This is a brief description of the Student Health Plan. The Plan is available for Emory University 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 Emory University 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.

EMORY UNIVERSITY STUDENT HEALTH AND COUNSELING SERVICES

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

WEBSITE

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

PRIMARY CARE

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

APPOINTMENTS

Appointments are recommended to address most of your health care needs. Appointments can be scheduled through your Patient Portal at https://www.shspnc.emory.edu/login_directory.aspx. However, urgent care and nurse visits are available during business hours, and students can consult with a health care provider by phone 24 hours a day, 365 days a year by calling the main appointment line at (404) 727-7551 x0 for the after hour’s doctor on call.

EMERGENCY CARE

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

You also can consult by phone any time of day or night, with a health care provider or counselor at the EUSHCS at (404) 727-7551 x0 who can offer advice. In the event of your treatment or hospitalization at an Emory Hospital for which follow up with a specialist is required, Emory Healthcare will share relevant medical information as needed for the continuity of your care.

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

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

The inability to pay should never be a barrier to receiving needed health care. If you have concerns about expenses connected to medical or mental health care, discuss them with the billing office staff before or during your visit to EUSHCS.
Emory Student Health Services: Is also now a member of 42 national PPO networks, including most major insurance carriers with the exception of Blue Cross/Blue Shield (BC/BS), who, at this time, has denied requests to contract with any student health services, including EUSHCS. Therefore, students on BC/BS will be out of network at EUSHCS and will be responsible at the time of the visit for any charges incurred. The Emory Clinic and the Emory University Hospitals are BC/BS providers and are considered in-network.

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

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

When you are away from campus, you do not need a referral to seek Preferred Care from Aetna’s Preferred Provider Network or to seek Non-Preferred Care. For a complete list of referral requirements and exceptions, refer to the Referral Requirements on page 11 of the 2015-16 Aetna Insurance Plan Design and Summary of Benefits.

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

EUSHCS Hours: Visit www.studenthealth.emory.edu for a listing of EUSHCS’s hours which vary during breaks, holidays, summer and winter session. Whenever EUSHCS is closed, you may consult by phone with the health care provider on call who can offer advice. In an emergency, call 911 or go the nearest hospital.

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

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

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

Graduated/Leave of Absence Students/ Continuation of Coverage

If you graduate in December 2015 or take a leave absence and do not return for the 2016 Spring Semester, coverage will terminate on January 7, 2016. You will then be eligible to extend coverage for an additional 3 months under the continuation plan. You will have 31 days from the termination date of your prior insurance to enroll. If you graduate in May 2016, coverage will remain active until the end of the policy year (7/31/16). You will also be able to extend coverage for an additional 3 months under the continuation plan once your coverage terminates. Benefits under the continuation plan remain the same as the basic student plan.

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

<table>
<thead>
<tr>
<th>Continuation of Coverage</th>
<th>Three months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$734</td>
</tr>
<tr>
<td>Spouse/Domestic Partner</td>
<td>$734</td>
</tr>
<tr>
<td>Child Only</td>
<td>$734</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>$1,468</td>
</tr>
</tbody>
</table>

Coverage Periods

Students: Please note that the Emory University Student Health Insurance Plan is an Annual Policy. Coverage purchased starting with the Fall 2015 Semester will continue through the following Summer 2016 Semester. Students enrolling during the Fall 2015 Semester are responsible for paying the insurance premium for the Spring/Summer Semester.

Enrollment: Only for the Spring/Summer Semester or the Summer Semester is restricted to students newly enrolled at Emory University at that time, or for students who lose their private insurance (parent’s or personal insurance) due to a change of life event. Examples of “change of life events” include: exceeding the age maximum on a parent’s policy, losing private insurance through loss of employment or divorce, etc.

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

<table>
<thead>
<tr>
<th></th>
<th>International Students</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Coverage</strong></td>
<td></td>
</tr>
<tr>
<td>08/01/2015 – 07/31/2016</td>
<td></td>
</tr>
<tr>
<td>Waiver Deadline Date:</td>
<td>08/26/2015</td>
</tr>
<tr>
<td><strong>Spring/Summer Semester</strong></td>
<td></td>
</tr>
<tr>
<td>01/08/2016 – 07/31/2016</td>
<td></td>
</tr>
<tr>
<td>Waiver Deadline Date:</td>
<td>01/19/2016</td>
</tr>
<tr>
<td><strong>Summer Semester</strong></td>
<td></td>
</tr>
<tr>
<td>05/18/2016 – 07/31/2016</td>
<td></td>
</tr>
<tr>
<td>Waiver Deadline Date:</td>
<td>05/19/2016</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Student Only</th>
<th>Spouse Only</th>
<th>Child Only</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Term</strong></td>
<td>$3,030</td>
<td>$3,030</td>
<td>$3,030</td>
<td>$6,060</td>
</tr>
<tr>
<td><strong>Spring/Summer Semester</strong></td>
<td>$1,703</td>
<td>$1,703</td>
<td>$1,703</td>
<td>$3,406</td>
</tr>
<tr>
<td><strong>Summer Semester</strong></td>
<td>$613</td>
<td>$613</td>
<td>$613</td>
<td>$1,226</td>
</tr>
</tbody>
</table>

*The rates above include both the premiums for the Student Health Plan underwritten by Aetna Life Insurance Company and Emory University’s $40 administrative charge.*

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

### Student Coverage

#### Eligibility

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

**Students must** actively and physically attend classes to be eligible for enrollment in this Plan. Students must actively attend classes for the first 31 days after the date for which coverage is purchased. Distance learning or online students taking home study, correspondence, or television courses are not eligible for coverage under the Plan.

