Aetna Student Health

Plan Design and Benefits Summary
University of Pennsylvania

Policy Year: 2016 - 2017
Policy Number: 724535

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www.aetnastudenthealth.com
(800) 841-5374

This is a brief description of the Student Health Plan. The Plan is available for University of Pennsylvania students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to the University of Pennsylvania and may be viewed online at **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits.

University Of Pennsylvania Student Health Service

The University provides outpatient medical care to students through the Student Health Service (SHS), a department of the Office of the Vice Provost for University Life. All full-time status students have coverage for care at the Student Health Service. The Student Health Service offers an array of clinical services, including initial and follow-up treatment of acute medical illness and injury, management of chronic health problems, health screening and preventive care. Student Health Service also coordinates referrals to specialists outside of Student Health. The Student Health Service website describes the services that we offer at **http://www.vpul.upenn.edu/shs/services.php.** The focus of the Student Health Service is outpatient primary care; therefore students also need medical insurance to cover the costs of care and services outside of SHS.

For more information, call the Health Services at (215) 746-3535 or visit us at **http://www.vpul.upenn.edu/shs/.**
In the event of an emergency, call 911 or the Campus Police at (215) 573-3333 or **511** from campus phone.

Coverage Periods

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

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/01/2016	07/31/2017	08/31/2016
Spring	01/01/2017	07/31/2017	01/31/2017
Summer	05/01/2017	07/31/2017	05/31/2017

Eligible Dependents: Coverage for dependents eligible under the Plan for the following Coverage Periods. Coverage will, 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 Master Policy.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
Annual	08/01/2016	07/31/2017	08/31/2016
Spring	01/01/2017	07/31/2017	01/31/2017
Summer	05/01/2017	07/31/2017	05/31/2017

December Graduates: If you are a December Graduate, your coverage will terminate at 11:59 p.m. (EST) on **January 31, 2017**. If you have enrolled dependents, their coverage will terminate in conjunction with your own. After enrollment, students may only add a spouse, child, or a domestic partner according to the Spouse/Domestic Partner and Newborn and Adopted Children Enrollment guidelines.

Students on Leave of Absence, or who drop or withdraw from the University after the first 30 days of classes:

Your coverage will terminate at 11:59 p.m. (EST) on **January 31, 2017** unless you enroll in classes in the spring term by **January 31, 2017**. If you have enrolled dependents, their coverage will terminate in conjunction with your own. After enrollment, students may only add a spouse, child, or a domestic partner according to the Spouse/Domestic Partner and Newborn and Adopted Children Enrollment guidelines.

Rates

Rates Undergraduates and Graduate Students			
	Annual	Spring Semester	Summer Semester
Student	$3,348	$1,944	$844
Spouse	$3,348	$1,944	$844
One Child	$3,348	$1,944	$844
Two or more children	$6,696	$3,888	$1,688

Student Coverage

Eligibility

All students of the University who are registered and are actively participating in credit courses leading to a degree or a certificate are eligible to participate in the Penn Student Insurance Plan (PSIP).

NOTE: **English Language Program (ELP) students are not eligible for PSIP and should contact their Program Director for other options**.

Students must actively attend classes for the first 31 days of the official start of university classes.

Internet classes and television (TV) courses may not fulfill this eligibility. If the eligibility requirements are not met, Aetna's only obligation is to refund the premium.

Enrollment

Eligible students can enroll online at **www.aetnastudenthealth.com** and search for your school, then click on Enroll to complete application. **Your PennKey and Password authentication is required. For details, please go to http://www.upenn.edu/computing/pennkey/**.

Each school year, all full-time, dissertation and exchange students here for one semester or more must either enroll in PSIP or waive coverage with proof of comparable coverage by the stated deadline. Selections from previous years are not rolled forward or renewed. Students who do not enroll or waive participation in the Plan by the stated deadline will be subject to default enrollment in PSIP with student coverage only. Dependents are not default enrolled. Part-time students in degree or certification seeking programs are eligible to purchase this coverage as well; however, they are not default enrolled in the Plan. Students who wish PSIP coverage are required to actively enroll online to ensure continuation of insurance benefit without disruption and to guarantee coverage in the event that their student registration status changes. Eligible students can enroll online at **http://www.vpul.upenn.edu/shs/insurance.php** during the designated open enrollment period. Follow the links to the enrollment site). You must have your PennKey to access the system.

