



**Aetna Student Health  
Plan Design and Benefits Summary  
Aetna Whole Health<sup>SM</sup> Duke Health, WakeMed & THN-  
Cone Health/OAMC**

**Duke University**

Policy Year: 2026 - 2027  
Policy Number: 278765  
[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)  
(877) 626-2308



This is a brief description of the Student Health Plan. The plan is available for Duke University students and their eligible dependents. 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 [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com). If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

### Duke Student Health

Duke Student Health offers a wide range of healthcare services for all Duke students, many of which are covered by the student health fee. Every time you need services, you'll discover professional and compassionate care that directly contributes to your well-being and overall success.

If you would like to make an appointment, call **(919) 681-9355**. Choose option 1 for non-urgent appointments. Choose option 2 for same-day appointments.

Online scheduling is available for non-same day medical provider appointments via the Duke My Health portal. Appointments for same-day sick visits, travel medicine, and immunizations need to be scheduled by phone. A My Duke Health account can be created when scheduling a first appointment by phone or during a first visit to Duke Student Health.

Students are seen by appointment only. Same-day appointments are available depending on the demand and time of day. If no appointments are available, students will be assessed by a triage nurse and provided with an appropriate plan of care. This may consist of guidance on how to manage symptoms at home and/or being scheduled for the next available appointment, emergency expedited care, or referred to an off-campus treatment center.

Duke Student Health is located on the 2nd floor of the Student Wellness Center on West Campus (305 Towerview Road) next to Penn Pavilion.

Hours: Monday - Wednesday: 8:00 am - 4:30 pm (closed daily 12:00 pm – 12:30 pm for lunch)  
Thursday: 9:00 am - 4:30 pm  
Friday: 8:00 am - 4:30 pm  
Saturday & Sunday: Closed

The Campus Center Pharmacy, located on the 1<sup>st</sup> floor of the Student Wellness Center on West Campus (305 Towerview Road) next to Penn Pavilion, provides prescriptions, over-the-counter medication, and more. The pharmacy is open to all students, faculty, and staff. New prescriptions may be sent to the Duke Campus Center Pharmacy. We offer prescription medication transfer services for those needing to refill their medications.

Hours: Monday - Friday: 9:00 am - 5:30 pm (closed daily 12:30 pm – 1:00 pm for lunch)  
Saturday & Sunday: Closed

For more information on services offered, visit <https://students.duke.edu/wellness/studenthealth/>.

## Coverage Periods

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

**Eligible Dependents:** Coverage for dependents of students eligible under the Plan will be for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage. NOTE: Dependent coverage does not automatically roll over from one plan year to the next. Students enrolled in the Plan may enroll their eligible dependents in the Plan during open enrollment by completing the online dependent enrollment application at [www.gallagherstudent.com/Duke](http://www.gallagherstudent.com/Duke).

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/01/2026	07/31/2027	09/15/2026
Spring/Summer	01/01/2027	07/31/2027	01/31/2027
Summer 1	05/13/2027	07/31/2027	06/25/2027
Summer 2	06/29/2027	07/31/2027	08/10/2027

## Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as Duke University administrative fee.

	Annual	Spring/Summer	Summer 1	Summer 2
Student	\$4,290.00	\$2,506.00	\$933.00	\$385.00
Add Spouse/ Domestic Partner*	\$4,257.00	\$2,473.00	\$933.00	\$385.00
Add Child(ren)*	\$4,257.00	\$2,473.00	\$933.00	\$385.00
Add Family*	\$8,514.00	\$4,946.00	\$1,866.00	\$770.00

\*Dependent Rates are in addition to the student/subscriber's own premium. Dependent coverage does not automatically roll over from one plan year to the next.

## Student Coverage

### Eligibility

Eligible Duke University students will be automatically enrolled in the SHIP each year they are enrolled at Duke. Non-international students who have current coverage with another insurance plan that meets specific criteria may waive or opt out of the Duke SHIP. International students holding an F1 or J1 visa are required to participate in the Duke SHIP and are not able to opt out of the medical plan.

Once you are enrolled in SHIP, you will remain enrolled in the plan for the full coverage period. You have no option to terminate coverage unless you enter the armed forces. In that case we will refund — or your student account will be credited — a pro-rated share of your premium.

### Enrollment

#### **International and PHD Students:**

No action is needed as you are automatically enrolled in the student health insurance plan (SHIP). To view your coverage details:

1. Go to <https://www.gallagherstudent.com/duke>.
2. Follow the login Instructions.
3. View "Account Details," found on the lower left side of landing page.

***Please note: If you are an international student holding an F1 or J1 visa, enrollment in the SHIP is mandatory.***

#### **Domestic Students:**

1. Go to <https://www.gallagherstudent.com/duke>.
2. Follow the login instructions.
3. Click on the "Enroll" button under "Plan Summary."
4. Follow the instructions to complete the form.
5. Enrollment confirmation email will be sent.