### Enrollment

All degree-seeking International Students who do not submit proof of comparable coverage through the Online Waiver system by the deadline date and who are automatically charged for the insurance will have an effective date of coverage as indicated in “Coverage Effective Dates”. If you have other coverage and wish to waive enrollment in the Emory Student Health Insurance Plan as listed above, please submit proof of comparable coverage through the Online Waiver system by the waiver deadline dates of **August 26, 2015** for Fall Semester, **January 19, 2016** for new students enrolling for the Spring Semester, and **May 19, 2016** for new students enrolling for the Summer.

#### To Waive Online:

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

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

**Dependent Coverage**

**Eligibility**

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

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

1. By the deadline date for dependent enrollment (by September 15, 2015 for Fall Semester, February 8, 2016 for the dependents of new students enrolling for the Spring/Summer Semester, and June 18, 2016 for the dependents of new students enrolling for the Summer Semester.)
2. Within 31 days after you acquire a new dependent.
3. Within 31 days after a dependent terminates coverage under another health insurance plan. The premium rate for the late addition of dependents will not be pro-rated. The student must pay the full premium for the enrollment period and the dependent will be made effective the date the enrollment application and premium are received and approved by Aetna Student Health.

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

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

**NEWBORN INFANT AND ADOPTED CHILD COVERAGE**

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

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

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 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 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.

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.

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 precertified services, where rendered within the time limits set in the pre-certification. There is no such liability if the member is no longer covered under the Plan at the time the services are received, benefits under the contract or Plan have been exhausted, or there is a substantiation of fraud by the member, provider, facility, or home health care provider.

What’s New This Year

- Annual premium of $3,030
- Maintained Dependent coverage for International students
- Increase In-network Deductible to $300 from $250
- Increase Out-of-network Deductible to $450 from $400
- Increase Core ER Copay to $75 per visit from $50 per visit
- Increase In-network and Out-of-network Office Visit Copay to $35 from $25
- Increase In-network and Out-of-network Brand copay for Prescription Drugs to $30 from $25

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 Emory University, 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).

<table>
<thead>
<tr>
<th>DEDUCTIBLE</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>The policy year deductible is waived for designated care (Core Network) and preferred care covered medical expenses that apply to Preventive Care Expense benefits. In compliance with Georgia State mandate(s), the policy year deductible is also waived for Child Wellness Services from birth to age 5. Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible.</td>
<td>Students: $150 per policy year</td>
<td>Students: $300 per policy year</td>
<td>Students: $450 per policy year</td>
</tr>
<tr>
<td></td>
<td>Spouse: $150 per policy year</td>
<td>Spouse: $300 per policy year</td>
<td>Spouse: $450 per policy year</td>
</tr>
<tr>
<td></td>
<td>Child: $150 per policy year</td>
<td>Child: $300 per policy year</td>
<td>Child: $450 per policy year</td>
</tr>
</tbody>
</table>
### COINSURANCE

Coinsurance is both the percentage of covered medical expenses that the plan pays, and the percentage of covered medical expenses that you pay. The percentage that the plan pays is referred to as “plan coinsurance” or the “payment percentage,” and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.

Covered Medical Expenses are payable at the plan coinsurance percentage specified below, after any applicable Deductible.

### OUT-OF-POCKET MAXIMUMS

<table>
<thead>
<tr>
<th></th>
<th>Core Network and Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>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:</td>
<td>Individual Out-of-Pocket: $6,350</td>
<td>Individual Out-of-Pocket: Unlimited</td>
</tr>
<tr>
<td>• Non-covered medical expenses;</td>
<td>Family Out-of-Pocket: $12,700</td>
<td>Family Out-of-Pocket: Unlimited</td>
</tr>
<tr>
<td>• Referral penalties because a required referral for the service(s) or supply was not obtained; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
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</tr>
</tbody>
</table>

### REFERRAL PENALTY

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

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

- Treatment of an Emergency medical condition; or
- When the EUSHCS (or the Oxford College Student Health Center for Oxford students) is closed; or
- When the service is rendered at another facility during breaks or vacation periods; or
- When medical care is received by a Covered person who is more than 50 miles from campus; or
- When medical care is received by a Covered person who is no longer able to use the EUSHCS due to a change in student status, such as graduating or LOA/withdrawal, or
- Ob/Gyn services; or
- Dermatological services; or
- Chiropractic services; or
REFERRAL PENALTY (continued)

- All X-rays, Labs, and High Cost Procedures.
- Routine Dental services including the treatment and extraction of wisdom teeth
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness).
- Continuation Plan