Late Enrollment

Coverage for late enrollees may be possible only under certain conditions. After the enrollment deadline, only those students who have involuntarily lost health insurance coverage through a "Qualifying Life Event" such as 1) removal from parent's health insurance coverage after achieving a landmark birthday that disqualifies them from a parent's health insurance plan or 2) losing private health insurance through loss of employment or divorce, may apply for late enrollment. A certificate of credible coverage stating the date of the involuntary loss of health coverage and a signed application must be submitted to the Student Health Insurance Office within 31 days of the qualifying life event. Please contact the Student Health Insurance Office at **(215) 746-3535**, option 3 for details.

Dependent Coverage

Eligibility

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

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting **www.aetnastudenthealth.com**, selecting the school name, and clicking on the "Plans & Products Offered to You" link on the left hand side of the screen, or by calling customer service at **(800) 841-5374** and requesting that an Enrollment Form be sent in the mail. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan). The completed Enrollment Form and premium must be sent to Aetna Student Health.

If, while you are covered by this plan, you have a covered dependent child who is called up for active duty (state National Guard or reserves) while he or she is a full time student, Aetna Student Health will extend this child's coverage upon his or her return until you are no longer covered by this plan. This dependent coverage will be available at the first Fall or Spring enrollment period after the dependent child has 1) returned from duty and 2) returned to full time student status. The offered coverage for this dependent child will continue until A) you are no longer a student covered by this plan; or B) the dependent child is no longer a full time student ***or*** a period of time equal to the duration of the child's military duty has passed.

A person who is eligible for Medicare at the time of enrollment under this plan is not eligible for medical expense coverage and prescribed medicines expense coverage. If a covered person becomes eligible for Medicare after he or she is enrolled in this plan, such Medicare eligibility will not result in the termination of medical expense coverage and prescribed medicines expense coverage under this plan. As used within this provision, persons are "eligible for Medicare" if they are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

Preferred Provider Network

Aetna Student Health has arranged for you to access a Preferred Provider Network in your local community. To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services.

If a service or supply that a covered person needs is covered under the Plan but not available from a Designated Care Provider or Preferred Care Provider, covered persons should contact Member Services for assistance at the toll-free number on the back of the ID card. In this situation, Aetna may issue a pre-approval for a covered person to obtain the

service or supply from a Non-Preferred Care Provider. When a pre-approval is issued by Aetna, covered medical expenses are reimbursed at the Designated Care Preferred Care network level of benefits.

Pre-certification Program

Your Plan requires pre-certification for certain services, such as inpatient stays, certain tests, procedures, outpatient surgery, therapies and equipment, and prescribed medications. Pre-certification simply means calling Aetna Student Health prior to treatment to get approval for coverage under your Plan for a medical procedure or service. For preferred care and designated care, the preferred care or designated care provider is responsible for obtaining pre-certification Since pre-certification is the preferred care or designated care provider's responsibility, there is no additional out-of-pocket cost to you as a result of a designated care provider's or a preferred care provider's failure to pre-certify services. For non-preferred care, you are responsible for obtaining pre-certification which can be initiated by you, a member of your family, a hospital staff member or the attending physician. The pre-certification process can be initiated by calling Aetna at the telephone number listed on your ID card.

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 penalty.

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

- All inpatient admissions, including length of stay, to a hospital, skilled nursing facility, rehabilitation facility, hospice facility, or a residential treatment facility for the treatment of mental disorders and substance abuse, or a residential treatment facility;
- All inpatient maternity care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- All partial hospitalization in a hospital, residential treatment facility, or facility established primarily for the treatment of mental disorders and substance abuse;
- Outpatient complex imaging;
- Inpatient and outpatient comprehensive infertility services;
- Inpatient and outpatient cosmetic and reconstructive surgery;
- Ambulance (emergency transportation by airplane);
- Home hemodialysis and home peritoneal dialysis equipment and medical supplies;
- Injectables, (immunoglobulins, growth hormones, Multiple Sclerosis medications, Osteoporosis medications, Botox, Hepatitis C medications);
- Kidney dialysis;
- Bariatric surgery (obesity);
- Outpatient back surgery not performed in a physician's office;
- Sleep studies;
- Inpatient or outpatient Transplant services;
- Inpatient or outpatient knee surgery; and
- Inpatient or outpatient wrist surgery.

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) day** before the outpatient services, treatments, procedures, visits or supplies are provided or scheduled.

Pre-certification of prenatal care and delivery

Prenatal 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.

Description of Benefits

The Plan excludes coverage for certain services and contains 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 Master Policy issued to University of Pennsylvania, you may access it online at **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits. All coverage is based on Recognized Charges unless otherwise specified.