***Please note that students who do not submit a waiver by the September 15, 2026 deadline will be automatically enrolled.***

## Dependent Coverage

### Eligibility

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

Note: An eligible dependent will not be considered a late enrollee if a court order requires the covered student to provide coverage for his or her eligible dependent. Such coverage will become effective on the date of the court order.

You may only enroll your dependents if you are enrolled in the student plan. Please be aware that you must purchase dependent insurance for the same coverage period as your own coverage; it can't be for a longer or shorter period than your own.

## Enrollment

To enroll the dependent(s) of a covered student:

1. Go to <https://www.gallagherstudent.com/duke>.
2. Follow the login instructions.
3. Click on the "Enroll" button under "Plan Summary."
4. Follow the instructions to complete the form to enter and enroll your "dependent spouse/partner" and/or "dependent children."
5. The first time you enroll your dependents, you will also need to provide documentation of your relationship. You will not need to provide this in subsequent years.

The required premium for a newborn or newly adopted child will be calculated beginning from the date of birth /date of adoption.

### Newborn child

- Your newborn child is covered on your health plan for the first 31 days from the moment of birth.
- To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31 day period.
- You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
- If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- If your coverage ends during this 31 day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

### Adopted child or a child legally placed with you for adoption

A child that you, or you and your spouse, civil union partner or domestic partner adopts or is placed with you for adoption, is covered on your plan for the first 31 days after the adoption or the placement is complete.

- To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption or placement for adoption.
- You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
- If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
- If your coverage ends during this 31 day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31 day period has not ended.

## Dependent coverage due to a court order

If you must provide coverage to a dependent because of a court order, your dependent is covered on your health plan for the first 31 days from the court order.

- To keep your dependent covered, we must receive your completed enrollment information within 31 days of the court order.
- You must still enroll the dependent within 31 days of the court order even when coverage does not require payment of an additional premium contribution for the dependent.
- If you miss this deadline, your dependent will not have health benefits after the first 31 days.
- If your coverage ends during this 31 day period, then your dependent's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

If you need information or have general questions about dependent enrollment, call Member Services at **(877) 626-2308**.

## Qualifying Events

If you waive SHIP and then lose coverage, you can enroll in the plan. Losing coverage is categorized as a Qualifying Life Event. Other Qualifying Life Events include:

- Reaching the age limit of another health insurance plan.
- Involuntary loss of coverage from another health insurance plan.

You can only add eligible dependent(s) outside of the enrollment period if one of these qualifying events occurs:

- You get married
- You have a child
- You get divorced
- Your dependent enters the country for the first time
- Your dependent loses coverage under another insurance plan

To initiate the Qualifying Life Event process:

1. Go to <https://www.gallagherstudent.com/duke>.
2. Follow the login instructions.
3. Click on "Enroll-Qualifying Life Event."
4. Complete the online form and upload the required supporting document, such as the loss of coverage letter from your prior health insurance company showing your name and the last day of coverage.

***Please note: Read the form carefully as it contains very specific information on the Qualifying Life Event process.***

## 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 premium payment has been received. No premium will be refunded.

### Withdrawal from Classes – Other than Leave of Absence

- If you withdraw from classes within 31 days after the start date of classes, 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 start date of classes, 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.

## Provider Network

As a member of an Aetna Whole Health – Duke Health, WakeMed & THN-Cone Health plan, it's easy for you to connect with doctors and other health care providers within a network dedicated to you.

Providers within the Aetna Whole Health – Duke Health, WakeMed & THN-Cone Health network collaborate closely with Aetna to improve coordination of member care, with the mutual aim of better care, better health and better cost savings for you.

When you use Aetna Whole Health – Duke Health, WakeMed & THN-Cone Health providers, you'll benefit from seeing doctors and other care providers within a network that's dedicated to:

- A team-based model of care, including treatment from primary care doctors, nurses, care managers, assistants and other providers for a well-rounded care plan
- Keeping you healthy and improving your health, not just treating you when you're sick or injured
- Encouraging you to play an active and informed role in your health and wellness decisions
- Creating programs to measurably improve your care
- Providing you with easier access to doctors and follow-up care

Outside of the Aetna Whole Health – Duke Health, WakeMed & THN-Cone Health network coverage area, you will have access to the Aetna Open Access<sup>®</sup> Managed Choice<sup>®</sup> broad network of In-network Providers.

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 pre-approval for you to receive the care from an Out-of-network Provider. When 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 pre-certification 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 pre-certify when required, there is a \$500 penalty for each type of eligible health service that was not pre-certified. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to <https://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:

Type of care	Timeframe
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 written notification to you and your physician of the precertification decision, where required by state law and within the time frame specified by state law. If your pre-certified services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

## CVS Virtual Care®

From everyday illnesses and chronic conditions to mental health support, we've got your back. Once you tell us what you need, we'll connect you with trusted, in-network providers so you can schedule a virtual visit. Most mental health visits are available within two weeks. You can access 24/7 care through our virtual clinic. General Care: 100% coverage. Behavioral Health: See the schedule of benefits for more information. Go to [www.cvs.com/virtual-care](http://www.cvs.com/virtual-care) to register and schedule an appointment.

