AGNES SCOTT
COLLEGE
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Aetna Student Health

Plan Design and Benefits Summary
Agnes Scott College

Policy Year: 2016 - 2017
Policy Number: 846572

aetna®

www.aetnastudenthealth.com
(855) 821-9715

This is a brief description of the Student Health Plan. The Plan is available for Agnes Scott College students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions governing this insurance, including definitions, are contained in the Master Policy issued to Agnes Scott College 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.

Agnes Scott College Health Services

The Wellness Center is the College's on-campus health facility. Staffed by Nurse Practitioners and Registered Nurses, we are open weekdays from 9:00 a.m. to 4:30 p.m. during the Fall and Spring semesters. A Nurse Practitioner is available during these hours. To schedule an appointment, please call **404-471-7100**. Appointments are strongly encouraged. Walk-ins are first come, first served.

For more information, please visit Agnes Scott College Student Health Services or go to their website at **studenthealthservice@agnesscott.edu**. In the event of an emergency, call 911 or the Campus Police at extension 6355.

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
Annual	08/15/2016	08/14/2017
Fall	08/15/2016	01/17/2017
New Spring	01/18/2016	08/14/2017

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 August 15, 2016, and will terminate at 11:59 PM on the Coverage End Date indicated August 14, 2017. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

Coverage Period	Coverage Start Date	Coverage End Date
Annual	08/15/2016	08/14/2017
Fall	08/15/2016	01/17/2017
Spring/Summer	01/18/2016	08/14/2017

Rates

Rates Undergraduates and Graduate Students			
	Annual	Fall Semester	Spring Semester
Student	$2,942	$1,257.40	$1,684.60
Spouse	$2,942	$1,257.40	$1,684.60
1 Child	$2,942	$1,257.40	$1,684.60
2 or more Children	$5,884	$2,514.80	$3,369.20

Student Coverage

Eligibility

All registered Domestic students enrolled in Agnes Scott College will automatically be enrolled in this insurance plan. The cost will be included in the tuition bill unless proof of comparable coverage is furnished and the waiver form is completed

Enrollment

If you wish to waive out of the Agnes Scott College Insurance program, or if you are interested in enrolling your dependents in the program, please visit **www.aetnastudenthealth.com** and enter school name: Agnes Scott College. The waiver must be completed by June 5, 2016.

If you withdraw from school within the first **31 days** of a coverage period, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After **31 days**, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Dependent Coverage

Eligibility

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

Enrollment:

To enroll your dependents, please visit **www.aetnastudenthealth.com** and enter school name: Agnes Scott College.

Medicare Eligibility Notice

As to medical expense coverage and prescribed medicines expense coverage only, a person eligible for Medicare at the time of enrollment under the Policyholder's 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 the Policyholder's plan, such Medicare eligibility will not result in the termination of medical expense coverage and prescribed medicines expense coverage under the 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.

Continuation of Coverage

A **covered student** who has graduated or is otherwise ineligible for coverage under this Policy; and has been continuously insured under the plan offered by the Policyholder (regular student plan); may be covered for up to 3 months provided that: (1) a written request for continuation has been forwarded to Aetna 31 days prior to the termination of coverage; and (2) premium payment has been made. Coverage under this provision ceases on the date this Policy terminates.

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 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 Preferred Care network level of benefits.

Continuity of Care

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

Pre-certification 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, the preferred care provider is responsible for obtaining pre-certification. Since precertification is the preferred care provider's responsibility, there is no additional out-of-pocket cost to you as a result of 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 precertification 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 benefit reduction.

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

- All inpatient maternity and newborn care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- Ambulance (emergency transportation by airplane);
- Autologous chondrocyte implantation, Carticel®
- Bariatric surgery (bariatric surgery is not covered under the Policy unless specifically described in the Policy.);
- BRCA genetic testing;
- Cardiac rhythm implantable devices;
- Cochlear device and/or implantation;
- Dental implants and oral appliances;
- Dorsal column (lumbar) neurostimulators: trial or implantation;
- Drugs and Medical Injectables;

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

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

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

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

Pre-certification of non-emergency admissions

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

Pre-certification of emergency admissions

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

Pre-certification of urgent admissions

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

Pre-certification of outpatient non-emergency medical services

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

Pre-certification of prenatal care and delivery

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

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

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

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 Agnes Scott College, 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 Georgia Insurance Law(s).

