WESLEYAN
UNIVERSITY

Aetna Student Health

Plan Design and Benefits Summary
Wesleyan University

Policy Year: 2016 - 2017
Policy Number: 867893
Customer Service: (866) 746-6590

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www.aetnastudenthealth.com

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

Coverage Periods

Students: Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated.

Eligible Dependents: Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

Coverage Period	Coverage Start Date	Coverage End Date	Waiver/Enrollment Deadline
Annual	08/12/2016	08/11/2017	08/15/2016
Fall Semester	08/12/2016	01/14/2017	08/15/2016
Spring/Summer Semester	01/15/2017	08/11/2017	01/29/2017

Rates

2016-2017 Rates*
Undergraduate Students and Dependents

	Annual	Fall Semester	Spring/Summer Semester
Student*	**$2,045**	**$882**	**$1,178**
Spouse	**$2,030**	**$867**	**$1,163**
One Child	**$2,030**	**$867**	**$1,163**
Two or More Children	**$4,060**	**$1,734**	**$2,326**

*The rates above are inclusive of any fees that may be assessed by Gallagher Student Health and by your school.

2016-2017 Rates*
Graduate Students and Dependents

	Annual	Fall Semester	Spring/Summer Semester
Student*	**$2,408**	**$1,037**	**$1,386**
Spouse	**$2,393**	**$1,022**	**$1,371**
One Child	**$2,393**	**$1,022**	**$1,371**
Two or More Children	**$4,786**	**$2,044**	**$2,742**

*The rates above are inclusive of any fees that may be assessed by Gallagher Student Health and by your school.

Student Coverage

Eligibility

All full-time undergraduate and graduate students are automatically enrolled in and billed for the Student Health Insurance Plan, unless proof of comparable coverage is provided.

All students must be enrolled at Wesleyan University, and actively attend classes for at least the first 31 days, after the date when coverage becomes effective.

Home study, correspondence, Internet classes, and television (TV) courses, do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

Enrollment

Eligible students are required to enroll in or waive the Student Health Insurance Plan by the specified enrollment/waiver deadlines listed above.

Waiver Process:

1. Log onto **www.gallagherstudent.com/Wesleyan**.
2. Click on the "Student Waive/Enroll" tab.
3. New users will be required to create a unique User Account; Returning users will simply log in.
4. Once logged in, click on the blue "I want to Waive/Enroll" button. Follow the online instructions to waive.

Immediately upon submitting the Waiver Form, you will receive a reference number indicating that the form has been successfully submitted. Print this reference number for your records. If you do not receive a reference number, you will need to correct any errors and resubmit the form. The online process is the only accepted process for waiving coverage.

Dependent Coverage

Eligibility

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

Enrollment

To enroll the dependent(s) of a covered student, Please refer to the Coverage Periods section of this document for coverage dates and deadline dates.

To Enroll Dependents Online:

1. Log onto **www.gallagherstudent.com/Wesleyan**.
2. Click on the "Dependent Enroll" tab.
3. New users will be required to create a unique User Account; Returning users will simply log in.
4. Once logged in, click on the "Dependent Enroll" button. Follow the online instructions to enroll.

Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.)

Medicare Notice

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

Preferred Provider Network

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

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

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 Pre-certification is the preferred care or designated care provider's responsibility, and 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.

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

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

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

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

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

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

Pre-certification of non-emergency admissions

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

Pre-certification of emergency admissions

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

Pre-certification of urgent admissions

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

Pre-certification of outpatient non-emergency medical services

Outpatient non-emergency medical services must be requested within **fifteen (15) days** 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 "Pre-certification" provision in the Master Policy for a list of services under the Plan that require pre-certification. Please see the Schedule of Benefits for any penalty or benefit reduction that may apply to your coverage when pre-certification is not obtained for the listed services or supplies when received from a non-preferred care provider.

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 Wesleyan University, you may access it online at **www.aetnastudenthealth.com.** If any discrepancy exists between this Brochure 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 Connecticut Insurance Law(s).

