Aetna Student Health
Plan Design and Benefits Summary
Preferred Provider Organization (PPO)

Kenyon College

Policy Year: 2025–2026
Policy Number: 246792
https://www.aetnastudenthealth.com
(877) 480-4161

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

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

Kenyon Health Services

Kenyon's Health Services provides primary care services for enrolled students. The medical professionals on the staff have extensive training and experience in addressing the unique health issues of college students and provide a full range of student-centered health care services in a compassionate, equitable and unbiased manner. Fees may be incurred if medication or testing is deemed necessary and will be determined at each visit.

Located on the first floor of the Cox Health and Counseling Center, Health Services is open Monday through Friday from 8:30 a.m.- noon. and 1 - 4:30 p.m. while classes are in session.

For more information, call the Health Services at **(740) 427-5525**. After hours or on weekends, **(740) 427-5555** (Campus Safety). In the event of an emergency, call **911**.

Who is eligible?

All registered full-time undergraduate students are eligible and required to have health insurance coverage, either through the Kenyon College Student Health Insurance Plan or through another individual or family plan. You will be automatically covered under the student health insurance plan, and the premiums will be charged to your account, unless you waive coverage and show proof of comparable coverage with another plan.

Special Note for International Students:
Kenyon College requires all registered international students to enroll in the school-sponsored insurance plan each academic year. All eligible international students will be automatically enrolled in the Student Health Insurance Plan.

Coverage Dates and Rates

Coverage for all insured students 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.

	Annual 08/15/25 - 08/14/26	Fall 08/15/25 – 12/31/25	Spring 01/01/26 - 08/14/26
Student	$1,846	$703	$1,143

Enrollment waivers for fall/annual Coverage must be submitted by: 08/15/2025
Enrollment waivers for spring coverage must be submitted by: 01/12/2026

Enrollment and Waivers

To enroll or waive online, log on to **https://www.aetnastudenthealth.com/kenyon** and then click on Enroll/Waive to access the online forms.

Medicare Eligibility Notice

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

Termination and Refunds

Withdrawal from Classes – leave of absence:

If you withdraw from classes under a school-approved leave of absence, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded.

Withdrawal from classes – other than leave of absence

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

In-network Provider Network

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

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

Precertification

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

Precertification Call

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

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

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

We will provide a notification to you and your physician of the precertification decision in accordance with state law timeframes, within 48 hours for urgent care, urgent medical services or urgent admissions and 10 days for non-urgent care, non-urgent medical services or non-emergency admissions and medical services requiring precertification. In the case of an urgent care, urgent medical services, or urgent admission precertification decision, and we need additional information to make a determination to approve, you and your physician will be notified within 24 hours of the specific information that is required and be allowed 48 hours to respond. If precertification was submitted through a secure electronic transmission, we will provide notification through the secure electronic transmission in which the request was received. If your precertified services are approved, the approval is valid for 30 days as long as you remain enrolled in the plan.

Coordination of Benefits (COB)

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

Description of Benefits

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

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

Policy year deductible	**In-network coverage**	**Out-of-network coverage**
Student	$250 per policy year	
This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.		
Eligible health services applied to the out-of-network policy year deductible will be applied to satisfy the in-network policy year deductible. Eligible health services applied to the in-network policy year deductible will be applied to satisfy the out-of-network policy year deductible.		
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network care for *Preventive care and wellness* • In-network care for *Pediatric dental care Type A services* • In-network care for *Pediatric vision care* • In-network care and out-of-network care for *Well newborn nursery care in a hospital or birthing center* • In-network care and out-of-network care for *Outpatient prescription drugs* • In-network care for *Hearing aids*		
Maximum out-of-pocket limit per policy year		
Student	$6,825 per policy year	
Eligible health services applied to the out-of-network maximum out-of-pocket limit will be applied to satisfy the in-network maximum out-of-pocket limit and eligible health services applied to the in-network maximum out-of-pocket limit will be applied to satisfy the out-of-network maximum out-of-pocket limit.		