## 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 [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

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

	<b>Select Care coverage Duke Health, WakeMed &amp; THN-Cone Health network</b>	<b>In-network coverage Open Access Managed Choice network</b>	<b>Out-of-network coverage</b>
<b>Policy year deductibles</b>			
<b>Student</b>	None	\$250 per policy year	\$400 per policy year
<b>Spouse</b>	None	\$250 per policy year	\$400 per policy year
<b>Each child</b>	None	\$250 per policy year	\$400 per policy year
<b>Family</b>	None	\$500 per policy year	\$800 per policy year
<b>Policy year deductible waiver</b>			
The policy year deductible is waived for all of the following eligible health services:			
<ul style="list-style-type: none"> <li>In-network care for Preventive care and wellness, Pediatric Dental Type A services, Pediatric Vision Care Services, Physician, specialist including Consultants Office visits (including MH/SA), Walk-in clinic visits (no emergency visit) Inpatient hospital, Outpatient surgery (facility charges), Hospice-Inpatient, Skilled nursing facility Xray/Lab</li> <li>In-network care and out-of-network care for Ambulance, Emergency Room, Urgent Care, Well newborn nursery care, and Outpatient prescription drugs</li> </ul>			
<b>Maximum out-of-pocket limits</b>			
	<b>Select Care coverage Duke Health, WakeMed &amp; THN-Cone Health network</b>	<b>In-network coverage Open Access Managed Choice network</b>	<b>Out-of-network coverage</b>
<b>Student</b>	\$2,000 per policy year	\$3,000 per policy year	\$4,000 per policy year
<b>Spouse</b>	\$2,000 per policy year	\$3,000 per policy year	\$4,000 per policy year
<b>Each child</b>	\$2,000 per policy year	\$3,000 per policy year	\$4,000 per policy year
<b>Family</b>	\$4,500 per policy year	\$9,000 per policy year	\$12,000 per policy year
Covered Medical Expenses cross-apply towards the Select Care and In-network out-of-pocket limits.			

	<b>Select Care coverage</b> <i>Duke Health, WakeMed &amp; THN-Cone Health network</i>	<b>In-network coverage</b> <i>Open Access Managed Choice network</i>	<b>Out-of-network coverage</b>
<b>Preventative care and wellness</b>			
<b>Routine physical exams</b>			
Performed at a physician's office			
Routine Physical exam	100% (of the negotiated charge) per visit	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.		
Routine physical exam limits for covered persons age 22 and over: maximum visits per policy year	1 visit		
<b>Preventive care immunizations</b>			
Performed in a facility or at a physician's office			
Preventive care immunizations	100% (of the negotiated charge) per visit	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Preventive care immunizations 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.		
The following is not covered under this benefit:			
<ul style="list-style-type: none"> <li>Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment</li> </ul>			

	<b>Select Care coverage Duke Health, WakeMed &amp; THN-Cone Health network</b>	<b>In-network coverage Open Access Managed Choice network</b>	<b>Out-of-network coverage</b>
<b>Well woman preventive visits</b>			
<b>Routine gynecological exams (including Pap smears)</b>			
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit	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		
<b>Preventive screening and counseling services</b>			
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	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Obesity and/or healthy diet counseling 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 and/or drugs counseling Maximum visits per policy year	5 visits		
Use of tobacco products counseling Maximum visits per policy year	8 visits		

Sexually transmitted infection counseling Maximum visits per policy year	2 visits		
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations		
Routine cancer screenings	100% (of the negotiated charge) per visit	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Routine cancer screening maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>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; and</li> <li>The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul>		
Lung cancer screening maximums	1 screening every 12 months		

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Lactation counseling services	100% (of the negotiated charge) per visit	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	100% (of the negotiated charge) per item  No copayment or policy year deductible applies	70% (of the recognized charge) per item
<b>Family planning services - female contraceptives counseling services</b>			
Female contraceptive counseling services office visit	100% (of the negotiated charge) per 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 visits per policy year either in a group or individual setting	2 visits		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per item	100% (of the negotiated charge) per item  No copayment or policy year deductible applies	70% (of the recognized charge) per item

	Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i>	In-network coverage <i>Open Access Managed Choice network</i>	Out-of-network coverage
<b>Female Voluntary sterilization</b>			
Inpatient provider services	100% (of the negotiated charge)	100% (of the negotiated charge)  No copayment or policy year deductible applies	70% (of the recognized charge)
Outpatient provider services	100% (of the negotiated charge) per visit	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care. These services are covered, just not under this benefit- see <i>Outpatient surgery</i>.</li> <li>• Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA</li> <li>• Male contraceptive methods, or devices, except for male condoms prescribed by a provider</li> </ul>			
<b>Physicians and other health professionals</b>			
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) (includes telemedicine consultations)	\$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	\$35 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit  No policy year deductible applies	70% (of the recognized charge) per visit
<b>Allergy testing and treatment</b>			
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.	Covered according to the type of benefit and the place where the service is received.
Allergy injections treatment performed at a physician's, or specialist office when you see the physician	80% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
<b>Physician and specialist surgical services</b>			
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 negotiated charge) per visit	60% (of the recognized charge) per visit
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 negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: <ul style="list-style-type: none"> <li>• A stay in a hospital (Hospital stays are covered in the <i>Eligible health services and exclusions - Hospital and other facility care</i> section)</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>			
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 negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: <ul style="list-style-type: none"> <li>• A stay in a hospital (Hospital stays are covered in the <i>Eligible health services and exclusions - Hospital and other facility care</i> section)</li> <li>• A separate facility charge for surgery performed in a physician's office</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>			