Metallic Level: Gold, Tested at 81.92%

DEDUCTIBLE	Preferred Care	Non-Preferred Care
The policy year deductible is waived for preferred care covered medical expenses that apply to Preventive Care Expense benefits. In compliance with Connecticut State Mandate(s) the Policy Year Deductible is also waived for: Bone Marrow Transplantation Antigen Testing, Initial and follow-up Colorectal Cancer Screenings and Early Intervention Services In addition to state and federal requirements for waiver of the policy year deductible, the plan will waive the policy year deductible for Preferred Care Pediatric Preventive Dental Services and Preferred Care and Non Preferred Care Pediatric Preventive Vision Services. ***Annual Deductible does not apply to these services**	Individual: **$250** per Policy Year	Individual: **$500** per Policy Year

COINSURANCE	Preferred Care	Non-Preferred Care
Coinsurance is both the percentage of covered medical expenses that the plan pays, and the percentage of covered medical expenses that you pay. The percentage that the plan pays is referred to as "plan coinsurance" or the "payment percentage," and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.	Covered Medical Expenses are payable at the plan coinsurance percentage specified below, after any applicable Deductible.	
OUT-OF-POCKET MAXIMUMS	**Preferred Care and Non-Preferred Care Combined**	
Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year. The following expenses do not apply toward meeting the plan's out-of-pocket limits: • Non-covered medical expenses; and • Expenses that are not paid because a required precertification for the service(s) or supply was not obtained from Aetna.	Individual Out-of-Pocket: **$6,350** per Policy Year Family Out-of-Pocket: **$12,700** per Policy Year	
INPATIENT HOSPITALIZATION BENEFITS	**Preferred Care**	**Non-Preferred Care**
Room and Board Expense The covered room and board expense does not include any charge in excess of the daily room and board maximum.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge for a semi-private room
Intensive Care The covered room and board expense does not include any charge in excess of the daily room and board maximum.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Miscellaneous Hospital Expense Includes but not limited to: operating room, laboratory tests/X rays, oxygen tent, drugs, medicines and dressings.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Licensed Nurse Expense Includes charges incurred by a covered person who is confined in a hospital as a resident bed patient and requires the services of a registered nurse or licensed practical nurse.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Well Newborn Nursery Care	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Non-Surgical Physicians Expense Includes hospital charges incurred by a covered person who is confined as an inpatient in a hospital for a surgical procedure for the services of a physician who is not the physician who may have performed surgery on the covered person.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
SURGICAL EXPENSES	**Preferred Care**	**Non-Preferred Care**
Surgical Expense (Inpatient and Outpatient) When injury or sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, covered medical expenses only include expenses incurred for the most expensive procedure.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge

SURGICAL EXPENSES (continued)	Preferred Care	Non-Preferred Care
Anesthesia Expense (Inpatient and Outpatient) If, in connection with such operation, the covered person requires the services of an anesthetist who is not employed or retained by the hospital in which the operation is performed, the expenses incurred will be Covered Medical Expenses.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Assistant Surgeon Expense (Inpatient and Outpatient)	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
OUTPATIENT EXPENSES	**Preferred Care**	**Non-Preferred Care**
Physician or Specialist Office Visit Expense Includes the charges made by the physician or specialist if a covered person requires the services of a physician or specialist in the physician's or specialist's office while not confined as an inpatient in a hospital. Coverage includes medical advice, diagnosis, care or treatment provided through telehealth, to the extent coverage is provided for such advice, diagnosis, care or treatment when provided through in-person consultation between the insured and a health care provider. "Telehealth" means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health, and includes (1) interaction between the patient at the originating site and the telehealth provider at a distant site, and (2) synchronous interactions, asynchronous store and forward transfers, or remote patient monitoring. Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail.	After a **$40** per visit Copay, **100%** of the Negotiated Charge	**50%** of the Recognized Charge
Laboratory and X-ray Expense	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Hospital Outpatient Department Expense	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Therapy Expense Covered medical expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis: • Radiation therapy; • Inhalation therapy; • Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy; • Kidney dialysis; and • Respiratory therapy.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Pre-Admission Testing Expense Includes charges incurred by a covered person for pre-admission testing charges made by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery.	Payable in accordance with the type of expense incurred and the place where service is provided.	