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

Metallic Level: Platinum, 89.20% Tested at

DEDUCTIBLE	Preferred Care	Non-Preferred Care
The policy year deductible is waived for preferred care covered medical expenses that apply to Preventive Care Expense benefits. In compliance with Pennsylvania mandate(s), the policy year deductible is also waived for: • Cervical Cytologic Screenings. • Child Immunization Services. • Nutritional Supplement Services. In addition to state and federal requirements for waiver of the policy year deductible, the plan will waive the policy year deductible for Emergency Room Expense, Prescribed Medicines Expense, Pap Smear Screening Expense, Vision Care Exam Expense, Immunizations Expense, Diagnostic Testing For Learning Disabilities Expense, Treatment of Mental and Nervous Disorders Expense (inpatient and outpatient), Alcoholism and Drug Addiction Treatment Expense (inpatient and outpatient), and Preferred Care Pediatric Preventive Dental and Vision Services. Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible.	Individual: Students: **$300** per policy year Spouse: **$300** per policy year Child: **$300** per policy year	Individual: Students: **$1,500** per policy year Spouse: **$1,500** per policy year Child: **$1,500** per policy year

COINSURANCE	Preferred Care	Non-Preferred Care
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	**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; • 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: **$900** Family Out-of-Pocket: **$1,800**	Individual Out-of-Pocket: **$4,000** Family Out-of-Pocket: **$8,000**

REFERRAL PENALTY

The covered student must contact the school health services before receiving any medical care. If the covered student does not obtain a referral from school health services, the non-preferred care level of benefits will apply to that care.

Exceptions:

- Emergency Care
- Annual Eye Exam
- Injury to sound natural teeth or the extraction of impacted wisdom teeth
- Mental Health and Substance Abuse
- Women's Health and Voluntary Termination of Pregnancy
- Dependents
- Students on Leave of Absence
- When Student Health Services are closed
- Services rendered **25** miles or greater from Campus
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness)
- Outpatient lab services

Dependents are not subject to the referral requirements and penalties.

INPATIENT HOSPITALIZATION BENEFITS	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.	After a **$100** Copay per admission, **100%** of the Negotiated Charge	After a **$100** per admission Deductible, **70%** 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.	After a **$100** Copay per admission, **100%** of the Negotiated Charge	After a **$100** per admission Deductible, **70%** of the Recognized Charge

INPATIENT HOSPITALIZATION BENEFITS (continued)	Preferred Care	Non-Preferred Care
Miscellaneous Hospital Expense Includes but not limited to: operating room, laboratory tests/X rays, oxygen tent, drugs, medicines and dressings.	**100%** of the Negotiated Charge	**70%** 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.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Well Newborn Nursery Care	**100%** of the Negotiated Charge	**70%** 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.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
SURGICAL EXPENSES	**Preferred Care**	**Non-Preferred Care**
Surgical Expense (Inpatient and 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 procedure, **100%** of the Negotiated Charge	**70%** 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.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Assistant Surgeon Expense (Inpatient and Outpatient)	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
OUTPATIENT EXPENSES	**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 **$30** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge
Laboratory and X-ray Expense	After a **$35** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge
Hospital Outpatient Department Expense	After a **$35** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
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.	After a **$30** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge
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.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Walk-in Clinic Visit Expense	After a **$30** Copay per visit, **100%** of the Negotiated Charge	**70%** 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. **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. 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.	After a **$100** Copay per visit (waived if admitted), **100%** of the Negotiated Charge*	After a **$100** per visit Deductible (waived if admitted), **100%** of the Recognized Charge*

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
Emergency Room Expense (continued) 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. Similarly, services rendered in the emergency room that are not included in the hospital emergency room visit benefit may be subject to coinsurance.	After a **$100** Copay per visit (waived if admitted), **100%** of the Negotiated Charge*	After a **$100** per visit Deductible (waived if admitted), **100%** 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	**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.

PREVENTIVE CARE EXPENSES	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*	**70%** of the Recognized Charge
Preventive Care Immunizations	**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*	**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*	**70%** of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
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*	**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*	**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*	**70%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Depression Screening Screening or test to determine if depression is present.	**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 (removal of polyps performed during a screening procedure is a covered medical expense); and Lung cancer screenings.	**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*	**70%** of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
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*	**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*	**70%** of the Recognized Charge
Preventive Care Breast Pumps and Supplies	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
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. **Contraceptive**s 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*	**70%** of the Recognized Charge
OTHER FAMILY PLANNING SERVICES EXPENSE	**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 • Voluntary termination of pregnancy	After a **$100** Copay per procedure, **100%** of the Negotiated Charge	**70%** of the Recognized Charge

