
Preventive care immunizations Performed in a facility or at a physician's office		
Preventive care immunizations	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Preventive care immunization maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel		
Well woman preventive visits **Routine gynecological exams (including Pap smears and cytology tests)**		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Well woman routine gynecological exam maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Maximum visits per policy year	1 visit	
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
Obesity and/or healthy diet counseling - Maximum visits	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	
Misuse of alcohol and/or drugs counseling - Maximum visits per policy year	5 visits	
Use of tobacco products counseling - Maximum visits per policy year	8 visits	
Sexually transmitted infection counseling - Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations	
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration.	
Lung cancer screening maximum	1 screening every 12 months	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Lactation counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
Family planning services – female contraceptives - Counseling services		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	Not covered
Female Voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	70% (of the recognized charge)
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a provider		
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) Includes telemedicine consultations	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Allergy injections treatment performed at a physician's or specialist office	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
The following are not covered under this benefit: • Allergy sera and extracts administered via injection		

Eligible health services	In-network coverage	Out-of-network coverage
Physician and specialist - surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	90% (of the negotiated charge)	70% (of the recognized charge)
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic		
Physician and specialist - surgical services (continued)		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit
Hospital and other facility care		
Inpatient hospital (room & board, including intensive care) and other miscellaneous services and supplies) Includes birthing center facility charges	90% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
In-hospital non-surgical physician services	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Preadmission testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	90% (of the negotiated charge)	70% (of the recognized charge)
The following are not covered under this benefit: • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		

Eligible health services	In-network coverage	Out-of-network coverage
Alternatives to hospital stays (continued)		
Home health care	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
The following are not covered under this benefit: • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities) • Transportation • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy		
Hospice - Inpatient	90% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
Hospice - Outpatient	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Respite care-maximum number of days	7 days per 30-day period	
The following are not covered under this benefit: • Funeral arrangements • Pastoral counseling • Bereavement counseling • Financial or legal counseling which includes estate planning and the drafting of a will • Homemaker or caretaker services that are services which are not solely related to your care and may include: - Sitter or companion services for either you or other family members - Transportation - Maintenance of the house		
Outpatient private duty nursing	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Skilled nursing facility - Inpatient	90% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
Emergency services and urgent care		
Hospital emergency room	$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered
Emergency services important note: • Out-of-network providers do not have a contract with us. The provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by the plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card and we will resolve any payment issue with the provider. Make sure the member ID is on the bill. • A separate hospital emergency room copayment will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment will be waived and your inpatient copayment will apply.		

- Covered benefits that are applied to the hospital emergency room copayment cannot be applied to any other copayment under the plan. Likewise, a copayment that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment.
- Separate copayment amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment amounts may be different from the hospital emergency room copayment. They are based on the specific service given to you.
- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment amounts.

The following are not covered under this benefit:
- Non-emergency services in a hospital emergency room facility, freestanding emergency medical care facility or comparable emergency facility

Eligible health services	**In-network coverage**	**Out-of-network coverage**
Urgent Care	$50 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$50 copayment then the plan pays 80% (of the balance of the recognized charge) per visit No policy year deductible applies
Non-urgent use of urgent care provider	Not covered	Not covered

The following is not covered under this benefit:
- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	80% (of the recognized charge) per visit
Type B services	70% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Pediatric dental care exclusions
These dental exclusions are in addition to the exclusions that apply to health coverage.
The following are not covered under this benefit:
- Any instruction for diet, plaque control and oral hygiene
- Cosmetic services and supplies including:
  - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance

    - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Eligible health services and exclusions* section
    - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
    - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
    - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary), mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of:
    - Splinting
    - To alter vertical dimension
    - To restore occlusion
    - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Orthodontic treatment except as covered above and in the [*Pediatric*] *dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits
- Services and supplies:
    - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
    - Provided for your personal comfort or convenience or the convenience of another person, including a provider
    - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider

Eligible health services	In-network coverage	Out-of-network coverage
Specific conditions		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Podiatric (foot care) treatment - Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Services and supplies for: - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet		
Impacted wisdom teeth	90% (of the negotiated charge)	90% (of the recognized charge)
Accidental injury to sound natural teeth	90% (of the negotiated charge)	90% (of the recognized charge)
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants		
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e., protocol-induced costs) • Services and supplies provided by the trial sponsor without charge to you • The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Cosmetic treatment and procedures		

Eligible health services	In-network coverage	Out-of-network coverage
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		
Well newborn nursery care in a hospital or birthing center	90% (of the negotiated charge) No policy year deductible applies	70% (of the recognized charge) No policy year deductible applies
Abortion – inpatient physician or specialist surgical services	90% (of the negotiated charge)	70% (of the recognized charge)
Abortion – outpatient physician or specialist surgical services	90% (of the negotiated charge)	70% (of the recognized charge)
Voluntary sterilization for males - Inpatient surgical services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Voluntary sterilization for males - Outpatient surgical services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not eligible health services under this benefit: • Any treatment, surgery, service, or supply that is not in the list above of eligible health services		
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing. Includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage	Out-of-network coverage
Behavioral Health **Mental Health & Substance related disorders**		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	90% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
Outpatient office visits (includes telemedicine consultations)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Eligible health services	**In-network coverage** (IOE facility)	**Out-of-network coverage** (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Transplant services		
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received	
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received	
Transplant services-travel and lodging	Covered	Covered
Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	$10,000	$10,000
Maximum payable for Lodging Expenses per IOE patient	$50 per night	$50 per night
Maximum payable for Lodging Expenses per companion	$50 per night	$50 per night
The following are not covered under this benefit: • Services and supplies furnished to a donor when the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness		

Eligible health services	In-network coverage	Out-of-network coverage
Infertility Services		
Treatment of Basic infertility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Comprehensive infertility services The cost shares and deductible, if any, that apply to comprehensive infertility services, do not apply to the maximum out-of-pocket limit.		
Inpatient and outpatient care	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Artificial insemination maximum per lifetime	6 attempts	
Maximum number of ovulation induction cycles per lifetime while on medications to stimulate the ovaries	6 attempts	
Maximum number of artificial insemination cycles per lifetime	6 attempts	

Infertility services exclusions

The following are not covered under the infertility services benefit:

- Infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All infertility services associated with or in support of an Advanced Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, and professional services
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers
  - Gestational carrier cycles
  - Any related services, products, or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery).
- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.

  Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy, and vasectomy only if obtained as a form of voluntary sterilization.
- Infertility treatment when infertility is due to a natural physiologic process such as age-related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's infertility clinical policy.
- Treatment for dependent children

Eligible health services	In-network coverage	Out-of-network coverage
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	90% (of the negotiated charge)	70% (of the recognized charge)
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	90% (of the negotiated charge)	70% (of the recognized charge)
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility	90% (of the negotiated charge)	70% (of the recognized charge)
Outpatient Chemotherapy, Radiation & Respiratory Therapy	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan • Enteral nutrition • Blood transfusions and blood products • Dialysis		
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Chiropractic services	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Other services		
Emergency ground, air, and water ambulance	$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per trip No policy year deductible applies	Paid the same as in-network coverage
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient care		
Durable medical and surgical equipment	90% (of the negotiated charge) per item	70% (of the recognized charge) per item
The following are not covered under this benefit:		

• Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Nutritional support	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition		
Prosthetic Devices & Orthotics	90% (of the negotiated charge) per item	70% (of the recognized charge) per item
The following are not covered under this benefit: • Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft • Communication aids • Cochlear implants		
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams (including refraction) performed by a legally qualified ophthalmologist or optometrist Includes comprehensive low vision evaluations Includes visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item	80% (of the recognized charge) per item

	No policy year deductible applies	
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3-month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set	
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Optical devices	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maximum number of optical devices per policy year	One optical device	
***Important note**: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.		
The following are not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		