Metallic Level: Platinum, tested at 88.25%

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 Georgia State mandate(s), the policy year deductible is also waived for: • Child Wellness Services from birth to age 5. In addition to state and federal requirements for waiver of the policy year deductible, the plan will waive the policy year deductible for Pediatric Routine Vision Expenses, Preferred Care Pediatric Dental Services, and Prescribed Medicines Expense. Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible.	Individual: **$250** per policy year	Individual: **$1,000** 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 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 precertification benefit reductions or penalties because a required precertification for the service(s) or supply was not obtained from Aetna.	Individual Combined Out-of-Pocket: **$2,500** Family Combined Out-of-Pocket: **$5,000**	
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. Includes inpatient services following a mastectomy or lymph node dissection as advised by the attending physician in consultation with the patient.	After a **$50** Copay per admission, **90%** of the Negotiated Charge	After a **$100** Copay per admission, **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 **$50** Copay per admission, **90%** of the Negotiated Charge	After a **$100** Copay per admission, **70%** of the Recognized Charge for a semi-private room
Miscellaneous Hospital Expense Includes but not limited to: operating room, laboratory tests/X rays, oxygen tent, drugs, medicines and dressings.	**90%** of the Negotiated Charge	**70%** of the Recognized Charge

INPATIENT HOSPITALIZATION BENEFITS (continued)	Preferred Care	Non-Preferred Care
Licensed Nurse Expense Includes charges incurred by a covered person who is confined in a hospital as a resident bed patient and requires the services of a registered nurse or licensed practical nurse. Not more than the Daily Maximum Benefit per shift will be paid. For purposes of determining this maximum, a shift means 8 consecutive hours.	**90%** of the Negotiated Charge	**70%** of the Recognized Charge
Well Newborn Nursery Care	**90%** 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.	**90%** 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.	**90%** 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.	**90%** of the Negotiated Charge	**70%** of the Recognized Charge
Assistant Surgeon Expense (Inpatient and Outpatient)	**90%** 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 **$20** Copay per visit, **100%** of the Negotiated Charge*	After a **$40** Copay per visit, **100%** of the Recognized Charge*
Laboratory and X-ray Expense	**90%** of the Negotiated Charge	**70%** of the Recognized Charge
Hospital Outpatient Department Expense	**90%** of the Negotiated Charge	**70%** of the Recognized Charge
Therapy Expense Covered medical expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis: • Radiation therapy; • Inhalation therapy; • Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy; • Kidney dialysis; and • Respiratory therapy.	**90%** of the Negotiated Charge	**70%** of the Recognized Charge

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
Pre-Admission Testing Expense Includes charges incurred by a covered person for pre-admission testing charges made by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Ambulatory Surgical Expense Covered medical expenses include expenses incurred by a covered person for outpatient surgery performed in an ambulatory surgical center. Covered medical expenses must be incurred on the day of the surgery or within 24 hours after the surgery.	**90%** of the Negotiated Charge	**70%** of the Recognized Charge
Walk-in Clinic Visit Expense	After a **$20** Copay per visit, **100%** of the Negotiated Charge*	After a **$40** Copay per visit, **100%** 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. 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.	After a **$200** Copay per visit, **90%** of the Negotiated Charge*	After a **$200** Copay per visit, **90%** of the Recognized Charge*

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
Emergency Room Expense **(continued)** Similarly, services rendered in the emergency room that are not included in the hospital emergency room visit benefit may be subject to coinsurance rates that are different from the coinsurance rate applicable to the hospital emergency room visit benefit. **Important Note**: Please note that Non-Preferred Care Providers do not have a contract with Aetna. The provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.	After a **$200** Copay per visit, **90%** of the Negotiated Charge*	After a **$200** Copay per visit, **90%** of the Recognized Charge*
Durable Medical and Surgical Equipment Expense Durable medical and surgical equipment would include: • Artificial arms and legs; including accessories; • Arm, back, neck braces, leg braces; including attached shoes (but not corrective shoes); • Surgical supports; • Scalp hair prostheses required as the result of hair loss due to injury; sickness; or treatment of sickness; and • Head halters.	**90%** of the Negotiated Charge	**70%** 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*	**100%** of the Recognized Charge*
Preventive Care Immunizations	**100%** of the Negotiated Charge*	**100%** of the Recognized Charge
Well Woman Preventive Visits Routine well woman preventive exam office visit, including Pap smears.	**100%** of the Negotiated Charge*	**100%** of the Recognized Charge*