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
<b>Alternatives to physician office visits</b>			
Walk-in clinic visits (non-emergency visit)	\$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	\$35 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit  No policy year deductible applies	70% (of the recognized charge) per visit
<b>Hospital and other facility care</b>			
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 negotiated charge) per admission  No policy year deductible applies	60% (of the recognized charge) per admission
The following are not eligible health services: <ul style="list-style-type: none"> <li>• All services and supplies provided in: <ul style="list-style-type: none"> <li>- Rest homes</li> <li>- Any place considered a person's main residence or providing mainly custodial or rest care</li> <li>- Health resorts</li> <li>- Spas</li> <li>- Schools or camps</li> </ul> </li> </ul>			
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.	Covered according to the type of benefit and the place where the service is received.
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit  No policy year deductible applies	60% (of the recognized charge) per visit

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
<b>Hospital and other facility care (continued)</b>			
Anesthesia and related facility charges for oral surgery or a dental procedure  For covered dependents below the age of 9, or for a covered person with serious mental or physical condition, or with significant behavioral problems	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.	Covered according to the type of benefit and the place where the service is received.
<b>Alternatives to hospital stays</b>			
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge)	70% (of the negotiated charge)  No policy year deductible applies	60% (of the recognized charge)
The following are not covered under this benefit: <ul style="list-style-type: none"> <li>• A stay in a hospital (See the <i>Hospital care – facility charges</i> benefit in this section)</li> <li>• A separate facility charge for surgery performed in a physician’s office</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>			
Home Health Care	80% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: <ul style="list-style-type: none"> <li>• 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)</li> <li>• Transportation</li> <li>• Homemaker or housekeeper services</li> <li>• Food or home delivered services</li> <li>• Maintenance therapy</li> </ul>			

	<b>Select Care coverage Duke Health, WakeMed &amp; THN-Cone Health network</b>	<b>In-network coverage Open Access Managed Choice network</b>	<b>Out-of-network coverage</b>
Hospice-Inpatient	80% (of the negotiated charge) per admission	70% (of the negotiated charge) per admission  No policy year deductible applies	60% (of the recognized charge) per admission
Hospice-Outpatient	80% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Funeral arrangements</li> <li>• Pastoral counseling</li> <li>• Financial or legal counseling which includes estate planning and the drafting of a will</li> <li>• Homemaker or caretaker services that are services which are not solely related to your care and may include: <ul style="list-style-type: none"> <li>- Sitter or companion services for either you or other family members</li> <li>- Transportation</li> <li>- Maintenance of the house</li> </ul> </li> </ul>			
Outpatient private duty nursing	80% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Skilled nursing facility-Inpatient	80% (of the negotiated charge) per admission	70% (of the negotiated charge) per admission  No policy year deductible applies	60% (of the recognized charge) per admission
Maximum days of confinement per policy year	60		
Emergency room	\$150 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	\$150 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit  No policy year deductible applies	Paid the same as select care coverage and in-network coverage

	Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i>	In-network coverage <i>Open Access Managed Choice network</i>	Out-of-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered	Not covered
<p><b>Important note:</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>A separate 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.</li> <li>Covered benefits that are applied to the 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 emergency room copayment/coinsurance.</li> <li>Separate copayment/coinsurance amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These copayment/coinsurance amounts may be different from the emergency room copayment/coinsurance. They are based on the specific service given to you.</li> <li>Services given to you in the emergency room that are not part of the emergency room benefit may be subject to copayment/coinsurance amounts.</li> </ul>			
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>Non-emergency services in a hospital emergency room or an independent freestanding emergency department</li> </ul>			
Urgent care  Urgent medical care provided by an urgent care provider	\$45 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	\$90 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit  No policy year deductible applies	\$90 copayment then the plan pays 100% (of the balance of the recognized charge) per visit  No policy year deductible applies
Non-urgent use of an urgent care provider	Not covered	Not covered	Not covered
<p>The following is not covered under this benefit:</p> <ul style="list-style-type: none"> <li>Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)</li> </ul>			

	Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i>	In-network coverage <i>Open Access Managed Choice network</i>	Out-of-network coverage
<b>Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)</b>			
Type A services	100% (of the negotiated charge) per visit	100% (of the negotiated charge) per visit  No copayment or deductible applies	70% (of the recognized charge) per visit
Type B services	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Type C services	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Orthodontic services	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Dental emergency 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.	Covered 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, or when performed on covered persons under age 9 or covered persons with serious mental or physical conditions or with significant behavioral problems.
- 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
- 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