AMBULANCE EXPENSE	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.	**100%** of the Negotiated Charge	**100%** of the Recognized Charge
ADDITIONAL BENEFITS	**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.	After a **$35** Copay per visit, **100%** of the Negotiated Charge*	**70%** of the Recognized Charge*
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.	After a **$50** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge
Urgent Care Expense	After a **$30** Copay per visit, **100%** of the Negotiated Charge	**70%** 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).	**90%** of the Actual 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 Actual 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 **$30** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Skilled Nursing Facility Expense	After a **$100** Copay per admission, **100%** of the Negotiated Charge	After a **$100** per admission Deductible, **70%** 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.	After a **$100** Copay per admission, **100%** of the Negotiated Charge	After a **$100** per admission Deductible, **70%** of the Recognized Charge
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 **60** visits per Policy Year.	**100%** of the Negotiated Charge	**100%** of the Recognized Charge
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: • Treatment for acne; • Cosmetic treatment and procedures; and Laboratory fees.	Payable in accordance with the type of expense incurred and the place where service is provided.	
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. The plan covers the first prosthesis a covered person need 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.	**90%** of the Negotiated Charge	**60%** of the Recognized Charge
Podiatric Expense 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.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
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.	
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.	Payable in accordance with the type of expense incurred and the place where service is provided.	
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	**60%** of the Recognized Charge
Vision Care Exam Expense Routine Eye Exam Expenses: Charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam. Contact Lens Exam Expenses: Charges for an eye exam performed for the sole purpose of the fitting of contact lenses. Covered medical expenses will not include charges for more than **one** routine eye exam and **one** contact lens exam per policy year.	**90%** 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.	Payable in accordance with the type of expense incurred and the place where service is provided.	
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.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Hospice Expense	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Blood and Body Fluid Exposure/ Needle Stick Coverage Expense Limited to those charges related to a clinical related injury. Any expense related to the treatment of any sickness resulting from a clinical related injury is not covered under this benefit. Incidents include, but are not limited to needle sticks, unprotected exposure to blood and body fluid, and unprotected exposure to highly contagious pathogens.	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.	
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. Benefits limited to 3 cycles of any combination of the following ART services 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 an 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.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
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; • 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 pre-certification 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)	Preferred Care	Non-Preferred Care

Gender Reassignment (Sex Change) Treatment Expense
Includes charges made in connection with a medically necessary gender reassignment surgery (sometimes called sex change surgery) as long the covered student or their covered dependent has obtained precertification from Aetna. The covered student or their covered dependent must be at least **18** years of age or older to be eligible for this benefit.
Covered medical expenses include:
• Charges made by a physician for:
  ○ Performing the surgical procedure; 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.
• Charges for blood transfusion and the cost of unreplaced blood and blood products.
• Charges made by a behavioral health provider for gender reassignment counseling.
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.	After a **$30** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge
SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE Includes charges made by a hospital for short-term rehabilitation therapy services, as described below, when prescribed by a physician. The services have to be performed by: • A licensed or certified physical or occupational therapist; or • A physician. Charges for the following short term rehabilitation expenses are covered: • Cardiac and Pulmonary Rehabilitation Benefits • Cardiac rehabilitation benefits are available as part of an inpatient hospital stay. A course of outpatient cardiac rehabilitation appropriate for a covered person's condition is covered for a cardiac condition that can be changed. The 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 are available as part of an inpatient hospital stay. A course of outpatient pulmonary rehabilitation appropriate for a covered person's condition is covered for the treatment of reversible pulmonary disease states.		
Cardiac Rehabilitation	**90%** of the Negotiated Charge	**60%** of the Recognized Charge
Pulmonary Rehabilitation	**90%** of the Negotiated Charge	**60%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
SHORT-TERM REHABILITATION AND HABILITATION THERAPIES 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 and Habilitation Therapies Expense Cognitive, Physical, and Occupational Rehabilitation and Habilitation Therapy Services (combined)	**90%** of the Negotiated Charge	**60%** of the Recognized Charge
Outpatient Speech Rehabilitation and Habilitation Therapy Services	After a **$30** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge
TREATMENT OF MENTAL DISORDER EXPENSE	**Preferred Care**	**Non-Preferred Care**
Inpatient Mental Health Expense & 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.	After a **$100** Copay per admission, **100%** of the Negotiated Charge*	**70%** of the Recognized Charge*
Inpatient Mental Health Physician Services per Admission Expense &Residential Mental Health Treatment Physician Services Expense	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge*
Outpatient Mental Health Expense	After a **$10** Copay per visit, **100%** of the Negotiated Charge*	**70%** of the Recognized Charge*
Outpatient Mental Health Partial Hospitalization Expense	After a **$100** Copay per admission, **100%** of the Negotiated Charge*	**70%** of the Recognized Charge*
ALCOHOLISM AND DRUG ADDICTION TREATMENT	**Preferred Care**	**Non-Preferred Care**
Inpatient Substance Abuse Treatment	Payable in accordance with the type of expense incurred and the place where service is provided.	
Inpatient Substance Abuse Physician Services per Admission Expense & Residential Treatment Physician Services Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Outpatient Substance Abuse Treatment 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.	Payable in accordance with the type of expense incurred and the place where service is provided.	