OUTPATIENT EXPENSES	Preferred Care	Non-Preferred Care
Ambulatory Surgical Expense Covered medical expenses include expenses incurred by a covered person for outpatient surgery performed in an ambulatory surgical center. Covered medical expenses must be incurred on the day of the surgery or within 24 hours after the surgery.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Walk-in Clinic Visit Expense	After a **$40** per visit Copay, **100%** of the Negotiated Charge	**50%** of the Recognized Charge
Emergency Room Expense Covered medical expenses incurred by a covered person for services received in the emergency room of a hospital while the covered person is not a full-time inpatient of the hospital. The treatment received must be emergency care for an emergency medical condition. There is no coverage for elective treatment, routine care or care for a non-emergency sickness. As to emergency care incurred for the treatment of an emergency medical condition or psychiatric condition, any referral requirement will not apply & any expenses incurred for non-preferred care will be paid at the same cost-sharing level as if they had been incurred for preferred care. **Important Notice:** A separate hospital emergency room visit benefit deductible or copay applies for each visit to an emergency room for emergency care. If a covered person is admitted to a hospital as an inpatient immediately following a visit to an emergency room, the emergency room visit benefit deductible or copay is waived. Covered medical expenses that are applied to the emergency room visit benefit deductible or copay cannot be applied to any other benefit deductible or copay under the plan. Likewise, covered medical expenses that are applied to any of the plan's other benefit deductibles or copays cannot be applied to the emergency room visit benefit deductible or copay. Separate benefit deductibles or copays may apply for certain services rendered in the emergency room that are not included in the hospital emergency room visit benefit. These benefit deductibles or copays may be different from the hospital emergency room visit benefit deductible or copay, and will be based on the specific service rendered.	After a **$175** per visit Copay (waived if admitted), **100%** of the Negotiated Charge	After a **$175** per visit Deductible (waived if admitted), **100%** of the Recognized Charge

OUTPATIENT EXPENSES	Preferred Care	Non-Preferred Care
Emergency Room Expense (continued) Similarly, services rendered in the emergency room that are not included in the hospital emergency room visit benefit may be subject to coinsurance. Important Note: Please note that Non-Preferred Care Providers do not have a contract with Aetna; the provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.	After a **$175** per visit Copay (waived if admitted), **100%** of the Negotiated Charge	After a **$175** per visit Deductible (waived if admitted), **100%** of the Recognized Charge
Durable Medical and Surgical Equipment Expense Durable medical and surgical equipment would include: Artificial arms and legs; including accessories; • Arm, back, neck braces, leg braces; including attached shoes (but not corrective shoes); • Surgical supports; • Scalp hair prostheses required as the result of hair loss due to injury; sickness; or treatment of sickness; and • Head halters.	**80%** of the Negotiated Charge	**80%** of the Recognized Charge

PREVENTIVE CARE EXPENSES

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

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

PREVENTIVE CARE EXPENSES	Preferred Care	Non-Preferred Care
Routine Physical Exam Includes routine vision & hearing screenings given as part of the routine physical exam.	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge
Preventive Care Immunizations	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge
Well Woman Preventive Visits Routine well woman preventive exam office visit, including Pap smears.	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Sexually Transmitted Infections Includes the counseling services to help a covered person prevent or reduce sexually transmitted infections.	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Screening and Counseling Services for Obesity and/or Healthy Diet Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Misuse of Alcohol and/or Drugs Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Use of Tobacco Products Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: • Cigarettes; • Cigars; • Smoking tobacco; • Snuff; • Smokeless tobacco; and • Candy-like products that contain tobacco.	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Depression Screening Screening or test to determine if depression is present.	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge
Preventive Care Routine Cancer Screenings Covered expenses include but are not limited to: Pap smears; Mammograms; Fecal occult blood tests; Digital rectal exams; Prostate specific antigen (PSA) tests; Sigmoidoscopies; Double contrast barium enemas (DCBE); Colonoscopies (removal of polyps performed during a screening procedure is a covered medical expense); and Lung cancer screenings.	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Genetic Risk for Breast and Ovarian Cancer Covered medical expenses include the counseling and evaluation services to help assess a covered person's risk of breast and ovarian cancer susceptibility.	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Prenatal Care Coverage for prenatal care under this Preventive Care Expense benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height). Refer to the Maternity Expense benefit for more information on coverage for maternity expenses under the Policy, including other prenatal care, delivery and postnatal care office visits.	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge
Preventive Care Lactation Counseling Services Lactation support and lactation counseling services are covered medical expenses when provided in either a group or individual setting.	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge
Preventive Care Breast Pumps and Supplies	**100%** of the Negotiated Charge*	**80%** of the Recognized Charge
Preventive Care Female Contraceptive Counseling Services, Preventive Care Female Contraceptive Generic, Brand Name, Biosimilar Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visit, Preventive Care Female Voluntary Sterilization (Inpatient), Preventive Care Female Voluntary Sterilization (Outpatient) Includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered medical expenses when provided in either a group or individual setting. **Voluntary Sterilization** Includes charges billed separately by the provider for female voluntary sterilization procedures & related services & supplies including, but not limited to, tubal ligation and sterilization implants. Covered medical expenses under this benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement. **Contraceptive**s can be paid either under this benefit or the prescribed medicines expense depending on the type of expense and how and where the expense is incurred. Benefits are paid under this benefit for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge
OTHER FAMILY PLANNING SERVICES EXPENSE	**Preferred Care**	**Non-Preferred Care**
Voluntary Termination of Pregnancy	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Voluntary Sterilization for Males (Outpatient) Covered medical expenses include charges for certain family planning services, even though not provided to treat a sickness or injury as follows. • Voluntary sterilization for males	Payable in accordance with the type of expense incurred and the place where service is provided.	