Eligible health services	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Routine physical exam limits for covered persons through age 21: maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Routine physical exam limits for covered persons age 22 and over: maximum visits per policy year	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel		
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Well woman routine gynecological exam maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Maximum Visits:	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling	
Misuse of Alcohol maximum per policy year	5 visits	
Tobacco Products Counseling maximum per policy year	8 visits	
Sexually transmitted infection counseling maximum per policy year	2 visits	
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Maximums	Subject to any age, family history and frequency guidelines as set forth in the most current: • Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF • Comprehensive guidelines supported by the Health Resources and Services Administration For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Lung cancer screening maximum	1 screening every 12 months	
Mammograms received out-of-network important note: The total amount payable by Aetna and you may not exceed 130% of the Medicare reimbursement amount. We will make the payment to your provider or facility in accordance to the plan. No provider shall seek or receive payment in excess of 130% of the Medicare reimbursement amount. Members can only be billed for deductibles, copayments and coinsurances.		
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services (continued)		
Lactation counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	70% (of the recognized charge) per item
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Contraceptive counseling services maximum per policy year	2 visits	
Female contraceptive prescription drugs and devices	100% (of the negotiated charge) per item No copayment or policy year deductible applies	70% (of the recognized charge) per item
Female voluntary sterilization - Inpatient & Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	70% (of the recognized charge)
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a provider		
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist, includes telemedicine consultations)	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Allergy injections treatment performed at a physician or specialist office	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Allergy sera and extracts administered via injection at a physician's or specialist's office	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Physician and specialist - surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge)	70% (of the recognized charge)
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Hospital care (facility charges including rehabilitation facility charges)		
Inpatient hospital (room and board and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
The following are not eligible health services: • All services and supplies provided in: - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps		
Preadmission testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage	Out-of-network coverage
Hospital care (facility charges including rehabilitation facility charges) (continued)		
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
The following are not covered under this benefit: • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Home health care	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Home health care maximum visits per policy year	100 visits	
The following are not covered under this benefit: • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities) • Transportation • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy • Materials such as handrails, ramps, telephones, air conditioners, and similar services, appliances, and devices • Physician charges		
Hospice - Inpatient	80% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
Hospice - Outpatient	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
The following are not covered under this benefit: • Funeral arrangements • Pastoral counseling • Respite care • Bereavement counseling • Financial or legal counseling which includes estate planning and the drafting of a will • Homemaker or caretaker services that are services which are not solely related to your care and may include: - Sitter or companion services for either you or other family members - Transportation - Maintenance of the house		
Outpatient private duty nursing	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Skilled nursing facility - Inpatient	80% (of the negotiated charge) per admission	70% (of the recognized charge) per admission

Eligible health services	In-network coverage	Out-of-network coverage
Emergency services and urgent care		
Emergency services within the capability of the emergency department of a hospital needed to treat the emergency medical condition	80% (of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered
The following are not covered under this benefit: • Non-emergency services in a hospital emergency room or an independent freestanding emergency department		
Important note: • As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/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. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply. • Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance. • Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you. • Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.		
Urgent Care	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
The following is not covered under this benefit: • Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)		
Pediatric dental care Limited to covered persons through the end of the month in which the person turns age 19 Dental benefits are subject to the medical plan's policy year deductibles and maximum out-of-pocket limits as explained on the schedule of benefits.		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	70% (of the recognized charge) per visit
Type B services	70% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric dental care (continued) Limited to covered persons through the end of the month in which the person turns age 19 Dental benefits are subject to the medical plan's policy year deductibles and maximum out-of-pocket limits as explained on the schedule of benefits.		
Orthodontic services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency services	Covered according to the type of benefit and the place where the service is received	Paid the same as in-network coverage according to the type of benefit and the place where the service is received

Pediatric dental care exclusions

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- Cosmetic services and supplies including:
  - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter, or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Eligible health services and exclusions* section
  - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary), mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication, or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing, or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse, or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits

(continued on next page)

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric dental care exclusions (continued) The following are not covered under this benefit: • Services and supplies: - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services - Provided for your personal comfort or convenience or the convenience of another person, including a provider - Provided in connection with treatment or care that is not covered under your policy • Surgical removal of impacted wisdom teeth only for orthodontic reasons • Treatment by other than a dental provider		
Specific conditions		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Cosmetic treatment and procedures		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Temporomandibular joint dysfunction treatment (TMJ) and craniomandibular joint dysfunction treatment (CMJ)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not eligible health services under this section: • Dental implants		
Wisdom teeth	80% (of the negotiated charge)	70% (of the recognized charge)
Accidental Dental Injury	80% (of the negotiated charge)	70% (of the recognized charge)
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants		
Maternity care and related well newborn nursery care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		