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.	Covered according to the type of benefit and the place where the service is received.
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	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
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.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Services and supplies for: <ul style="list-style-type: none"> <li>- The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches</li> <li>- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes</li> <li>- Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies</li> <li>- Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet</li> </ul> </li> </ul>			
Accidental injury to sound natural teeth	80% (of the negotiated charge)	70% (of the negotiated charge)	60% (of the recognized charge)
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• The care, filling, removal or replacement of teeth and treatment of diseases of the teeth</li> <li>• Dental services related to the gums</li> <li>• Apicoectomy (dental root resection)</li> <li>• Orthodontics</li> <li>• Root canal treatment</li> <li>• Soft tissue impactions</li> <li>• Bony impacted teeth</li> <li>• Alveolectomy</li> <li>• Augmentation and vestibuloplasty treatment of periodontal disease</li> <li>• False teeth</li> <li>• Prosthetic restoration of dental implants</li> <li>• Dental implants</li> </ul>			
Temporomandibular joint dysfunction (TMJ) and Craniomandibular joint dysfunction (CMJ) 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.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Dental implants</li> </ul>			

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
<b>Clinical trials</b>			
Experimental or investigational therapies	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.	Covered according to the type of benefit and the place where the service is received.
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.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not eligible health services:</p> <ul style="list-style-type: none"> <li>• Services and supplies related to data collection and record-keeping needed only for the clinical trial</li> <li>• Services and supplies provided by the trial sponsor for free</li> </ul> <p>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)</p>			
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.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Cosmetic treatment and procedures</li> </ul>			
Obesity Surgery and 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.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not eligible health services:</p> <ul style="list-style-type: none"> <li>• Weight management treatment.</li> <li>• Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate.</li> <li>• Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes: <ul style="list-style-type: none"> <li>- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications</li> <li>- Hypnosis, or other forms of therapy</li> <li>- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.</li> </ul> </li> </ul>			

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
Reconstructive surgery and supplies (includes reconstructive breast surgery)	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.	Covered according to the type of benefit and the place where the service is received.
Sexual dysfunction 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.	Covered according to the type of benefit and the place where the service is received.
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.	Covered according to the type of benefit and the place where the service is received.
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge)	70% (of the negotiated charge)  No policy year deductible applies	60% (of the recognized charge)  No policy year deductible applies
<b>Voluntary sterilization for males</b>			
Inpatient physician or specialist surgical services	80% (of the negotiated charge)	70% (of the negotiated charge)	60% (of the recognized charge)
Outpatient physician or specialist surgical services	80% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
<b>Abortion</b>			
Inpatient physician or specialist surgical services	80% (of the negotiated charge)	70% (of the negotiated charge)	60% (of the recognized charge)
Outpatient physician or specialist surgical services	80% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
<b>Gender affirming treatment</b>			
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.	Covered according to the type of benefit and the place where the service is received.
<b>Autism spectrum disorder</b>			
Autism spectrum disorder treatment, diagnosis and testing, Includes Applied behavior analysis and 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.	Covered according to the type of benefit and the place where the service is received.
<b>Mental Health treatment</b>			
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission	80% (of the negotiated charge) per admission  No policy year deductible applies	60% (of the recognized charge) per admission
Outpatient office visits (includes telemedicine consultations)	\$10 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	\$10 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit  No policy year deductible applies	70% (of the recognized charge) per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit  No policy year deductible applies	60% (of the recognized charge) per visit

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
<b>Substance Related Disorders treatment</b>			
Inpatient hospital substance related disorders detoxification (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission	80% (of the negotiated charge) per admission  No policy year deductible applies	60% (of the recognized charge) per admission
Outpatient substance related disorders office visits to a physician or behavioral health provider (Includes telemedicine consultations)	\$10 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	\$10 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit  No policy year deductible applies	70% (of the recognized charge) per visit
Other outpatient substance related disorder services (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit  No policy year deductible applies	60% (of the recognized charge) per visit
<b>Transplant services</b>			
Inpatient and outpatient transplant 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.	Covered according to the type of benefit and the place where the service is received.
Inpatient and outpatient transplant 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.	Covered according to the type of benefit and the place where the service is received.
Transplant services-travel and lodging	Covered	Covered	Covered

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>IOE facility</i></b>	<b>Out-of-network coverage <i>Includes providers who are otherwise part of Aetna's network but are non-IOE providers</i></b>
<b>Transplant services (continued)</b>			
Lifetime maximum payable for travel and lodging expenses for any one transplant, including tandem transplants	\$10,000	\$10,000	\$10,000
Maximum payable for lodging expenses per IOE patient	\$50 per night	\$50 per night	\$50 per night
Maximum payable for Lodging Expenses per companion	\$50 per night	\$50 per night	\$50 per night
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Services and supplies furnished to a donor when the recipient is not a covered person</li> <li>• Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness</li> <li>• 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</li> </ul>			