AMBULANCE EXPENSE	Preferred Care	Non-Preferred Care
Ground, Air, Water and Non-Emergency Ambulance Includes charges incurred by a covered person for the use of a professional ambulance in an emergency. Covered medical expenses for the service are limited to charges for ground transportation to the nearest hospital equipped to render treatment for the condition. Air transportation is covered only when medically necessary.	**80%** of the Negotiated Charge	**80%** of the Recognized Charge
ADDITIONAL BENEFITS	**Preferred Care**	**Non-Preferred Care**
Allergy Testing and Treatment Expense Includes charges incurred by a covered person for diagnostic testing and treatment of allergies and immunology services.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Diagnostic Testing For Learning Disabilities Expense Covered medical expenses include charges incurred by a covered person for diagnostic testing for: • Attention deficit disorder; or • Attention deficit hyperactive disorder.	Payable in accordance with the type of expense incurred and the place where service is provided.	
High Cost Procedures Expense Includes charges incurred by a covered person as a result of certain high cost procedures provided on an outpatient basis. Covered medical expenses for high cost procedures include; but are not limited to; charges for the following procedures and services: • Computerized Axial Tomography (C.A.T.) scans; • Magnetic Resonance Imaging (MRI); and • Positron Emission Tomography (PET) Scans.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Urgent Care Expense	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Dental Expense for Impacted Wisdom Teeth Includes charges incurred by a covered person for services of a dentist or dental surgeon for removal of one or more impacted wisdom teeth. Includes expenses for the treatment of: the mouth; teeth; and jaws; but only those for services rendered and supplies needed for the following treatment of; or related to conditions; of the: • mouth; jaws; jaw joints; or • supporting tissues; (this includes: bones; muscles; and nerves).	**100%** of the Negotiated Charge	**100%** of the Recognized Charge
Accidental Injury to Sound Natural Teeth Expense Covered medical expenses include charges incurred by a covered person for services of a dentist or dental surgeon as a result of an injury to sound natural teeth.	**80%** of the Negotiated Charge	**80%** of the Recognized Charge
Non-Elective Second Surgical Opinion Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Consultant Expense Includes the charges incurred by covered person in connection with the services of a consultant. The services must be requested by the attending physician to confirm or determine a diagnosis. Coverage may be extended to include treatment by the consultant.	After a **$40** per visit Copay, **100%** of the Negotiated Charge	**50%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Skilled Nursing Facility Expense	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Rehabilitation Facility Expense Includes charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Home Health Care Expense Covered medical expenses **will not** include: • Services by a person who resides in the covered person's home, or is a member of the covered person's immediate family • Homemaker or housekeeper services; • Maintenance therapy; • Dialysis treatment; • Purchase or rental of dialysis equipment; • Food or home delivered services; or • Custodial care.	**80%** of the Negotiated Charge	**75%** of the Recognized Charge
Temporomandibular Joint Dysfunction Expense Covered medical expenses include physician's charges incurred by a covered person for treatment of Temporomandibular Joint (TMJ) Dysfunction.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Dermatological Expense Includes physician's charges incurred by a covered person for the diagnosis and treatment of skin disorders. Related laboratory expenses are covered under the Lab and X-ray Expense benefit. Unless specified above, not covered under this benefit are charges incurred for: • Cosmetic treatment and procedures; and Laboratory fees.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Prosthetic Devices Expense Includes charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by sickness, injury or congenital defect. Covered medical expenses also include instruction and incidental supplies needed to use a covered prosthetic device. The plan covers the first prosthesis a covered person need that temporarily or permanently replaces all or part of an body part lost or impaired as a result of sickness or injury or congenital defects as described in the list of covered devices below for an: • Internal body part or organ; or • External body part. The list of covered devices includes, but is not limited to,: • An artificial arm, leg, hip, knee or eye; • Eye lens; • An external breast prosthesis and the first bra made solely for use with it after a mastectomy; • A breast implant after a mastectomy; • Ostomy supplies, urinary catheters and external urinary collection devices;	**80%** of the Negotiated Charge	**50%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Prosthetic Devices Expense (continued) • Speech generating device; • Orthopedic shoes; foot orthotics; or other devices to support the feet but only when required for the treatment of, or to prevent complications of, diabetes; • A cardiac pacemaker and pacemaker defibrillators; and • A durable brace that is custom made for and fitted for the covered person. **Limitations** Unless specified above, not covered under this benefit are charges for: • Eye exams; • Eyeglasses; • Vision aids; • Cochlear implants; • Hearing aids; • Communication aids.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Podiatric Expense Includes charges incurred by a covered person for podiatric services; provided on an outpatient basis following an injury. Unless specified above, not covered under this benefit are charges incurred for routine foot care, such as trimming of corns, calluses, and nails.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Hypodermic Needles Expense Includes expenses incurred by a covered person for hypodermic needles and syringes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Convalescent Facility Expense	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Maternity Expense Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person, and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother and done in accordance with the rules and regulations promulgated by State Mandate. Covered medical expenses may include home visits, parent education, and assistance and training in breast or bottle-feeding.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Non-Prescription Enteral Formula Expense Includes charges incurred by a covered person, for non-prescription enteral formulas for which a physician has issued a written order, and are for the treatment of malabsorption caused by: • Crohn's Disease; • Ulcerative colitis; • Gastroesophageal reflux;	**80%** of the Negotiated Charge	**50%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