TRANSPLANT SERVICE EXPENSE	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.	$50 per night Maximum Benefit for Lodging Expenses per IOE patient & $50 per night Maximum Benefit for Lodging Expenses per companion up to $10,000 per transplant.	
PEDIATRIC DENTAL SERVICES EXPENSE (Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	**Preferred Care**	**Non-Preferred Care**
Type A Expense (Pediatric Routine Dental Exam Expense) Benefits are limited to **1** visit every **6** months.	**100%** of the Negotiated Charge*	**80%** of the Recognized Charge
Type B Expense (Pediatric Basic Dental Care Expense)	**70%** of the Negotiated Charge*	**50%** of the Recognized Charge
Type C Expense (Pediatric Major Dental Care Expense)	**50%** of the Negotiated Charge*	**50%** of the Recognized Charge
Pediatric Orthodontia Expense • Orthodontics • Medically necessary comprehensive treatment • Replacement of retainer (limit one per lifetime)	**50%** of the Negotiated Charge*	**50%** 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)	**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. Benefit Maximum of **1** exam per Policy Year	**100%** of the Negotiated Charge*	**80%** 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.	**100%** of the Negotiated Charge*	**80%** of the Recognized Charge*

PEDIATRIC ROUTINE VISION (continued) (Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	Preferred Care	Non-Preferred Care
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*	**80%** 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.**		
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
Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs. (for two 90-day treatment regimens only)	**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.	**$20** Copay per supply	**$20** Deductible per supply
PREFERRED BRAND-NAME PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	**$40** Copay per supply	**$40** Deductible per supply
NON-PREFERRED BRAND-NAME PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	**$40** Copay per supply	**$40** Deductible per supply

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 Precertification 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 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.

9. Expense covered by any other valid and collectible medical; health or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.

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 treatment of temporomandibular joint dysfunction and associated myofascial pain except as specifically covered in the Policy.

15. Treatment for injury to the extent benefits are payable under any state no-fault automobile coverage; first party medical benefits payable under any other mandatory no-fault law.

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

17. 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).

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

19. Expense incurred for custodial care.

20. 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.

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

22. 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.

23. Expenses incurred for breast reduction/mammoplasty.

24. Expenses incurred for gynecomastia (male breasts).

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 care or services to the extent the charge would have been covered under Medicare Part A or Part B; even though the covered person is eligible; but did not enroll in Part B.

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

32. 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.

33. Expense for services or supplies provided for the treatment of obesity and/or weight control except screening and counseling services as specifically covered under the Policy. Not covered is any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions, including but not limited to:
    - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery;
    - surgical procedures, medical treatments, weight control/loss programs and other services and supplies that are 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 or food supplements, appetite suppressants and other medications;
    - Counseling, coaching, training, hypnosis, or other forms of therapy; and
    - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy, or other forms of activity or activity enhancement.

34. Expense for incidental surgeries; and standby charges of a physician.

35. Expense incurred for injury resulting from the plan or practice of intercollegiate sports (participating in sports clubs; or intramural athletic activities; is not excluded).

36. Expenses incurred for massage therapy.

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

38. 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.

39. 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.

40. 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.

41. 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.

42. 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.

43. 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).

44. 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.

45. 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.

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

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

48. Expenses incurred for jaw joint disorder treatment, services and supplies, except as specifically covered in the Policy, to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

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

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

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 University of Pennsylvania Student Health Insurance Plan is underwritten 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).

Combined Disclaimer

*Fully insured student health insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Self-insured plans are funded by the applicable school, with claims 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).

Fully Insured Disclaimer

The University of Pennsylvania Student Health Insurance Plan is underwritten 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).

Self-Funded Disclaimer

The University of Pennsylvania plan is self-funded by The University of Pennsylvania, 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).

Notice of Non-Discrimination:

Aetna Life Insurance Company does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.

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**.