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
<b>Infertility services</b>			
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.	Covered according to the type of benefit and the place where the service is received.
Inpatient and outpatient care	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.	Covered according to the type of benefit and the place where the service is received.
Maximum number of ovulation induction cycles with menotropins per lifetime	3		
Maximum number of Intrauterine insemination cycles per lifetime	3		
<b>Infertility services exclusions</b>			
The following are not covered under the infertility services benefit:			
<ul style="list-style-type: none"> <li>• All infertility services associated with or in support of an Advanced Reproductive Technology (ART) cycle. These include, but are not limited to: <ul style="list-style-type: none"> <li>- Imaging, laboratory services, and professional services</li> <li>- In vitro fertilization (IVF)</li> <li>- Zygote intrafallopian transfer (ZIFT)</li> <li>- Gamete intrafallopian transfer (GIFT)</li> <li>- Cryopreserved embryo transfers</li> <li>- Gestational carrier cycles</li> <li>- Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery).</li> </ul> </li> <li>• Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.</li> <li>• Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.</li> <li>• Infertility medication not injected by your provider, including but not limited to menotropins, hCG, and GnRH agonists</li> <li>• 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.</li> <li>• Home ovulation prediction kits or home pregnancy tests.</li> <li>• The purchase of donor embryos, donor eggs or donor sperm.</li> </ul>			

**Infertility services exclusions (continued)**

- 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.
- Treatment for dependent children, except for fertility preservation as described above.

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
<b>Specific therapies and tests</b>			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge)	70% (of the negotiated charge)  No policy year deductible applies	60% (of the recognized charge)
Diagnostic lab work performed in a physician’s office, the outpatient department of a hospital or other facility	80% (of the negotiated charge)	70% (of the negotiated charge)  No policy year deductible applies	60% (of the recognized charge)
Diagnostic radiological services performed in a physician’s office, the outpatient department of a hospital or other facility	80% (of the negotiated charge)	70% (of the negotiated charge)  No policy year deductible applies	60% (of the recognized charge)

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
Outpatient Chemotherapy, Radiation, Infusion & Respiratory Therapy	80% (of the negotiated charge)	70% (of the negotiated charge)  No policy year deductible applies	60% (of the recognized charge)
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	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.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan</li> <li>• Enteral nutrition</li> <li>• Blood transfusions and blood products</li> <li>• Dialysis</li> </ul>			
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)  Combined for short- term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Chiropractic services	80% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	30		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
<b>Other services</b>			
<b>Ambulance services</b>			
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	\$150 Copay then the plan pays 100% (of the negotiated charge) per trip	\$150 Copay then the plan pays 100% (of the negotiated charge) per trip  No policy year deductible applies	Paid the same as select care coverage and in-network coverage
The following are not eligible health services:			
<ul style="list-style-type: none"> <li>Ambulance services for routine transportation to receive outpatient or inpatient care</li> </ul>			
Durable medical and surgical equipment	80% (of the negotiated charge) item	70% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit:			
<ul style="list-style-type: none"> <li>Whirlpools</li> <li>Portable whirlpool pumps</li> <li>Sauna baths</li> <li>Massage devices</li> <li>Over bed tables</li> <li>Elevators</li> <li>Communication aids</li> <li>Vision aids</li> <li>Telephone alert systems</li> <li>Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician</li> </ul>			
Nutritional support	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.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit:			
<ul style="list-style-type: none"> <li>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</li> </ul>			
Cochlear implants	80% (of the negotiated charge) item	70% (of the negotiated charge) per item	60% (of the recognized charge) per item

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
Prosthetic Devices & Orthotics	80% (of the negotiated charge) item	70% (of the negotiated charge) per item	60% (of the recognized charge) per item
Orthotic devices to correct positional plagiocephaly	1 per lifetime		
Cranial prosthetics ( <i>Medical wigs</i> )	80% (of the negotiated charge) item	80% (of the negotiated charge) per item	80% (of the Actual charge) per item
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Services covered under any other benefit</li> <li>• 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</li> <li>• Trusses, corsets, and other support items</li> <li>• Repair and replacement due to loss, misuse, abuse or theft</li> <li>• Communication aids</li> </ul>			
<b>Hearing aids and Exams</b>			
Hearing exam	80% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hearing exam maximum	1 hearing exams every 36 month consecutive period		
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay</li> </ul>			
Hearing Aids	80% (of the negotiated charge) item	70% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids maximum per ear	One hearing aid per ear every 36 month consecutive period		
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• A replacement of: <ul style="list-style-type: none"> <li>- A hearing aid that is lost, stolen or broken</li> <li>- A hearing aid installed within the prior 36 month period</li> </ul> </li> <li>• Replacement parts or repairs for a hearing aid</li> <li>• Batteries or cords</li> <li>• Cochlear implants</li> <li>• A hearing aid that does not meet the specifications prescribed for correction of hearing loss</li> <li>• Any ear or hearing exam performed by a physician or audiologist who is not certified as an otolaryngologist or otologist</li> </ul>			