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

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

<table>
<thead>
<tr>
<th>INPATIENT HOSPITALIZATION BENEFITS</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board Expense</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge for a semi-private room</td>
</tr>
<tr>
<td>Room and Board Expense</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The covered room and board expense does</td>
<td></td>
<td></td>
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<tr>
<td>not include any charge in excess of the daily</td>
<td></td>
<td></td>
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<tr>
<td>room and board maximum.</td>
<td></td>
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<tr>
<td>Includes inpatient services following a</td>
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</tr>
<tr>
<td>mastectomy or lymph node dissection as advised by</td>
<td></td>
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<tr>
<td>the attending physician in consultation with the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>patient.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Care</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>Intensive Care</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The covered room and board expense does</td>
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<tr>
<td>not include any charge in excess of the daily</td>
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<tr>
<td>room and board maximum.</td>
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</tr>
<tr>
<td>Miscellaneous Hospital Expense</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>Miscellaneous Hospital Expense</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes but not limited to: operating room,</td>
<td></td>
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<tr>
<td>laboratory tests/X rays, oxygen tent, drugs,</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>medicines and dressings.</td>
<td></td>
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</tr>
<tr>
<td>Licensed Nurse Expense</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>Licensed Nurse Expense</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Includes charges incurred by a covered person who</td>
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<tr>
<td>is confined in a hospital as a resident bed</td>
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<tr>
<td>patient and requires the services of a</td>
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<tr>
<td>registered nurse or licensed practical nurse.</td>
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<tr>
<td>Not more than the Daily Maximum Benefit per</td>
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<tr>
<td>shift will be paid. For purposes of determining</td>
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<tr>
<td>this maximum, a shift means 8 consecutive hours.</td>
<td></td>
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</tr>
<tr>
<td>Well Newborn Nursery Care</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>Well Newborn Nursery Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Surgical Physicians Expense</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>Non-Surgical Physicians Expense</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes hospital charges incurred by a covered</td>
<td></td>
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<tr>
<td>person who is confined as an inpatient in a</td>
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<tr>
<td>hospital for a surgical procedure for the services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of a physician who is not the physician who may</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>have performed surgery on the covered person.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>SURGICAL EXPENSES</strong></td>
<td><strong>Core Network</strong></td>
<td><strong>Preferred Care</strong></td>
<td><strong>Non-Preferred Care</strong></td>
</tr>
<tr>
<td>-----------------------</td>
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</tr>
<tr>
<td><strong>Surgical Expense (Inpatient)</strong>&lt;br&gt;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.</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Surgical Expense (Outpatient)</strong>&lt;br&gt;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.</td>
<td>After a $100 Copay per surgery, 90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Anesthesia Expense (Inpatient and Outpatient)</strong>&lt;br&gt;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.</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Assistant Surgeon Expense (Inpatient and Outpatient)</strong></td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>OUTPATIENT EXPENSES</strong></td>
<td><strong>Core Network</strong></td>
<td><strong>Preferred Care</strong></td>
<td><strong>Non-Preferred Care</strong></td>
</tr>
<tr>
<td><strong>Physician or Specialist Office Visit Expense</strong>&lt;br&gt;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.</td>
<td>After a $25 Copay per visit, 90% of the Negotiated Charge</td>
<td>After a $35 Copay per visit, 80% of the Negotiated Charge</td>
<td>After a $35 per visit Deductible, 60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Laboratory Expense</strong></td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>X-ray Expense</strong></td>
<td>After a $25 Copay per visit, 90% of the Negotiated Charge</td>
<td>After a $35 Copay per visit, 80% of the Negotiated Charge</td>
<td>After a $35 per visit Deductible, 60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Hospital Outpatient Department Expense</strong></td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Therapy Expense</strong>&lt;br&gt;Covered medical expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis:&lt;br&gt;• Radiation therapy;&lt;br&gt;• Inhalation therapy;&lt;br&gt;• Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy;&lt;br&gt;• Kidney dialysis; and&lt;br&gt;• Respiratory therapy.</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
</tbody>
</table>
### OUTPATIENT EXPENSES

<table>
<thead>
<tr>
<th>Expense Type</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Admission Testing Expense</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
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</tr>
<tr>
<td><strong>Ambulatory Surgical Expense</strong></td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Walk-in Clinic Visit Expense</strong></td>
<td>After a $25 Copay per visit, 90% of the Negotiated Charge</td>
<td>After a $35 Copay per visit, 80% of the Negotiated Charge</td>
<td>After a $35 per visit Deductible, 60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Emergency Room Expense</strong></td>
<td>After a $75 Copay per visit (waived if admitted), 90% of the Negotiated Charge</td>
<td>After a $75 Copay per visit (waived if admitted), 80% of the Negotiated Charge</td>
<td>After a $75 per visit Deductible (waived if admitted), 80% of the Recognized Charge</td>
</tr>
<tr>
<td>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 &amp; 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.</td>
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</tbody>
</table>

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.
OUTPATIENT EXPENSES (continued)

<table>
<thead>
<tr>
<th>Durable Medical and Surgical Equipment Expense</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable medical and surgical equipment</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>would include:</td>
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<tr>
<td>• Artificial arms and legs; including</td>
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<tr>
<td>accessories;</td>
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<tr>
<td>• Arm, back, neck braces, leg braces;</td>
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<tr>
<td>including attached shoes (but not</td>
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<tr>
<td>corrective shoes);</td>
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<tr>
<td>• Surgical supports;</td>
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<tr>
<td>• Scalp hair prostheses required as the</td>
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<tr>
<td>result of hair loss due to injury; sickness;</td>
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<td></td>
<td></td>
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<tr>
<td>or treatment of sickness; and</td>
<td></td>
<td></td>
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<tr>
<td>• Head halters.</td>
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</tbody>
</table>

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](http://uspreventiveservicestaskforce.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](http://www.hrsa.gov/index.html).