Eligible health services	In-network coverage	Out-of-network coverage
Maternity care and related well newborn nursery care (continued)		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	70% (of the recognized charge) No policy year deductible applies
Voluntary sterilization for males - inpatient surgical services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Voluntary sterilization for males - outpatient surgical services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not eligible health services under this benefit: • Any treatment, surgery, service, or supply that is not in the list above of eligible health services		
Autism spectrum disorder		
Autism spectrum disorder diagnosis and testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Autism spectrum disorder treatment (includes physician and specialist office visits)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Mental/behavioral health outpatient services (consultation, assessment, development, oversight of treatment plans)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Mental Health & Substance related disorders treatment		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
Outpatient office visits (includes telemedicine consultations)	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit

Eligible health services	In-network coverage (IOE facility)	Out-of-network coverage Network Non-IOE facility and out-of-network facility (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Transplant services		
Transplant services Inpatient and outpatient facility services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Transplant services Inpatient and outpatient physician and specialist services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Live donor health services - Inpatient (room and board and other miscellaneous services and supplies) and outpatient	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Live donor health services -physician and specialist services (including office visits)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Transplant services-travel and lodging	Covered	
Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	$10,000	
Maximum payable for Lodging Expenses per IOE patient	$50 per night	
Maximum Lodging Expenses per companion	$50 per night	
Maximum Benefit for unrelated donor search services	$30,000 per transplant	
The following are not covered under this benefit: • Services and supplies furnished to a donor when the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness		

Eligible health services	In-network coverage	Out-of-network coverage
Infertility services		
Treatment of basic infertility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Infertility services exclusions The following are not covered under the infertility services benefit: • All infertility services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services. • Infertility medication, including but not limited to menotropins, hCG, and GnRH agonists. • Intrauterine (IUI)/intracervical insemination (ICI) services. • Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue. • Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue. • All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father. • Home ovulation prediction kits or home pregnancy tests. • The purchase of donor embryos, donor eggs or donor sperm. • Obtaining sperm from a person not covered under this plan. • Infertility treatment when a successful pregnancy could have been obtained through less costly treatment. • Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy, and vasectomy only if obtained as a form of voluntary sterilization. • Infertility treatment when infertility is due to a natural physiologic process such as age-related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's infertility clinical policy.		
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Outpatient infusion therapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan • Blood transfusions and blood products • Dialysis		

Eligible health services	In-network coverage	Out-of-network coverage
Specific therapies and tests (continued)		
Cardiac and Pulmonary Rehabilitation	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
The following is not a covered service: • Pulmonary rehabilitation in an acute inpatient rehabilitation setting		
Outpatient physical, occupational, speech, cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Maximum visits per policy year	Unlimited	
Day rehabilitation services (physical medicine and rehabilitation)	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Outpatient inhalation therapy	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Acupuncture	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Maximum visits per policy year	30 visits	
Note: A visit is equal to no more than 1 hour of therapy.		
The following is not covered under this benefit: • Acupressure		
Chiropractic services Cost share will not be greater than the cost share for a Physician's office visit		
Chiropractic services	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Maximum visits per policy year	30 visits	
Other services and supplies		
Emergency ground, air, and water ambulance	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient care		
Clinical trial therapies (experimental or investigational)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not eligible health services: • Services and supplies related to data collection and record-keeping needed only for the clinical trial • Services and supplies provided by the trial sponsor for free • The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)		

Eligible health services	In-network coverage	Out-of-network coverage
Other services and supplies (continued)		
Durable medical and surgical equipment	80% (of the negotiated charge) per item	70% (of the recognized charge) per item
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician • Items used in the home for general use such as Band-Aids, thermometers, and petroleum jelly • Ice bags/cold pack pump • Raised toilet seats • Rental of equipment if you're in a facility that is expected to provide such equipment		
Nutritional support	80% (of the negotiated charge) per item	70% (of the recognized charge) per item
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods, and other nutritional items, even if it is the sole source of nutrition, except as described above		
Orthotic devices	80% (of the negotiated charge) per item	70% (of the recognized charge) per item
Prosthetic Devices, Cranial prosthetics *(Medical wigs)* & Surgical bras following mastectomy	80% (of the negotiated charge) per item	70% (of the recognized charge) per item
Maximum cranial prosthetics per policy year Surgical bras following mastectomy maximum per policy year	1 item 4 items	
Cochlear implants	80% (of the negotiated charge) per item	70% (of the recognized charge) per item
The following are not covered under this benefit: • Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse, or theft • Communication aids other than listed above • Dentures, dental appliances, or replacing teeth or structures directly supporting teeth • Artificial heart implants • Wigs except as specifically provided in the *Coverage and exclusions* section • Penile prosthesis		