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Screening and Counseling Services for Sexually Transmitted Infections Includes the counseling services to help a covered person prevent or reduce sexually transmitted infections.	**100%** of the Negotiated Charge*	**100%** of the Recognized Charge*
Mammograms (Age 35 and older) Although not included in the guidelines recommended by the United States Preventive Services Task Force or the guidelines supported by the Health Resources and Services Administration, this Plan also covers one baseline mammogram for a woman age 35 and over or when medically necessary and bone density measurement screening.	**100%** of the Negotiated Charge*	**100%** of the Recognized Charge*
Preventive Care Screening and Counseling Services for Obesity and/or Healthy Diet Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.	**100%** of the Negotiated Charge*	**100%** of the Recognized Charge*
Preventive Care Screening and Counseling Services for Misuse of Alcohol and/or Drugs Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.	**100%** of the Negotiated Charge*	**100%** of the Recognized Charge*
Preventive Care Screening and Counseling Services for Use of Tobacco Products Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco; and candy-like products that contain tobacco.	**100%** of the Negotiated Charge*	**100%** of the 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*	**100%** of the Recognized Charge*

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
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*	**100%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Genetic Risk for Breast and Ovarian Cancer Covered medical expenses include the counseling and evaluation services to help assess a covered person's risk of breast and ovarian cancer susceptibility.	**100%** of the Negotiated Charge*	**100%** of the Recognized Charge*
Preventive Care Prenatal Care Coverage for prenatal care under this Preventive Care Expense benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height). Refer to the Maternity Expense benefit for more information on coverage for maternity expenses under the Policy, including other prenatal care, delivery and postnatal care office visits.	**100%** of the Negotiated Charge*	**100%** of the Recognized Charge*
Preventive Care Lactation Counseling Services Lactation support and lactation counseling services are covered medical expenses when provided in either a group or individual setting.	**100%** of the Negotiated Charge*	**100%** of the Recognized Charge*
Preventive Care Breast Pumps and Supplies	**100%** of the Negotiated Charge*	**80%** 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.	**100%** of the Negotiated Charge*	**80%** of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Female Contraceptive Counseling Services, Preventive Care Female Contraceptive Generic, Brand Name, Biosimilar Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visit, Preventive Care Female Voluntary Sterilization (Inpatient), Preventive Care Female Voluntary Sterilization (Outpatient) **(continued)** **Contraceptives** can be paid either under this benefit or the prescribed medicines expense depending on the type of expense and how and where the expense is incurred. Benefits are paid under this benefit for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.	**100%** of the Negotiated Charge*	**80%** of the Recognized Charge
OTHER FAMILY PLANNING SERVICES EXPENSE	**Preferred Care**	**Non-Preferred Care**
Voluntary Sterilization for Males (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	Payable in accordance with the type of expense incurred and the place where service is provided.	
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.	**90%** of the Negotiated Charge	**90%** 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.	Payable in accordance with the type of expense incurred and the place where service is provided.	
High Cost Procedures Expense Includes charges incurred by a covered person as a result of certain high cost procedures provided on an outpatient basis. Covered medical expenses for high cost procedures include; but are not limited to; charges for the following procedures and services: • Computerized Axial Tomography (C.A.T.) scans; • Magnetic Resonance Imaging (MRI); and • Positron Emission Tomography (PET) Scans.	**90%** of the Negotiated Charge	**70%** of the Recognized Charge
Urgent Care Expense	After a **$50** Copay per visit, **90%** of the Negotiated Charge*	After a **$75** Copay per visit, **70%** of the Recognized Charge*