<table>
<thead>
<tr>
<th>Routine Physical Exam</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes routine vision &amp; hearing screenings given as part of the routine physical exam.</td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
<td>70% of the Recognized Charge</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventive Care Immunizations</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes travel immunizations and flu shots.</td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
<td>70% of the Recognized Charge</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Well Woman Preventive Visits</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine well woman preventive exam office visit, including Pap smears.</td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
<td>70% of the Recognized Charge</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventive Care Screening and Counseling Services for Sexually Transmitted Infections</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes the counseling services to help a covered person prevent or reduce sexually transmitted infections.</td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
<td>70% of the Recognized Charge</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mammograms (Age 35 and older)</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
<td>70% of the Recognized Charge</td>
</tr>
<tr>
<td>PREVENTIVE CARE EXPENSES (continued)</td>
<td>Core Network</td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>--------------------------------------</td>
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</tr>
<tr>
<td>Preventive Care Screening and Counseling Services for Obesity and/or Healthy Diet</td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
<td>70% of the Recognized Charge*</td>
</tr>
</tbody>
</table>
| 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. | | | |
| Preventive Care Screening and Counseling Services for Misuse of Alcohol and/or Drugs | 100% of the Negotiated Charge* | 100% of the Negotiated Charge* | 70% of the Recognized Charge* |
| 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. | | | |
| Preventive Care Screening and Counseling Services for Use of Tobacco Products | 100% of the Negotiated Charge* | 100% of the Negotiated Charge* | 70% of the Recognized Charge* |
| 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. | | | |
| Preventive Care Screening and Counseling Services for Depression Screening | 100% of the Negotiated Charge* | 100% of the Negotiated Charge* | 70% of the Recognized Charge* |
| Screening or test to determine if depression is present. | | | |
### Preventive Care Expenses (continued)

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Cancer Screenings</strong>&lt;br&gt;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.</td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
<td>70% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Screening and Counseling Services for Genetic Risk for Breast and Ovarian Cancer</strong>&lt;br&gt;Covered medical expenses include the counseling and evaluation services to help assess a covered person's risk of breast and ovarian cancer susceptibility.</td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
<td>70% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Prenatal Care</strong>&lt;br&gt;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).&lt;br&gt;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.</td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
<td>70% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Lactation Counseling Services</strong>&lt;br&gt;Lactation support and lactation counseling services are covered medical expenses when provided in either a group or individual setting.</td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
<td>70% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Breast Pumps and Supplies</strong></td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
<td>70% of the Recognized Charge</td>
</tr>
</tbody>
</table>
### PREVENTIVE CARE EXPENSES (continued)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
<td>70% of the Recognized Charge</td>
</tr>
<tr>
<td>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 &amp; related services &amp; supplies including, but not limited to, tubal ligation and sterilization implants. Covered medical expenses under this benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement. Contraceptives can be paid either under this benefit or the prescribed medicines expense depending on the type of expense and how and where the expense is incurred. Benefits are paid under this benefit for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.</td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
<td>70% of the Recognized Charge</td>
</tr>
</tbody>
</table>