Outpatient prescription drugs
Policy year deductible and copayment waiver for risk reducing breast cancer
The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.
Policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs
The policy year deductible and the prescription drug copayment will not apply to the first two 90-day treatment regimens] for tobacco cessation prescription drugs and OTC drugs when obtained at a retail or mail order, in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your policy year deductible and any prescription drug copayment will apply after those two regimens have been exhausted.
Policy year deductible and copayment waiver for contraceptives
The policy year deductible and the prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy. This means that such contraceptive methods are paid at 100% for: Certain over-the-counter (OTC) and contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%.

The policy year deductible and the prescription drug copayment continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Outpatient prescription drugs		
Preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$90 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Non-preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$135 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Non-preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$135 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Contraceptives (birth control)		
For each fill up to a 30-day supply of generic and OTC drugs and devices filled at a retail or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	Not covered
For each fill up to a 30-day supply of brand name prescription drugs and devices filled at a retail or mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Not covered
Orally administered anti-cancer prescription drugs For each fill up to a 30-day supply filled at a retail or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	Not covered
Preventive care drugs and supplements filled at a retail or mail order pharmacy For each 30–day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Not covered
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30–day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Not covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30–day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Not covered
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	

Outpatient prescription drug exclusions

The following are not eligible health services:

• Allergy sera and extracts given by injection

• Any services related to providing, injecting or application of a drug

• Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones

• Cosmetic drugs including medication and preparations used for cosmetic purposes

• Devices, products and appliances unless listed as an eligible health service

• Dietary supplements including medical foods

• Drugs or medications:

- Administered or entirely consumed at the time and place they are prescribed or provided

- Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception

- That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception

- Not approved by the FDA or not proven safe or effective

- Provided under your medical plan while inpatient at a healthcare facility

- Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception

- That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)

- That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as an eligible health service

- That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications

- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the covered person meets one or more clinical criteria detailed in our [precertification] and clinical policies

• Duplicative drug therapy; for example, two antihistamines for the same condition

• Genetic care including:

- Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as an eligible health service

• Immunizations related to travel or work

• Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate

• Infertility:
- Prescription drugs used primarily for the treatment of infertility
• Injectables including:
- Any charges for the administration or injection of prescription drugs
- Needles and syringes except for those used for insulin administration
- Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
• Off-label drug use except for indications recognized through peer-reviewed medical literature
• Prescription drugs:
- That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
- That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
- That are used for the purpose of improving visual acuity or field of vision
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
• Replacement of lost or stolen prescriptions
• Tobacco cessation drugs, unless recommended by the USPSTF
• We reserve the right to exclude:
- A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide
- Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

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

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

Out of Country claims

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

General Exclusions

Acupuncture

- Acupuncture
- Acupressure

Air or space travel

- Traveling in, on or descending from any aircraft, including a hang glider, while the aircraft is in flight. This includes descending by a parachute, wingsuit or any other similar device.

This exclusion does not apply if:

- You are traveling solely as a fare-paying passenger
- You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
- You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
  - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved
  - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the policyholder performing duties for the policyholder

Alternative health care

- Services and supplies given by a provider for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and traditional Chinese medicine.

Armed forces

- Services and supplies received from a provider as a result of an injury sustained, or illness contracted, while in the service of the armed forces of any country. When you enter the armed forces of any country, we will refund any unearned pro-rata premium.

Behavioral health treatment

- Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association:
  - Stay in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
  - Education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation
  - Sexual deviations and disorders except as described in the Eligible health services and exclusions section
  - Tobacco use disorders except as described in the Eligible health services and exclusions – Preventive care and wellness section

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

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

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

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

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

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

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

Custodial care
Services and supplies meant to help you with activities of daily living or other personal needs.
Examples of these are:
- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care [except in connection with hospice care], adult (or child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training
- For behavioral health (mental health treatment and substance related disorders treatment):

- Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
- Services given mainly to:
  - Maintain, not improve, a level of function
  - Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults

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

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

Educational services

Examples of these services are:

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

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Felony

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

Gene-based, cellular and other innovative therapies (GCIT)

The following are not eligible health services unless you receive prior written approval from us:

- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the *Medical necessity and precertification requirements* section in the certificate.