• Gastrointestinal motility; • Chronic intestinal pseudo obstruction; and • Inherited diseases of amino acids and organic acids. Covered medical expenses for inherited diseases of amino acids; and organic acids; will also include food products modified to be low protein.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Acupuncture in Lieu of Anesthesia Expense Includes charges incurred by a covered person for acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician; practicing within the scope of their license.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Transfusion or Kidney Dialysis of Blood Expense Includes charges incurred by a covered person for the transfusion or kidney dialysis of blood, including the cost of: Whole blood; blood components; and the administration of whole blood and blood components.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Hospice Expense	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Diabetes Benefit Expense Includes charges for services, supplies, equipment, & training for the treatment of insulin and non-insulin dependent diabetes &elevated blood glucose levels during pregnancy. Self-management training provided by a licensed health care provider certified in diabetes self-management training.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Autism Spectrum Disorder Expense Includes charges incurred for services and supplies required for the diagnosis & treatment of autism spectrum disorder when ordered by a physician or behavioral health provider as part of a treatment plan.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Basic Infertility Expense Covered medical expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Comprehensive Infertility Expenses Comprehensive Infertility Services Benefits • Ovulation induction with menotropins is subject to the maximum benefit of 4 cycles per Policy Year. • Intrauterine insemination is subject to the maximum benefit of 4 cycles per Policy Year.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Advanced Reproductive Technology (ART) Expenses Advanced Reproductive Technology is defined as: • In vitro fertilization (IVF); • Zygote intrafallopian transfer (ZIFT); • Gamete intra-fallopian transfer (GIFT); • Cryopreserved embryo transfers; and • Intracytoplasmic sperm injection (ICSI); or ovum microsurgery.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Advanced Reproductive Technology (ART) Expenses (continued) Benefits are limited to 3 cycles of any combination of the following ART services which only include: • IVF; GIFT; ZIFT; or cryopreserved embryo transfers; • IVF; GIFT; ZIFT; or cryopreserved embryo transfers subject to the maximum benefit, if any shown on the Schedule of Benefits while covered under an Aetna plan; • ICSI or ovum microsurgery; • Payment for charges associated with the care of the an eligible covered person under this Plan who is participating in a donor IVF program, including fertilization and culture; and • Charges associated with obtaining the spouse's sperm for ART, when the spouse is also covered under the Policy. **Limitations:** Unless otherwise specified above, the following charges will not be payable as covered medical expenses under the Policy: • ART services for a female attempting to become pregnant who has not had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the infertility program; • ART services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal; • Reversal of sterilization surgery; • Infertility Services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle; • The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier; • Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); • Home ovulation prediction kits; • Drugs related to the treatment of non-covered medical expenses or related to the treatment of infertility that are not medically necessary; • Injectable infertility medications, including but not limited to, menotropins, and hCG, GnRH agonists; • Any service or supply provided without precertification from Aetna's infertility case management unit; • Infertility Services that are not reasonably likely to result in success;	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Advanced Reproductive Technology (ART) Expenses (continued) • 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.	
Clinical Trials Expense (Experimental or Investigational Treatment) Includes charges made by a provider for experimental or investigational drugs, devices, treatments or procedures "under an approved clinical trial" only when a covered person has cancer or a terminal illness.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Clinical Trials Expense Routine Patient Costs Covered Percentage Includes charges made by a provider for "routine patient costs" furnished in connection with a covered person's participation in an "approved clinical trial" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Gender Reassignment (Sex Change) Surgery Expense 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. Covered medical expenses include: • Charges made by a physician for: o Performing the surgical procedure; and o Pre-operative and post-operative hospital and office visits. • Charges made by a hospital for inpatient and outpatient services (including outpatient surgery). • Charges made by a Skilled Nursing Facility for inpatient services and supplies. • Charges made for the administration of anesthetics. • Charges for outpatient diagnostic laboratory and x-rays. • Charges for blood transfusion and the cost of unreplaced blood and blood products. • Charges made by a behavioral health provider for gender reassignment counseling. No benefits will be paid for covered medical expenses under this benefit unless they have been precertified by Aetna. Refer to the Precertification section for more information.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Chiropractic Treatment Expense Includes charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE Inpatient rehabilitation benefits for the services listed will be paid as part of the Hospital Expense and Skilled Nursing Facility Expense benefits. **Cardiac Rehabilitation Benefits** • Cardiac rehabilitation benefits received at a hospital, skilled nursing facility, or physician's office. This Plan will cover charges in accordance with a treatment plan as determined by a covered person's risk level when recommended by a physician. **Pulmonary Rehabilitation Benefits** • Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.		
Cardiac Rehabilitation	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Pulmonary Rehabilitation	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
SHORT-TERM REHABILITATION SERVICES EXPENSE Includes charges for short-term rehabilitation services, as described below, when prescribed by a physician. Short-term rehabilitation services must follow a specific treatment plan that: • Details the treatment, and specifies frequency and duration; • Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and • Allows therapy services, provided in a covered person's home, if the covered person is homebound. Inpatient rehabilitation benefits for the services listed will be paid as part of the inpatient hospital and skilled nursing facility benefits.		
Outpatient Cognitive, Physical, and Occupational Rehabilitation and Habilitation Therapy Services (combined).	After a **$30** per visit Copay, **100%** of the Negotiated Charge	**50%** of the Recognized Charge
Speech Rehabilitation and Habilitation	After a **$40** per visit Copay, **100%** of the Negotiated Charge	**50%** of the Recognized Charge
HEARING AIDS	**Preferred Care**	**Non-Preferred Care**
Hearing Aid Expenses Covered medical expenses for hearing care includes charges for prescribed hearing aids and hearing aid expenses. • 1 Hearing Aid per hearing impaired ear per Policy Year	**100%** of the Negotiated Charge	**100%** of the Recognized Charge
TREATMENT OF MENTAL DISORDER EXPENSE	**Preferred Care**	**Non-Preferred Care**
Inpatient Mental Health Expense & Residential Mental Health Treatment Facility Expense Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Inpatient Mental Health Physician Services per Admission Expense &Residential Mental Health Treatment Physician Services Expense	**80%** of the Negotiated Charge	**50%** of the Recognized Charge