### OTHER FAMILY PLANNING SERVICES EXPENSE

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary Sterilization for Males (Outpatient)</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Voluntary Termination of Pregnancy (Outpatient)</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>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</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Benefits for Voluntary Termination of Pregnancy limited to $500 per policy year.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>AMBULANCE EXPENSE</td>
<td>Core Network</td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
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<td>-------------------------------------</td>
</tr>
<tr>
<td>Ground, Air, Water and Non-Emergency Ambulance</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Recognized Charge</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADDITIONAL BENEFITS</td>
<td>Core Network</td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>Allergy Testing and Treatment Expense</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes charges incurred by a covered person for diagnostic testing and treatment of allergies and immunology services.</td>
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</tr>
<tr>
<td>Diagnostic Testing For Learning Disabilities Expense</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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<tr>
<td>Covered medical expenses include charges incurred by a covered person for diagnostic testing for:</td>
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<tr>
<td>• Attention deficit disorder; or</td>
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<tr>
<td>• Attention deficit hyperactive disorder.</td>
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</tr>
<tr>
<td>High Cost Procedures Expense</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>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:</td>
<td></td>
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<tr>
<td>• Computerized Axial Tomography (C.A.T.) scans;</td>
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<tr>
<td>• Magnetic Resonance Imaging (MRI); and</td>
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<tr>
<td>• Positron Emission Tomography (PET) Scans.</td>
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<tr>
<td>Urgent Care Expense</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>Dental Expense for Impacted Wisdom Teeth</td>
<td>90% of the Actual Charge</td>
<td>80% of the Actual Charge</td>
<td>80% of the Actual Charge</td>
</tr>
<tr>
<td>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:</td>
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<tr>
<td>• mouth; jaws; jaw joints; or</td>
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<tr>
<td>• supporting tissues; (this includes: bones; muscles; and nerves). Referral not required.</td>
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</tr>
<tr>
<td>ADDITIONAL BENEFITS (continued)</td>
<td>Core Network</td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
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<tr>
<td>---------------------------------</td>
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</tr>
<tr>
<td><strong>Accidental Injury to Sound Natural Teeth Expense</strong>&lt;br&gt;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.</td>
<td>90% of the Actual Charge</td>
<td>80% of the Actual Charge</td>
<td>80% of the Actual Charge</td>
</tr>
<tr>
<td><strong>Second Surgical Opinion Expense</strong>&lt;br&gt;Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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</tr>
<tr>
<td><strong>Non-Elective Second Surgical Opinion Expense</strong>&lt;br&gt;Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>After a $25 Copay per visit, 90% of the Negotiated Charge</td>
<td>After a $35 Copay per visit, 80% of the Negotiated Charge</td>
<td>After a $35 per visit Deductible, 60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Consultant Expense</strong>&lt;br&gt;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.&lt;br&gt;Coverage may be extended to include treatment by the consultant.</td>
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<tr>
<td><strong>Skilled Nursing Facility Expense</strong>&lt;br&gt;90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation Facility Expense</strong>&lt;br&gt;Includes charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility.&lt;br&gt;90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care Expense</strong>&lt;br&gt;Covered medical expenses will not include:&lt;br&gt;• Services by a person who resides in the covered person's home, or is a member of the covered person's immediate family&lt;br&gt;• Homemaker or housekeeper services;&lt;br&gt;• Maintenance therapy;&lt;br&gt;• Dialysis treatment;&lt;br&gt;• Purchase or rental of dialysis equipment;&lt;br&gt;• Food or home delivered services; or&lt;br&gt;• Custodial care.&lt;br&gt;Benefits limited to 120 visits per policy year.</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Temporomandibular Joint Dysfunction Expense</strong>&lt;br&gt;Covered medical expenses include physician’s charges incurred by a covered person for surgical and non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction.</td>
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<tr>
<td><strong>Temporomandibular Joint Dysfunction Expense</strong>&lt;br&gt;Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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</tbody>
</table>
### ADDITIONAL BENEFITS (continued)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
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</thead>
<tbody>
<tr>
<td><strong>Dermatological Expense</strong></td>
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<tr>
<td>Includes physician’s charges incurred by a</td>
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<tr>
<td>covered person for the diagnosis and</td>
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<tr>
<td>treatment of skin disorders. Related</td>
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<tr>
<td>laboratory expenses are covered under the</td>
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<tr>
<td>Lab and X-ray Expense benefit.</td>
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<tr>
<td>Unless specified above, not covered under</td>
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<tr>
<td>this benefit are charges incurred for:</td>
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<tr>
<td>• Treatment for acne;</td>
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<tr>
<td>• Cosmetic treatment and procedures; and</td>
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<tr>
<td>Laboratory fees.</td>
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<tr>
<td>Referral not required.</td>
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<td></td>
<td>90% of the</td>
<td>80% of the</td>
<td>60% of the</td>
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<td>Negotiated</td>
<td>Negotiated</td>
<td>Recognized Charge</td>
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<td>Charge</td>
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<tr>
<td><strong>Prosthetic Devices Expense</strong></td>
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<tr>
<td>Includes charges made for internal and</td>
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<tr>
<td>external prosthetic devices and special</td>
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<tr>
<td>appliances, if the device or appliance</td>
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<tr>
<td>improves or restores body part function</td>
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<tr>
<td>that has been lost or damaged by sickness,</td>
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<tr>
<td>injury or congenital defect. Covered</td>
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<tr>
<td>medical expenses also include instruction</td>
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<tr>
<td>and incidental supplies needed to use a</td>
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<tr>
<td>covered prosthetic device. The plan</td>
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<tr>
<td>covers the first prosthesis a covered</td>
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<tr>
<td>person needs that temporarily or</td>
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<tr>
<td>permanently replaces all or part of an</td>
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<td>body part lost or impaired as a result of</td>
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<tr>
<td>sickness or injury or congenital defects</td>
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<tr>
<td>as described in the list of covered</td>
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<tr>
<td>devices below for an:</td>
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<tr>
<td>• Internal body part or organ; or</td>
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<tr>
<td>• External body part.</td>
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<tr>
<td><strong>Pediatric Expense</strong></td>
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<tr>
<td>Includes charges incurred by a covered</td>
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<td>Payable in</td>
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<tr>
<td>person for pediatric services; provided</td>
<td></td>
<td>accordance with</td>
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<tr>
<td>on an outpatient basis following an injury.</td>
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<td>the type of</td>
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<tr>
<td>Unless specified above, not covered under</td>
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<td>expense incurred</td>
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<tr>
<td>this benefit are charges incurred for</td>
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<td>and the place</td>
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<tr>
<td>routine foot care, such as trimming of</td>
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<td>where service is</td>
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<td>corns, calluses, and nails.</td>
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<td>provided.</td>
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<tr>
<td><strong>Hypodermic Needles Expense</strong></td>
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<td>Payable in</td>
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<tr>
<td>Includes expenses incurred by a covered</td>
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<td>accordance with</td>
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<tr>
<td>person for hypodermic needles and syringes.</td>
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<td>the type of</td>
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<td>expense incurred</td>
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<td></td>
<td></td>
<td>and the place</td>
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<td></td>
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<td>where service is</td>
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<td></td>
<td></td>
<td>provided.</td>
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<td></td>
<td>90% of the</td>
<td>80% of the</td>
<td>60% of the</td>
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<td></td>
<td>Negotiated</td>
<td>Negotiated</td>
<td>Recognized Charge</td>
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<tr>
<td><strong>Convalescent Facility Expense</strong></td>
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<td>Payable in</td>
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<td></td>
<td></td>
<td>accordance with</td>
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<td></td>
<td></td>
<td>the type of</td>
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<td></td>
<td></td>
<td>expense incurred</td>
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<td></td>
<td></td>
<td>and the place</td>
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<td></td>
<td></td>
<td>where service is</td>
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<td></td>
<td></td>
<td>provided.</td>
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<tr>
<td></td>
<td>90% of the</td>
<td>80% of the</td>
<td>60% of the</td>
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<tr>
<td></td>
<td>Negotiated</td>
<td>Negotiated</td>
<td>Recognized Charge</td>
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<td></td>
<td>Charge</td>
<td>Charge</td>
<td></td>
</tr>
</tbody>
</table>
## ADDITIONAL BENEFITS (continued)