Eligible health services	In-network coverage	Out-of-network coverage
Other services and supplies (continued)		
Hearing aids	100% (of the negotiated charge) per item No copayment or policy year deductible applies	70% (of the recognized charge) per item
Hearing aids maximum	1 hearing aid per hearing-impaired ear up to $2,500 every 48 months for a covered person 21 years of age or younger	
The following are not eligible health services under this section: • A replacement of: - A hearing aid that is lost, stolen, or broken - A hearing aid installed within the prior 36-month period • Replacement parts or repairs for a hearing aid • Batteries or cords • A hearing aid that does not meet the specifications prescribed for correction of hearing loss • Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist		
Podiatric (foot care) treatment - Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Services and supplies for: - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working, or wearing shoes - Supplies (including orthopedic shoes, except for diabetics), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices, and supplies - Routine pedicure services, such as cutting of nails, corns, and calluses when there is no illness or injury of the feet		
Pediatric vision care Limited to covered persons through the end of the month in which the person turns age 19		
Pediatric routine vision exams (including refraction) performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations)	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit	
Pediatric vision care services & supplies - Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	70% (of the recognized charge) per item
Maximum number Per year: Eyeglass frames Prescription lenses	One set of eyeglass frames One pair of prescription lenses	

Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3-month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maximum number of optical devices per policy year	One optical device	
The following are not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		
Pediatric vision care important note: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both. All prescription lenses include scratch resistant coating with no additional copayment.		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Adult vision care Limited to covered persons age 19 and over		
Adult routine vision exams (including refraction) performed by a legally qualified ophthalmologist or optometrist Includes fitting of prescription contact lenses	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Adult routine vision exam per policy year	1 visit	
Fitting of Contact maximum per policy year	1 visit	
Eyeglass frames, prescription lenses or prescription contact lenses	80% (of the negotiated charge) per trip	70% (of the recognized charge) per trip
Maximum per policy year - eyeglass frames, prescription lenses or prescription contact lenses	$150 per policy year for eyeglass frames and prescription lenses $75 per policy year for contact lenses	
Adult vision care services and supplies exclusions • Special supplies such as non-prescription sunglasses • Special vision procedures, such as orthoptics or vision therapy • Eye exams during your stay in a hospital or other facility for health care • Eyeglasses or duplicate or spare eyeglasses or lenses or frames • Replacement of lenses or frames that are lost or stolen or broken • Acuity tests • Eye surgery for the correction of vision, including radial keratotomy, LASIK, and similar procedures • Services to treat errors of refraction		

Outpatient prescription drugs		
Copayment/coinsurance waiver for risk reducing breast cancer drugs		
The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
Copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs		
The outpatient prescription drug copayment/coinsurance will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your outpatient prescription drug copayment/coinsurance will apply after those two regimens per policy year have been exhausted.		
Copayment/coinsurance waiver for contraceptives		
The outpatient prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy. This means that such contraceptive methods are paid at 100% for: • Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. • If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%. Also, you may qualify for a medical exception. If your provider documents a medical exception and submits the exception to us, certain FDA-approved brand-name or non-formulary contraceptives may also be covered as preventive care. We will defer to the provider's determination. The outpatient prescription drug copayment/coinsurance will continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Preferred generic prescription drugs		
For each fill up to a 30-day supply filled at a retail pharmacy	$10 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$10 copayment per supply then the plan pays 70% (of the balance of the recognized charge) No policy year deductible applies
Preferred brand-name prescription drugs		
For each fill up to a 30-day supply filled at a retail pharmacy	$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$30 copayment per supply then the plan pays 70% (of the balance of the recognized charge) No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Non-preferred generic prescription drugs		
For each fill up to a 30-day supply filled at a retail pharmacy	$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 70% (of the balance of the recognized charge) No policy year deductible applies
Non-preferred brand-name prescription drugs		
For each fill up to a 30-day supply filled at a retail pharmacy	$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 70% (of the balance of the recognized charge) No policy year deductible applies
Diabetic insulin important note: Your cost share will not exceed $25 per 30-day supply of a covered preferred prescription insulin drug filled at an in-network pharmacy. No policy year deductible applies for preferred insulin.		
Specialty drugs		
For each fill up to a 30-day supply filled at a retail pharmacy	$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$100 copayment per supply then the plan pays 70% (of the balance of the recognized charge) No policy year deductible applies
Anti-cancer drugs taken by mouth For each fill up to a 30-day supply	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Preventive care drugs and supplements filled at a retail pharmacy For each 30–day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30–day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30-day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage is permitted for two 90-day treatment regimens only.	