TREATMENT OF MENTAL DISORDER EXPENSE (continued)	Preferred Care	Non-Preferred Care
Outpatient Mental Health Expense	After a **$40** per visit Copay, **100%** of the Negotiated Charge	**50%** of the Recognized Charge
Outpatient Mental Health Partial Hospitalization Expense	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
ALCOHOLISM AND DRUG ADDICTION TREATMENT	**Preferred Care**	**Non-Preferred Care**
Inpatient Substance Abuse Treatment Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Inpatient Substance Abuse Physician Services per Admission Expense	**80%** of the Negotiated Charge	**50%** of the Recognized Charge
Outpatient Substance Abuse Treatment	After a **$40** per visit Copay, **100%** of the Negotiated Charge	**50%** of the Recognized Charge
TRANSPLANT SERVICE EXPENSE	**Preferred Care**	**Non-Preferred Care**
Transplant Services Expense Benefits may vary if an Institute of Excellence™ (IOE) facility or non-IOE or non-preferred care provider is used. Through the IOE network, the covered person will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure the covered person requires. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Transplant Travel and Lodging Expense The plan will reimburse a covered person for some of the cost of their travel and lodging expenses.	$50 per night Maximum Benefit for Lodging Expenses per IOE patient & $50 per night Maximum Benefit for Lodging Expenses per companion up to 10,000 per transplant.	
PEDIATRIC DENTAL SERVICES EXPENSE **(Coverage is limited to covered persons until the end of the month in which the covered person turns 19)**	**Preferred Care**	**Non-Preferred Care**
Type A Expense (Pediatric Routine Dental Exam Expense) Benefit maximum of 1 visit every 6 months	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Type B Expense (Pediatric Basic Dental Care Expense)	**70%** of the Negotiated Charge*	**50%** of the Recognized Charge
Type C Expense (Pediatric Major Dental Care Expense)	**50%** of the Negotiated Charge*	**50%** of the Recognized Charge
Pediatric Orthodontia Expense Orthodontics Medically necessary comprehensive treatment • Replacement of retainer (limit one per lifetime).	**50%** of the Negotiated Charge*	**50%** of the Recognized Charge