<table>
<thead>
<tr>
<th>Maternity Expense</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
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<tr>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Prescription Enteral Formula Expense</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
</table>
| 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. |
| 90% of the Negotiated Charge | 80% of the Negotiated Charge | 60% of the Recognized Charge |

| Covered medical expenses for inherited diseases of amino acids; and organic acids; will also include food products modified to be low protein. |

<table>
<thead>
<tr>
<th>Acupuncture in Lieu of Anesthesia Expense</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>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>
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<tr>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
<td></td>
</tr>
</tbody>
</table>
### ADDITIONAL BENEFITS (continued)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transfusion or Kidney Dialysis of Blood Expense</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
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</tr>
<tr>
<td>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>
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</tr>
<tr>
<td><strong>Hospice Expense</strong></td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Blood and Body Fluid Exposure/ Needle Stick Coverage Expense</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
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</tr>
<tr>
<td>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>
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<tr>
<td><strong>Private Duty Nursing</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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<tr>
<td>Includes private duty nursing services provided by an R.N. or L.P.N. if the covered person’s condition requires skilled nursing care and visiting nursing care is not adequate</td>
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</tr>
<tr>
<td><strong>Diabetes Benefit Expense</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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</tr>
<tr>
<td>Includes charges for services, supplies, equipment, &amp; training for the treatment of insulin and non-insulin dependent diabetes &amp; elevated blood glucose levels during pregnancy. Self-management training provided by a licensed health care provider certified in diabetes self-management training.</td>
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</tr>
<tr>
<td><strong>Autism Spectrum Disorder Expense</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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</tr>
<tr>
<td>Includes charges incurred for services and supplies required for the diagnosis &amp; treatment of autism spectrum disorder when ordered by a physician or behavioral health provider as part of a treatment plan.</td>
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<tr>
<td><strong>Basic Infertility Expense</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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<tr>
<td>Covered medical expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.</td>
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</tbody>
</table>
### ADDITIONAL BENEFITS (continued)

<table>
<thead>
<tr>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive Infertility Expenses</strong>&lt;br&gt;Comprehensive Infertility Services Benefits&lt;br&gt;- Ovulation induction with menotropins is subject to the maximum benefit of 6 cycles per lifetime.&lt;br&gt;- Intrauterine insemination is subject to the maximum benefit of 6 cycles per lifetime.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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</tr>
<tr>
<td><strong>Advanced Reproductive Technology (ART) Expenses</strong>&lt;br&gt;Advanced Reproductive Technology is defined as:&lt;br&gt;- In vitro fertilization (IVF);&lt;br&gt;- Zygote intrafallopian transfer (ZIFT);&lt;br&gt;- Gamete intra-fallopian transfer (GIFT);&lt;br&gt;- Cryopreserved embryo transfers; and&lt;br&gt;- Intracytoplasmic sperm injection (ICSI); or ovum microsurgery.&lt;br&gt;<strong>Maximum:</strong>&lt;br&gt;- Up to 3 cycles of any combination of the following ART services per lifetime which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers;&lt;br&gt;- 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;&lt;br&gt;- ICSI or ovum microsurgery;&lt;br&gt;- 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&lt;br&gt;- Charges associated with obtaining the spouse’s sperm for ART, when the spouse is also covered under the Policy.&lt;br&gt;<strong>Limitations:</strong>&lt;br&gt;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;</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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</tbody>
</table>
## ADDITIONAL BENEFITS (continued)

### Advanced Reproductive Technology (ART) Expenses (continued)

- 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 precertification from Aetna’s infertility case management unit;
- Infertility Services that are not reasonably likely to result in success;
- Ovulation induction and intrauterine insemination services if a covered person is not infertile;
- Any ART procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”), and intra-cytoplasmic sperm injection (“ICSI”);
- Any charges associated with care required to obtain ART services (e.g., office, hospital, ultrasounds, laboratory tests, etc.); and any charges associated with obtaining sperm for any ART procedures.

Payable in accordance with the type of expense incurred and the place where service is provided.
### ADDITIONAL BENEFITS (continued)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bariatric Surgery Expense</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
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</tr>
<tr>
<td>Covered medical expenses for the treatment of morbid obesity include one bariatric surgical procedure including related outpatient services, within a two-year period, beginning with the date of the first bariatric surgical procedure, unless a multi-stage procedure is planned.</td>
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<tr>
<td><strong>Clinical Trials Expense (Experimental or Investigational Treatment)</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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</tr>
<tr>
<td>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.</td>
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</tr>
<tr>
<td><strong>Clinical Trials Expense Routine Patient Costs Covered Percentage</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes charges made by a provider for &quot;routine patient costs&quot; 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.</td>
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</tr>
<tr>
<td><strong>Gender Reassignment (Sex Change) Surgery Expense</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes charges made in connection with a medically necessary gender reassignment surgery (sometimes called sex change surgery) as long as 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.</td>
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<tr>
<td>Covered medical expenses include:</td>
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<tr>
<td>• Charges made by a physician for:</td>
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<tr>
<td>- Performing the surgical procedure; and</td>
<td></td>
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<tr>
<td>- Pre-operative and post-operative hospital and office visits.</td>
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<tr>
<td>• Charges made by a hospital for inpatient and outpatient services (including outpatient surgery).</td>
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<tr>
<td>• Charges made by a Skilled Nursing Facility for inpatient services and supplies.</td>
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<tr>
<td>• Charges made for the administration of anesthetics.</td>
<td></td>
<td></td>
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<tr>
<td>• Charges for outpatient diagnostic laboratory and x-rays.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADDITIONAL BENEFITS (continued)</td>
<td>Core Network</td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
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<tr>
<td>----------------------------------</td>
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</tr>
<tr>
<td><strong>Gender Reassignment (Sex Change) Surgery Expense (continued)</strong>&lt;br&gt;• Charges for blood transfusion and the cost of unreplaced blood and blood products.&lt;br&gt;• Charges made by a behavioral health provider for gender reassignment counseling.&lt;br&gt;No benefits will be paid for covered medical expenses under this benefit unless they have been pre-certified by Aetna. Refer to the Precertification section for more information.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic Treatment Expense</strong>&lt;br&gt;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.</td>
<td>After a $25 Copay per visit, 90% of the Negotiated Charge</td>
<td>After a $35 Copay per visit, 80% of the Negotiated Charge</td>
<td>After a $35 per visit Deductible, 60% of the Recognized Charge</td>
</tr>
</tbody>
</table>

**SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE**<br>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:<br>• A licensed or certified physical or occupational therapist; or<br>• A physician.<br>Charges for the following short term rehabilitation expenses are covered:<br>• Cardiac and Pulmonary Rehabilitation Benefits<br>• 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.<br>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.<br><br| **Cardiac Rehabilitation** | 90% of the Negotiated Charge | 80% of the Negotiated Charge | 60% of the Recognized Charge |
| **Pulmonary Rehabilitation** | 90% of the Negotiated Charge | 80% of the Negotiated Charge | 60% of the Recognized Charge |

**SHORT-TERM REHABILITATION AND HABILITATION THERAPIES EXPENSE**<br>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:<br>• Details the treatment, and specifies frequency and duration;<br>• Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and<br>• Allows therapy services, provided in a covered person’s home, if the covered person is homebound.<br>Inpatient rehabilitation benefits for the services listed will be paid as part of the inpatient hospital and skilled nursing facility benefits.<br><br| **Short-Term Rehabilitation and Habilitation Therapies Expense**<br>Outpatient Cognitive, Physical, Occupational and Speech Rehabilitation and Habilitation Therapy Services (combined) | After a $25 Copay per visit, 90% of the Negotiated Charge | After a $35 Copay per visit, 80% of the Negotiated Charge | After a $35 per visit Deductible, 60% of the Recognized Charge |
### ADDITIONAL BENEFITS (continued)

<table>
<thead>
<tr>
<th>In-Hospital Dental Procedure Expense</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered expenses include charges for general anesthesia and associated hospital or ambulatory surgical facility charges for dental care provided if the covered person is:</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
<td></td>
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<tr>
<td>- 7 years of age or younger or is developmentally disabled;</td>
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<tr>
<td>- 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</td>
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<tr>
<td>- an individual who has sustained extensive facial or dental trauma, unless otherwise covered by workers’ compensation.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Telemedicine Expense</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>TREATMENT OF MENTAL DISORDER EXPENSE</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non -Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Mental Health &amp; Residential Mental Health Treatment Facility Expense</strong></td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>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.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Mental Health Physician Services per Admission &amp; Residential Mental Health Treatment Physician Services Expense</th>
<th>90% of the Negotiated Charge</th>
<th>80% of the Negotiated Charge</th>
<th>60% of the Recognized Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>After a $10 Copay per visit, 90% of the Negotiated Charge</td>
<td>After a $10 Copay per visit, 80% of the Negotiated Charge</td>
<td>After a $10 per visit Deductible, 80% of the Recognized Charge</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Mental Health Expense</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>After a $10 Copay per visit, 90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Mental Health Partial Hospitalization Expense</th>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
<td></td>
</tr>
<tr>
<td>ALCOHOLISM AND DRUG ADDICTION TREATMENT</td>
<td>Core Network</td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>----------------------------------------</td>
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</tr>
<tr>
<td>Inpatient Substance Abuse &amp; Residential Substance Abuse Treatment Facility Expense</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Substance Abuse Physician Services per Admission &amp; Residential Substance Abuse Treatment Physician Services Expense</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>Outpatient Substance Abuse Treatment</td>
<td>90% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>TRANSPLANT SERVICE EXPENSE</td>
<td>Core Network</td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>Transplant Services Expense</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
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</tr>
<tr>
<td>Transplant Travel and Lodging Expense</td>
<td>Up to $50 per night</td>
<td></td>
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</tr>
<tr>
<td>The plan will reimburse a covered person for some of the cost of their travel and lodging expenses. Benefits are limited to $10,000 per transplant.</td>
<td></td>
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</tr>
<tr>
<td>PEDIATRIC DENTAL SERVICES EXPENSE (Coverage is limited to covered persons through age 18)</td>
<td>Core Network</td>
<td>Preferred Care</td>
<td>Non -Preferred Care</td>
</tr>
<tr>
<td>Type A Expense (Pediatric Routine Dental Exam Expense)</td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Recognized Charge</td>
</tr>
<tr>
<td>Type B Expense (Pediatric Basic Dental Care Expense)</td>
<td>70% of the Negotiated Charge*</td>
<td>70% of the Negotiated Charge*</td>
<td>70% of the Recognized Charge</td>
</tr>
<tr>
<td>Type C Expense (Pediatric Major Dental Care Expense)</td>
<td>50% of the Negotiated Charge*</td>
<td>50% of the Negotiated Charge*</td>
<td>50% of the Recognized Charge</td>
</tr>
</tbody>
</table>
| **PEDiATRIC DENTAL SERVICES EXPENSE**  
(Coverage is limited to covered persons through age 18) | Core Network | Preferred Care | Non-Preferred Care |
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Pediatric Orthodontia Expense</strong></td>
<td>50% of the Negotiated Charge*</td>
<td>50% of the Negotiated Charge*</td>
<td>50% of the Recognized Charge*</td>
</tr>
<tr>
<td>• Orthodontics</td>
<td></td>
<td></td>
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<tr>
<td>• Medically necessary comprehensive treatment</td>
<td></td>
<td></td>
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<tr>
<td>• Replacement of retainer (limit one per lifetime)</td>
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</tbody>
</table>