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
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. Not more than the Maximum Benefit will be paid. 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 Negotiated Charge	**70%** of the Recognized Charge
Accidental Injury to Sound Natural Teeth Expense Covered medical expenses include charges incurred by a covered person for services of a dentist or dental surgeon as a result of an injury to sound natural teeth.	**90%** of the Negotiated Charge	**70%** of the Recognized Charge
Second Surgical Opinion Expense	After a **$20** Copay per visit, **100%** of the Negotiated Charge*	After a **$40** Copay per visit, **100%** of the Recognized Charge*
Non-Elective Second Surgical Opinion Expense	After a **$20** Copay per visit, **100%** of the Negotiated Charge*	After a **$40** Copay per visit, **100%** of the Recognized Charge*
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 **$20** Copay per visit, **100%** of the Negotiated Charge*	After a **$40** Copay per visit, **100%** of the Recognized Charge*
Skilled Nursing Facility Expense	After a **$50** Copay per admission, **90%** of the Negotiated Charge	After a **$100** Copay per admission, **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.	**90%** of the Negotiated Charge	**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.	**90%** of the Negotiated Charge	**70%** of the Recognized Charge
Temporomandibular Joint Dysfunction Expense Covered medical expenses include physician's charges incurred by a covered person for surgical and non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
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	**70%** 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.	
Hypodermic Needles Expense Includes expenses incurred by a covered person for hypodermic needles and syringes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Convalescent Facility Expense	After a **$50** Copay per admission, **90%** of the Negotiated Charge	After a **$100** Copay per admission, **70%** of the Recognized Charge
Maternity Expense Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person, and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother and done in accordance with the rules and regulations promulgated by State Mandate. Covered medical expenses may include home visits, parent education, and assistance and training in breast or bottle-feeding.	Payable in accordance with the type of expense incurred and the place where service is provided.	

<table>
<tr><th>ADDITIONAL BENEFITS (continued)</th><th>Preferred Care</th><th>Non-Preferred Care</th></tr>
<tr><td>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.</td><td>90% of the Negotiated Charge</td><td>70% of the Recognized Charge</td></tr>
<tr><td>Acupuncture Expense
Includes charges incurred by a covered person for acupuncture therapy.</td><td>90% of the Negotiated Charge</td><td>70% of the Recognized Charge</td></tr>
<tr><td>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.</td><td>90% of the Negotiated Charge</td><td>70% of the Recognized Charge</td></tr>
<tr><td>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.</td><td colspan="2">Payable in accordance with the type of expense incurred and the place where service is provided.</td></tr>
<tr><td>Hospice Expense</td><td>90% of the Negotiated Charge</td><td>70% of the Recognized Charge</td></tr>
<tr><td>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.</td><td colspan="2">Payable in accordance with the type of expense incurred and the place where service is provided.</td></tr>
<tr><td>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.</td><td colspan="2">Payable in accordance with the type of expense incurred and the place where service is provided.</td></tr>
<tr><td>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.</td><td colspan="2">Payable in accordance with the type of expense incurred and the place where service is provided.</td></tr>
</table>

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
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.	
Clinical Trials Expense (Experimental or Investigational Treatment) Includes charges made by a provider for experimental or investigational drugs, devices, treatments or procedures "under an approved clinical trial" only when a covered person has cancer or a terminal illness.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Clinical Trials Expense Routine Patient Costs Includes charges made by a provider for "routine patient costs" furnished in connection with a covered person's participation in an "approved clinical trial" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.	Payable in accordance with the type of expense incurred and the place where service is provided.	
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.	**90%** of the Negotiated Charge	**70%** of the Recognized Charge
In-Hospital Dental Procedure Expense Covered expenses include charges for general anesthesia and associated hospital or ambulatory surgical facility charges for dental care provided if the covered person is: • 7 years of age or younger or is developmentally disabled; • an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition; or • an individual who has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Telemedicine Expense Telemedicine: The practice of health care delivery, diagnosis, consultation, and treatment of a covered illness or injury by way of the transfer of medical data by electronic means including audio, video, or data communications.	Payable in accordance with the type of expense incurred and the place where service is provided.	

SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE

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

Cardiac Rehabilitation Benefits

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

Pulmonary Rehabilitation Benefits

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

SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE (continued)	Preferred Care	Non-Preferred Care
Cardiac Rehabilitation	**90%** of the Negotiated Charge	**70%** of the Recognized Charge
Pulmonary Rehabilitation	**90%** of the Negotiated Charge	**70%** of the Recognized Charge

SHORT-TERM REHABILITATION EXPENSE

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

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

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

Short-Term Rehabilitation Expense **Outpatient Cognitive, Physical, Occupational and Speech Rehabilitation and Habilitation Therapy Services (combined)**	**90%** of the Negotiated Charge	**70%** of the Recognized Charge

TREATMENT OF MENTAL DISORDER EXPENSE	Preferred Care	Non-Preferred Care
Inpatient Mental Health & Residential Mental Health Treatment Facility Expense Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	After a **$50** Copay per admission, **90%** of the Negotiated Charge	After a **$100** Copay per admission, **70%** of the Recognized Charge
Inpatient Mental Health Physician Services per Admission & Residential Mental Health Treatment Physician Services Expense	**90%** of the Negotiated Charge	**70%** of the Recognized Charge
Outpatient Mental Health Expense	**100%** of the Negotiated Charge*	After a **$40** Copay per visit, **100%** of the Recognized Charge*
Outpatient Mental Health Partial Hospitalization Expense	After a **$50** Copay per admission, **90%** of the Negotiated Charge	After a **$100** Copay per admission, **70%** of the Recognized Charge

ALCOHOLISM AND DRUG ADDICTION TREATMENT	Preferred Care	Non-Preferred Care
Inpatient Substance Abuse & Residential Substance Abuse Treatment Facility Expense	After a **$50** Copay per admission, **90%** of the Negotiated Charge	After a **$100** Copay per admission, **70%** of the Recognized Charge
Inpatient Substance Abuse Physician Services per Admission & Residential Substance Abuse Treatment Physician Services Expense	**90%** of the Negotiated Charge	**70%** of the Recognized Charge

ALCOHOLISM AND DRUG ADDICTION TREATMENT (continued)	Preferred Care	Non-Preferred Care
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.	After a **$20** Copay per visit, **100%** of the Negotiated Charge*	After a **$40** Copay per visit, **100%** of the Recognized Charge*
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. Maximum benefit of **$10,000** Per Transplant.	**$50** per night Maximum Benefit for Lodging Expenses per IOE patient & **$50** per night Maximum Benefit for Lodging Expenses per companion	
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) Minimum benefit of **1** visit every **6** months	**100%** of the Negotiated Charge*	**100%** of the Recognized Charge*
Type B Expense (Pediatric Basic Dental Care Expense)	**70%** of the Negotiated Charge*	**70%** of the 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. Benefits are limited to **1** visit 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.	**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 (continued) Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a non-preferred care provider. Coverage includes charges incurred for: • Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses. Aphakic prescription lenses prescribed after cataract surgery has been performed. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.	**100%** of the Negotiated Charge*	**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	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits
Other preventive care drugs and supplements For each **30**-day supply filled at a retail pharmacy.	**100%** per supply	**80%** 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	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits
All OTHER PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each **30**-day supply filled at a retail pharmacy.	**100%** of the Negotiated Charge	**80%** 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		
Generic Prescription Drugs	**Preferred Care**	**Non-Preferred Care**
For each **30**-day supply filled at a retail pharmacy.	**$15** Copay per supply	None
Preferred Brand-Name Prescription Drug	**Preferred Care**	**Non-Preferred Care**
For each **30**-day supply filled at a retail pharmacy.	**$45** Copay per supply	None
Non-Preferred Brand-Name Prescription Drugs	**Preferred Care**	**Non-Preferred Care**
For each **30**-day supply filled at a retail pharmacy.	**$75** Copay per supply	None

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** *Precertification Department* at 1-855-240-0535, faxing the request to 1-877-269-9916 or submitting the request in writing to:

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

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

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

Waiver for Prescription Drug Contraceptives

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

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

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

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

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

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

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

A covered person's prescriber may seek a medical exception by submitting a request to Aetna's 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 elective treatment or elective surgery except as specifically covered under the Policy and provided while the Policy is in effect.

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

10. Expense 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.

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

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

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

14. 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.