Genetic care

- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects

Growth/Height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

Hearing aids

Any tests, appliances and devices to:

- Improve your hearing
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Hearing exams

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

Incidental surgeries

- Charges made by a physician for incidental surgeries. These are non-medically necessary surgeries performed during the same procedure as a medically necessary surgery.

Jaw joint disorder
- Surgical treatment of jaw joint disorders
- Non-surgical treatment of jaw joint disorders
- Jaw joint disorders treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to jaw joint disorders including associated myofascial pain

Judgment or settlement
- Services and supplies for the treatment of an injury or illness to the extent that payment is made as a judgment or settlement by any person deemed responsible for the injury or illness (or their insurers)

Mandatory no-fault laws
- Treatment for an injury to the extent benefits are payable under any state no-fault automobile coverage or first party medical benefits payable under any other mandatory no-fault law

Maintenance care
- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the *Eligible health services and exclusions – Habilitation therapy service*s section in the certificate

Medical supplies – outpatient disposable
- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Syringes
  - Blood or urine testing supplies
  - Other home test kits
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Medicare
- Services and supplies available under Medicare, if you are entitled to premium-free Medicare Part A or enrolled in Medicare Part B, or if you are not entitled to premium-free Medicare Part A or enrolled in Medicare Part B because you refused it, dropped it, or did not make a proper request for it

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

Obesity (bariatric) surgery and services

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Eligible health services and exclusions – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
  - Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer

Outpatient prescription or non-prescription drugs and medicines

- Outpatient prescription drugs or non-prescription drugs and medicines provided by the policyholder
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan

Personal care, comfort or convenience items

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

Riot

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

Routine exams

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

Services not permitted by law

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

Services provided by a family member

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

Sexual dysfunction and enhancement

- Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function,

enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Not eligible for coverage are prescription drugs in 60-day supplies

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

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

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

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

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

Therapies and tests
- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

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

Treatment in a federal, state, or governmental entity

- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Vision care for adults

- Routine vision exam provided by an ophthalmologist or optometrist, including refraction and glaucoma testing
- Vision care services and supplies

Voluntary sterilization

- Reversal of voluntary sterilization procedures, including related follow-up care

Wilderness treatment programs

See *Educational services* within this section

Work related illness or injuries

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

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

Sanctioned Countries

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

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

Language accessibility statement

Interpreter services are available for free.

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-877-480-4161** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-480-4161** (TTY: **711**).

አማርኛ/Amharic

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-877-480-4161** (መስማት ለተሳናቸው: **711**).

العربية/Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-480-4161** (رقم الهاتف النصي: **711**).

Ɓàsɔ̀ɔ̀ Wùɖù/Bassa

Dè dɛ nìà kɛ dyɛ́dɛ́ gbo: Ɔ jǔ kɛ́ m̀ dyí Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ nɨ́, nɨ̀ì à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpáa.
Ɖá **1-877-480-4161** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-877-480-4161** (TTY: **711**)。

فارسی/Farsi

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-877-480-4161** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d’une assistance gratuite dans votre langue en composant le **1-877-480-4161** (TTY: **711**).

ગુજરાતી/Gujarati

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે.
કૉલ કરો **1-877-480-4161** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-480-4161** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n’efu, dịịrị gị. Kpọọ **1-877-480-4161** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-877-480-4161**(TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-877-480-4161** (TTY: **711**). Estes serviços são oferecidos gratuitamente.

Русский/Russian

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-877-480-4161** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-480-4161** (TTY: **711**).

Urdu/اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (TTY: **711**) **1-877-480-4161** پر کال کریں.

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị.
Gọi số **1-877-480-4161** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-877-480-4161** (TTY: **711**).

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