PEDIATRIC ROUTINE VISION (Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	Preferred Care	Non-Preferred Care
Pediatric Routine Vision Exams (including refractions) Includes charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction & glaucoma testing. Limited to 1 exam per Policy Year.	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge*
Comprehensive Low Vision Evaluations	Payable in accordance with the type of expense incurred and the place where service is provided.	
Preferred Optical Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	
Non-Preferred Optical Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	
Pediatric Visit for the fitting of prescription contact lenses, Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses Includes charges for the following vision care services and supplies: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a preferred care provider. Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a non-preferred care provider. Coverage includes charges incurred for: • Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses. Aphakic prescription lenses prescribed after cataract surgery has been performed. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.	**100%** of the Negotiated Charge*	**50%** of the Recognized Charge*

PRESCRIBED MEDICINES EXPENSE

COVERED PERCENTAGE*	Preferred Care	Non-Preferred Care
Preventive Care Drugs and Supplements **Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.**		
Risk Reducing Breast Cancer Prescription Drugs For each 30 day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	60% of the Recognized Charge
Other preventive care drugs and supplements For each 30 day supply filled at a retail pharmacy.	100% per supply	60% of the Recognized Charge
Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs (for two 90-day treatment regimens only)	100% per supply	60% of the Recognized Charge
CONTRACEPTIVES	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	60% of the Recognized Charge
All OTHER PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	100% of the Negotiated Charge	60% of the Recognized Charge

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

PER PRESCRIPTION COPAY/DEDUCTIBLE	Preferred Care	Non-Preferred Care
Generic Prescription Drugs For each 30 day supply filled at a retail pharmacy.	$5 Copay per supply	Deductible per supply of 40% of the Recognized Charge
For all fills of at least a 31-101 day supply and up to a 31–101 day supply filled at a mail order pharmacy	Copay per supply of 2.5 times the initial 30 day copay per supply	Copay per supply of 2.5 times the initial 30 day copay per supply
PREFERRED BRAND-NAME PRESCRIPTION DRUG	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	$40 Copay per supply	Deductible per supply of 40% of the Recognized Charge
Preferred Brand-Name Prescription Drugs For all fills of at least a 31-101 day supply and up to a 31–101 day supply filled at a mail order pharmacy	Copay per supply of 2.5 times the initial 30 day copay per supply	Copay per supply of 2.5 times the initial 30 day copay per supply