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 gastric bypass and any restrictive procedures for weight loss except screening and counseling services specifically covered under the Policy.
24. Expenses incurred for breast reduction/mammoplasty.
25. Expenses incurred for gynecomastia (male breasts).
26. Expense incurred by a covered person not a United States citizen for services performed within the covered person's home country if the covered person's home country has a socialized medicine program.
27. Expense incurred for alternative holistic medicine and/or therapy, including but not limited to yoga and hypnotherapy, unless specifically covered under the Policy.
28. Expense for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns, bunions, or calluses; (d) care of toenails; and (e) care of fallen arches, weak feet or chronic foot strain, except that (c) and (d) are not excluded when medically necessary because the covered person is diabetic or suffers from circulatory problems.
29. 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.
30. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
31. 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.

32. 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.

33. Expense for telephone consultations (except telemedicine), charges for failure to keep a scheduled visit, or charges for completion of a claim form.

34. Expense for the cost of supplies used in the performance of any occupational therapy.

35. 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.

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

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

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

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

40. Expenses incurred for massage therapy.

41. Expense incurred for or related to gender reassignment (sex change) surgery.

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

43. 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.

44. 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.

45. 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.

46. 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.

47. 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.

48. Expense incurred for preferred care charges in excess of the negotiated charge.

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

50. Expense incurred in a facility for care, services or supplies provided in:
    - Rest homes;
    - Assisted living facilities;
    - Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
    - Health resorts;
    - Spas, sanitariums;
    - Infirmaries at schools, colleges or camps; and
    - Wilderness Treatment Programs or any such related or similar program, school and/or education service.

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

52. 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).

53. Expense incurred for drugs, medications and supplies, except as specifically covered in the Policy. Not covered are:
    - Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
    - Services related to the dispensing, injection or application of a drug;
    - A prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
    - Needles, syringes and other injectable aids, except as covered for diabetic supplies, and for a covered drug;
    - Drugs related to the treatment of non-covered medical expenses;
    - Performance enhancing steroids;
    - Implantable drugs and associated devices;
    - Injectable drugs if an alternative oral drug is available, unless medically necessary;

- Any expenses for prescription drugs, and supplies covered under the Pharmacy Plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy whether functional or organic.

54. Expense incurred for educational services:
    - Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
    - Evaluation or treatment of learning disabilities, attention deficit disorder, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
    - Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills;
    - Services eligible under the Individuals with Disabilities in Education Act (IDEA).

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

56. 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.

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

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

59. Expense incurred for outpatient speech therapy. Except as specifically covered in the Policy, not covered are charges for:
    - Any services unless provided in accordance with a specific treatment plan;
    - Services provided during a stay in a hospital, skilled nursing facility or hospice facility except as specifically covered in the Policy;
    - Services provided by a home health care agency;

- Services not performed by a physician, or speech therapist or under the direct supervision of a physician;
- Services provided by a physician or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's or your domestic partner's family; and
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

60. Expense incurred for therapies and tests: Any of the following treatments or procedures including but not limited to:
    - Aromatherapy;
    - Bio-feedback and bioenergetic therapy;
    - Carbon dioxide therapy;
    - Chelation therapy (except for heavy metal poisoning);
    - Computer-aided tomography (CAT) scanning of the entire body;
    - Early intensive behavioral interventions (including Applied Behavior Analysis, Denver, LEAP, TEACHH, Rutgers programs) except as specifically covered in the What the Medical Plan Covers Section;
    - Educational therapy;
    - Gastric irrigation;
    - Hair analysis;
    - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
    - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
    - Lovaas therapy;
    - Massage therapy;
    - Megavitamin therapy;
    - Primal therapy;
    - Psychodrama;
    - Purging;
    - Recreational therapy;
    - Rolfing;
    - Sensory or auditory integration therapy;
    - Sleep therapy;
    - Thermograms and thermography

Additional Pediatric Dental Services Exclusions and Limitations

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

61. Expenses incurred for cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth whether or not for psychological or emotional reasons, except to the extent coverage is specifically covered in the Policy. Facings on molar crowns and pontics will always be considered cosmetic.

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

63. Expenses incurred for dental examinations that are:
    - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;

- Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
- Required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
- Any special medical reports not directly related to treatment except when provided as part of a covered service.

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

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

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

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

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

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

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

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

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

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

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

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

The Agnes Scott College 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).

IMPORTANT NOTICES:

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.

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

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

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