**PEDiATRIC ROUTINE VISION**  
(Coverage is limited to covered persons through age 18)

<table>
<thead>
<tr>
<th>Core Network</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pediatric Routine Vision Exams (including refractions)</strong></td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
</tr>
<tr>
<td>Includes charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction &amp; glaucoma testing. Benefits are limited to 1 visit per policy year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric Visit for the fitting of prescription contact lenses, Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses</strong></td>
<td>100% of the Negotiated Charge*</td>
<td>100% of the Negotiated Charge*</td>
</tr>
<tr>
<td>Includes charges for the following vision care services and supplies:</td>
<td></td>
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<tr>
<td>• Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses.</td>
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<td></td>
</tr>
<tr>
<td>• Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a preferred care provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a non-preferred care provider.</td>
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<td></td>
</tr>
<tr>
<td>Coverage includes charges incurred for:</td>
<td></td>
<td></td>
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<tr>
<td>• 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.</td>
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</tr>
<tr>
<td>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.</td>
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</tbody>
</table>

*Annual Deductible does not apply to these services*
PRESCRIBED MEDICINES EXPENSE

<table>
<thead>
<tr>
<th>Covered Percentage*</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care Drugs and Supplements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
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</tr>
<tr>
<td><strong>Risk Reducing Breast Cancer Prescription Drugs</strong></td>
<td>Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits</td>
<td>100% of the Recognized Charge</td>
</tr>
<tr>
<td>For each 30-day supply filled at a retail pharmacy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other preventive care drugs and supplements</strong></td>
<td>100% per supply</td>
<td>100% of the Recognized Charge</td>
</tr>
<tr>
<td>For each 30-day supply filled at a retail pharmacy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CONTRACEPTIVES</strong></td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>For each 30-day supply filled at a retail pharmacy.</td>
<td>Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits</td>
<td>100% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>ALL OTHER PRESCRIPTION DRUGS</strong></td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>For each 30-day supply filled at a retail pharmacy.</td>
<td>100% of the Negotiated Charge</td>
<td>100% of the Recognized Charge</td>
</tr>
</tbody>
</table>

*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.

<table>
<thead>
<tr>
<th>Per Prescription Copay/Deductible</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic Prescription Drugs</strong></td>
<td></td>
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</tr>
<tr>
<td>For each 30-day supply filled at a retail pharmacy.</td>
<td>$15 Copay per supply</td>
<td>$15 Deductible per supply</td>
</tr>
<tr>
<td><strong>Preferred Brand-Name Prescription Drug</strong></td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>For each 30-day supply filled at a retail pharmacy.</td>
<td>$30 Copay per supply</td>
<td>$30 Deductible per supply</td>
</tr>
<tr>
<td><strong>Non-Preferred Brand-Name Prescription Drugs</strong></td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>For each 30-day supply filled at a retail pharmacy.</td>
<td>$30 Copay per supply</td>
<td>$30 Deductible per supply</td>
</tr>
</tbody>
</table>

Prescriptions exceeding the standard 30-day supply require authorization (override) by Aetna Pharmacy Management at (888) RX-AETNA.

**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. Repair an injury (including reconstructive surgery for prosthetic device for a covered person who has undergone a mastectomy) which occurs while the covered person is covered under the Policy. Surgery must be performed:
   • in the policy year of the accident which causes the injury; or
   • in the next policy year.

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

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

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

13. Expense incurred for any services rendered by a member of the covered person’s immediate family or a person who lives in the covered person’s home.
14. Expense incurred for the male or female reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.

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

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

17. Expense incurred for custodial care.

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

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

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

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

22. Expenses incurred for gastric bypass; and any restrictive procedures; for weight loss except screening and counseling services specifically covered under the Policy.

23. Expenses incurred for breast reduction/mammoplasty.

24. Expenses incurred for gynecomastia (male breasts).

25. 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.

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

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 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.

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

30. 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.

31. 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.

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

33. 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.

34. 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.

35. 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.

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

37. 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.

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

39. 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.

40. 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.

41. 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.

42. 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.

43. 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.

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

45. 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.

46. 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.

47. 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.

48. 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).
49. Expense incurred for drugs, medications and supplies, except as specifically covered in the Policy. Not covered are:
   • Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
   • Services related to the dispensing, injection or application of a drug;
   • A prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
   • Immunizations related to travel or work;
   • Needles, syringes and other injectable aids, except as covered for diabetic supplies, and for a covered drug;
   • Drugs related to the treatment of non-covered medical expenses;
   • Performance enhancing steroids;
   • Injectable 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.

50. 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).

51. 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.

52. 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.

53. 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.

54. 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.

55. 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.

56. 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:

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

58. 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 vestibuoplasty, 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.

59. 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.

60. 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.

61. 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.

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

63. 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.

64. 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.

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

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

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

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

69. Expenses incurred for routine dental exams and other preventive services and supplies, except as specifically covered in the Policy.
70. Expenses incurred for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

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

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

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

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