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
<b>Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)</b>			
Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations & contact fitting)	100% (of the negotiated charge) per visit  No policy year deductible applies	100% (of the negotiated charge) per visit  No policy year deductible applies	70% (of the recognized charge) per visit
Office fitting of contact lenses	100% (of the negotiated charge) per visit  No policy year deductible applies	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	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 Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set		

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
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.	Covered according to the type of benefit and the place where the service is received.
<p><b>*Important note:</b> Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.</p> <p>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.</p> <p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes</li> </ul> <p>Limited to covered persons through the end of the month in which the person turns age 19.</p>			
<b>Adult vision care Limited to covered persons age 19 and over</b>			
Adult routine vision exams (including refraction) Performed by a legally qualified ophthalmologist or therapeutic optometrist, or any other providers acting within the scope of their license  Includes fitting of prescription contact lenses	100% (of the negotiated charge) per visit	100% (of the negotiated charge) per visit  No policy year deductible applies	70% (of the recognized charge) per visit
Maximum visits per policy year Fitting of Contact maximum		1 visit  1 visit	

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item	100% (of the negotiated charge) per item  No policy year deductible applies	70% (of the recognized charge) per item  No policy year deductible applies
Maximum number per policy year: Eyeglass frames Prescription lenses	One set of eyeglass frames One pair of prescription lenses		
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and 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		
Maximum per policy year eyeglass frames, prescription lenses or prescription contact lenses	\$100		
<p><b>*Important note:</b> 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.</p>			
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes</li> <li>• Special supplies such as non-prescription sunglasses</li> <li>• Special vision procedures, such as orthoptics or vision therapy</li> <li>• Eye exams during your stay in a hospital or other facility for health care</li> <li>• Eye exams for non-prescription contact lenses or their fitting</li> <li>• Eyeglasses or duplicate or spare eyeglasses or lenses or frames</li> <li>• Replacement of lenses or frames that are lost or stolen or broken</li> <li>• Acuity tests</li> <li>• Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures</li> <li>• Services to treat errors of refraction</li> </ul>			

<b>Outpatient prescription drugs</b>			
	<b>Select Care coverage</b> <i>Duke Health, WakeMed &amp; THN-Cone Health network</i>	<b>In-network coverage</b> <i>Open Access Managed Choice network</i>	<b>Out-of-network coverage</b>
<b>Time waiver for state of emergency or disaster</b>			
You cannot refill a prescription until 30 days of the supply has been used, except under certain circumstances during a state of emergency or disaster.			
<b>Copayment waiver for risk reducing breast cancer</b>			
The prescription drug copayment will not apply to risk reducing breast cancer prescription drugs filled at a retail or in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.			
<b>Copayment waiver for tobacco cessation prescription and over-the-counter drugs</b>			
The prescription drug copayment 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%.			
Any prescription drug copayment will apply after those two regimens per policy year have been exhausted.			
<b>Copayment waiver for contraceptives</b>			
The prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network and out-of-network pharmacy.			
This means that such contraceptive methods are paid at 100% for:			
<ul style="list-style-type: none"> <li>• 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%.</li> <li>• 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%.</li> </ul>			
The prescription drug copayment 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.			

	<b>Select Care coverage</b> <i>Duke Health, WakeMed &amp; THN-Cone Health network</i>	<b>In-network coverage</b> <i>Open Access Managed Choice network</i>	<b>Out-of-network coverage</b>
<b>Preferred generic prescription drugs</b>			
For each fill up to a 30 day supply filled at a retail pharmacy	\$5 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies		\$5 copayment per supply then the plan pays 100% (of the balance of the recognized charge)  No policy year deductible applies
<b>Preferred brand-name prescription drugs</b>			
For each fill up to a 30 day supply filled at a retail pharmacy	\$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies		\$20 copayment per supply then the plan pays 100% (of the balance of the recognized charge)  No policy year deductible applies
<b>Non-preferred generic prescription drugs</b>			
For each fill up to a 30 day supply filled at a retail pharmacy	\$35 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies		\$35 copayment per supply then the plan pays 100% (of the balance of the recognized charge)  No policy year deductible applies
<b>Non-preferred brand-name prescription drugs</b>			
For each fill up to a 30 day supply filled at a retail pharmacy	\$35 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies		\$35 copayment per supply then the plan pays 100% (of the balance of the recognized charge)  No policy year deductible applies
<b>Preferred Specialty drugs</b>			
For each fill up to a 30 day supply filled at a specialty pharmacy or a retail pharmacy	\$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies		\$60 copayment per supply then the plan pays 100% (of the balance of the recognized charge)  No policy year deductible applies

	Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i>	In-network coverage <i>Open Access Managed Choice network</i>	Out-of-network coverage
<b>Non-preferred Specialty drugs</b>			
For each fill up to a 30 day supply filled at a specialty pharmacy or a retail pharmacy	Copayment per supply of 25% of the negotiated charge then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	Copayment per supply of 25% of the recognized charge then the plan pays 100% (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	
<b>Diabetic insulin important note:</b>			
Your cost share will not exceed \$25 per 30 day supply of a covered preferred prescription insulin drug filled at an in-network pharmacy.			
<b>Contraceptives (birth control)</b>			
For each fill up to a 12 month 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 12 month 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	
Preventive care drugs and supplements filled at a retail pharmacy  For each 30 day supply	100% (of the negotiated charge per prescription or refill)	Paid according to the type of drug per the schedule of benefits, above	

	<b>Select Care coverage <i>Duke Health, WakeMed &amp; THN-Cone Health network</i></b>	<b>In-network coverage <i>Open Access Managed Choice network</i></b>	<b>Out-of-network coverage</b>
Risk reducing breast cancer prescription drugs filled at a pharmacy  For each 30 day supply	100% (of the negotiated charge) per prescription or refill		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		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.		

## **Outpatient prescription drug exclusions**

The following are not eligible health services:

- 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
- 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

- Off-label drug use except for indications recognized through peer-reviewed medical literature
- 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
  - 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

#### **Outpatient prescription drugs important note:**

##### **Dispense As Written (DAW)**

If a provider prescribes a covered brand-name prescription drug when a generic prescription drug equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost share for the brand-name drug. If a provider does not specify DAW and you request a covered brand-name prescription drug, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug. The cost difference related to a prescription not specified as DAW does not apply toward your policy year deductible or maximum out-of-pocket limit.

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

## Travel and Lodging Reimbursement

We will reimburse you for travel and lodging expenses when you need to travel at least 100 to access eligible health services because a law or regulation where you are located prohibits those eligible health services. The following are covered travel and lodging expenses:

- U.S. domestic travel expenses for the covered person and the covered person's travel companion in the 48 contiguous states (coach class air, bus, train or shuttle fares, taxi or ride share fares for local travel)
- Mileage costs, not to exceed amounts permitted by Internal Revenue Service guidelines
- Parking and tolls
- Lodging costs of up to \$50 per night, per covered person or \$100 per night, total, for the covered person and the covered person's travel companion, not to exceed amounts permitted by Internal Revenue Service guidelines

You must submit a travel and lodging claim form to be reimbursed. You will need to confirm travel was necessary because no provider within 100 miles of where you are located was available to provide the eligible health services when you submit your travel and lodging claim form.

Call the toll-free number on your ID card to:

- Obtain a travel and lodging claim form
- Get assistance in locating a provider
- Get information about these eligible health services including specific eligibility requirements and limitations

The following are not covered travel and lodging expenses:

- Expenses for more than one travel companion unless two parents are traveling with a minor child
- Gasoline/fuel costs
- Car rentals
- Meals, groceries, hotel room service, alcohol/tobacco products
- Personal care/convenience items, (e.g. shampoo, clothing, deodorant)
- Entertainment/souvenir expenses
- Telephone calls
- Taxes
- Tips, gratuities
- Childcare expenses
- Lost wages

Description	Amount
Travel and lodging reimbursement	100% No policy year deductible applies
Limit per occurrence per policy year	\$3,000

## Out of Country claims

Out of Country claims should be submitted with appropriate medical service and payment information from the provider of service. Covered services received outside the United States will be considered at the In-net level of benefits.

## General Exclusions

The following are not eligible health services under your plan:

### Acupuncture

- Acupuncture
- Acupressure

### 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 service* 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 except in connection with hospice 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 disorders 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, or 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

### **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 except as specifically covered under the student policy. Examples of these are:
  - 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

### **Other primary payer**

- Payment for a portion of the charge 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

### **Private duty nursing**

- Services provided by a close relative or a member of the household

### **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

### **School health services**

- Services and supplies normally provided by the policyholder's:
  - School health services
  - Infirmary
  - Hospital
  - Pharmacy
- Services and supplies provided by health professionals who the policyholder:
  - Employs
  - Is affiliated with
  - Has an agreement or arrangement with
  - Otherwise designates

### **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.

### **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

### **Sexual dysfunction and enhancement**

- Except as required under the *Eligible health services under your plan - Sexual dysfunction services* and the *Eligible health services under your plan -sexual dysfunction* sections, treatments such as:
  - 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

### **Telemedicine**

- Services including:
  - Telephone calls
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

### **Therapies and tests**

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

### **Tobacco cessation**

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
  - Counseling, except as specifically provided in the *Eligible health services and exclusions – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Eligible health services and exclusions – Outpatient prescription drugs* section
  - Nicotine patches
  - Gum

### **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

### **Vision care for adults**

- Routine vision exam provided by an ophthalmologist or optometrist, including refraction and glaucoma testing
- Vision care services and supplies

### **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**

- Services or supplies for the treatment of an occupational injury or illness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

**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 Duke University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health<sup>SM</sup> 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>.

## 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](tel:1-877-480-4161) (TTY: [711](tel: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](tel:1-800-648-7817), TTY: [711](tel:711)  
Email: [CRCoordinator@aetna.com](mailto: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, 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.*