	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Contraceptives (birth control)		
For each fill up to a 30-day supply of generic and OTC drugs and devices filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
For each fill up to a 30-day supply of brand-name prescription drugs and devices filled at a retail pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above

Outpatient prescription drug exclusions

The following are not eligible health services:

- Abortion drugs used for elective termination of pregnancy except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products, and appliances unless listed as an eligible health service
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance, or increase sexual desire, including drugs, implants, devices, or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ unless listed as an eligible health service
  - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications except as described in the certificate
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service, or supply to alter the body’s genes, genetic makeup or the expression of the body’s genes unless listed as an eligible health service

- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate

Outpatient prescription drug exclusions (continued)

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

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug. The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:
CVS Health
ATTN: Aetna PA
1300 E Campbell Road
Richardson, TX 75081

General Exclusions

Abortion

- Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

Abortion drugs

- Drugs used for elective termination of pregnancy except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

Behavioral health treatment

- Services for the following based on categories, conditions, diagnoses, or equivalent terms as listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association:
  - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work, or recreational activities
  - Transportation

Blood and blood products

- Blood, blood products, and related services that are supplied to your provider free of charge

Cosmetic services and plastic surgery

- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, except where described in the *Eligible health services and exclusions* section

Court-ordered testing

- Court-ordered testing or care unless medically necessary

Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs.
Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- Respite care, adult or child day care, or convalescent care
- Institutional care, including room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and substance related disorder treatment):

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

Dental care for adults

- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolectomy
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth
  - Prosthetic restoration of dental implants
  - Dental implants except when part of an approved treatment plan for an eligible health service described in the *Eligible health services and exclusions – Reconstructive surgery and supplies* section.

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

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations

Any health or dental examinations needed:

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

Experimental, investigational, or unproven

- Experimental, investigational, or unproven drugs, devices, treatments, or procedures unless otherwise covered under clinical trials

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

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

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

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

This exclusion does not apply to covered benefits for treatment of TMJ and CMJ as described in the *Eligible health services and exclusions – Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment* section.

Maintenance care
- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services.

Medical supplies – outpatient disposable
- Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

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

Obesity surgery and services
- Weight management treatment or drugs intended to decrease or increase body weight, control weight, or treat obesity, including morbid obesity except as described in the Eligible health services and exclusions section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass, and other forms of bariatric surgery
  - Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

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

Outpatient prescription or non-prescription drugs and medicines
- Specialty prescription drugs except as stated in the *Eligible health services and exclusions* section

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

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

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

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

Sexual dysfunction and enhancement
- Any treatment, prescription drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices, or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance
- Services, devices, and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance, or physical performance

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

Therapies and tests
- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Treatment in a federal, state, or governmental entity

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

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

Wilderness treatment programs
See Educational services in this section

Work related illness or injuries
- Coverage available to you under workers' compensation or a similar program under local, state, or federal law for any illness or injury related to employment or self-employment

Important note:
A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

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

Sanctioned Countries

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

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

Assistive Technology

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

Smartphone or Tablet

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

Discrimination is Against the Law

Aetna Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). Aetna Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.
Aetna Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call **1-877-480-4161** (TTY: **711**) or the number on the back of your ID card.

If you believe that Aetna Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332,
Woonsocket, RI 02895
Phone: **1-800-648-7817**, TTY: **711**
Email: **CRCoordinator@aetna.com**

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, **1-800-537-7697** (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

This notice is available at Aetna Inc.'s website: **https://www.aetnastudenthealth.com**.

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

Language accessibility statement
Interpreter services are available for free.

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

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

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

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

Bàsɔ̀ɔ̀ Wùɖù/Bassa
Dè dɛ nìà kɛ dyeɖeˈ gbo: ɔ juˇ keˈ m̀ dyi Bàsɔ́ɔ̀-wùɖù-po-nyɔ̀ juˇ niˇ, nìiˈ à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpaˈa.
Ɗaˈ **1-877-480-4161** (TTY: **711**).

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

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

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

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

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

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

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

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

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

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

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

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

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

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