NON-PREFERRED BRAND-NAME PRESCRIPTION DRUGS	Preferred Care	Non-Preferred Care
For each 30 day supply filled at a retail pharmacy.	$40 Copay per supply	Deductible per supply of 40% of the Recognized Charge
Non-Preferred Brand-Name Prescription Drugs For all fills of at least a 31-101 day supply and up to a 31–101 day supply filled at a mail order pharmacy	Copay per supply of 2.5 times the initial 30 day copay per supply	Copay per supply of 2.5 times the initial 30 day copay per supply
Orally Administered Anti-Cancer Prescription Drugs (including Chemotherapy Drugs)	Payable on the same basis as covered cancer chemotherapy medications that are administered intravenously or by injection.	

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug.

The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916** or submitting the request in writing to:

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

Aetna will make a coverage determination within 24 hours after receipt of the request and will notify the covered person, the covered person's designee or the covered person's prescriber of Aetna's decision.

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

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

Waiver for Prescription Drug Contraceptives

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

- Female contraceptives that are:
  - Oral prescription drugs that are generic prescription drugs.
  - Injectable prescription drugs that are generic prescription drugs.
  - Vaginal ring prescription drugs that are generic prescription drugs, brand-name prescription drugs and biosimilar prescription drugs.
  - Transdermal contraceptive patch prescription drugs that are generic prescription drugs, brand-name prescription drugs, and biosimilar prescription drugs.

- Female contraceptive devices.
- FDA-approved female:
  - generic emergency contraceptives; and
  - generic over-the-counter (OTC) emergency contraceptives.

when obtained at a preferred care pharmacy. This means that such contraceptive methods will be paid at 100%. The per prescription copay/deductible and policy year deductible continue to apply:

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

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

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

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

Exclusions

This Plan does not cover nor provide benefits for:

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

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

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

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

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

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

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

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

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

10. Expense 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

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

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

14. 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), to the extent allowed by law.

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

16. Expense incurred for custodial care.

17. 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.

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

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

20. Expense for care or services covered under Medicare Part A or Part B and the covered person is enrolled in Medicare Part A or B.

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

22. 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.

23. 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.

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

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

26. 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.

27. Expenses incurred for massage therapy.

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

29. 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.

30. 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.

31. 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.

32. 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).

33. 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.

34. 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.

35. Expenses incurred for orthodontic treatment except as specifically covered in the Orthodontic Treatment Rule section of the Policy.

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

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

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

IMPORTANT NOTICES:

Notice of Non-Discrimination:

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

Sanctioned Countries:

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

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

Additional Information

This plan is underwritten by Aetna Life Insurance Company, which was incorporated in Connecticut on June 14, 1853. Aetna Life Insurance Company is wholly owned by Aetna Inc.

Utilization Review Data

The following utilization review data includes utilization review performed by all companies which may be sub-contracted, including carve-out services under contract with the Managed Care Organization care enrollees:

A. Total number of utilization review requests: 190

B. Total number of adverse determinations (denials)* based on A: 18

C. The total number of adverse determinations in B above regarding an admission, service, procedure, or an extension of stay that were appealed. (if multiple levels of appeals, count only once) 4

D. Total number of adverse decisions in B above regarding an admission, service, procedure, or extension of stay that were reversed on appeal: 1

*****Negotiated or partial certifications are included in this figure.

Health Care Providers

Total number of participating primary care physicians located in :

Fairfield County	1058
Hartford County	1062
Litchfield County	149
Middlesex County	186
New Haven County	1192
New London County	238
Tolland County	151
Windham County	135

Total number of participating specialists located in:

Fairfield County	2221
Hartford County	2334
Litchfield County	534
Middlesex County	464

New Haven County	2822
New London County	610
Tolland County	292
Windham County	230
Total number of participating acute care hospitals located in:	
Fairfield County	7
Hartford County	14
Litchfield County	4
Middlesex County	2
New Haven County	10
New London County	3
Tolland County	2
Windham County	3
No. of Pharmacies-Locations	710

Medical Loss Ratio: 97.7%

The medical loss ratio if defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss, reinsurance, enrollee educational programs, or other cost containment programs or features.