Student Health Insurance

Preferred Provider Organization (PPO)
Medical and Outpatient Prescription Drug Plan

Schedule of benefits

Prepared exclusively for:

Policyholder: Husson University
Policyholder number: 686157
Student policy effective date: 08/01/2023
Plan effective date: 08/01/2023
Plan issue date: 11/30/2023
Actuarial value and metallic level: 84.08% - Gold

Underwritten by Aetna Life Insurance Company in the State of Maine
Schedule of benefits

This schedule of benefits lists the policy year deductibles, copayments and coinsurance that apply to the services you receive under this plan. You should review this schedule of benefits to become familiar with your policy year deductibles, copayments and coinsurance and any limits that apply to the services and supplies.

How to read your schedule of benefits

- When we say:
  - “In-network coverage”, we mean you get care from our in-network providers.
  - “Out-of-network coverage”, we mean you can get care from out-of-network providers.
- The policy year deductibles, copayments and coinsurance listed in the schedule of benefits below reflect the policy year deductibles, copayments and coinsurance amounts under your plan.
- The coinsurance listed in the schedule of benefits reflects the plan coinsurance percentage. This is the coinsurance amount that the plan pays. You are responsible for paying any remaining coinsurance.
- You are responsible for paying any policy year deductibles, copayments and your coinsurance.
- You are responsible for full payment of any health care services you received that are not covered benefits.
- This plan has maximums for specific covered benefits. For example, these could be visit, day or dollar maximums. They are separate maximums for in-network providers and out-of-network providers unless we state otherwise.
- At the end of this schedule of benefits you will find detailed explanations about your:
  - Policy year deductibles
  - Copayments
  - Maximums
  - Coinsurance
  - Maximum out-of-pocket limits

Important note:

All covered benefits are subject to the policy year deductible, copayment and coinsurance unless otherwise noted in the schedule of benefits below. The Surprise bill section in the certificate of coverage explains your protections from a surprise bill.

How to contact us for help

We are here to answer your questions.

- Log in to your Aetna® website at https://www.aetnastudenthealth.com
- Call Member Services at the toll-free number on your ID card

The coverage described in this schedule of benefits will be provided under Aetna’s student policy. This schedule of benefits replaces any schedule of benefits previously in effect under the student policy for medical and pharmacy coverage. Keep this schedule of benefits with your certificate of coverage.
Important note about your cost sharing
The way the cost sharing works under this plan, you pay the policy year deductible first. Then you pay your copayment and then you pay your coinsurance. Your copayment does not apply towards any policy year deductible.

You are required to pay the policy year deductible before eligible health services are covered benefits under the plan, and then you pay your copayment and coinsurance.

Here’s an example of how cost sharing works:
- You pay your policy year deductible of $1,000
- Your physician charges $120
- Your physician collects the copayment from you – $20
- The plan pays 80% coinsurance – $80
- You pay 20% coinsurance – $20

Plan features
Policy year deductibles
You have to meet your policy year deductible before this plan pays for benefits.

<table>
<thead>
<tr>
<th>Deductible type</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$250 per policy year</td>
<td>$500 per policy year</td>
</tr>
</tbody>
</table>

Policy year deductible waiver
The policy year deductible is waived for all of the following eligible health services:
- In-network care for Preventive care and wellness
- In-network care for Pediatric dental care
- In-network care and out-of-network care for Pediatric vision care
- In-network care and out-of-network care for Outpatient prescription drugs

Maximum out-of-pocket limits
Maximum out-of-pocket limit per policy year

<table>
<thead>
<tr>
<th>Maximum out-of-pocket type</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$6,500 per policy year</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>
Eligible health services

Coinsurance listed in the schedule of benefits
The coinsurance listed in the schedule of benefits below reflects the plan coinsurance percentage. This is the coinsurance amount that the plan pays. You are responsible for paying any remaining coinsurance.

1. Preventive care and wellness

Routine physical exams
Performed at a physician's office

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine physical exam</td>
<td>100% (of the negotiated charge) per visit</td>
<td>80% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Routine physical exam limits for covered persons through age 21: maximum age and visit limits per policy year</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For details, contact your physician or Member Services by logging in to your Aetna website at <a href="https://www.aetnastudenthealth.com">https://www.aetnastudenthealth.com</a> or calling the toll-free number on your ID card.</td>
<td></td>
</tr>
<tr>
<td>Routine physical exam limits for covered persons age 22 and over: maximum visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
</tbody>
</table>

Preventive care immunizations
Performed in a facility or at a physician’s office

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care immunizations</td>
<td>100% (of the negotiated charge) per visit</td>
<td>80% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Preventive care immunization maximums</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For details, contact your physician or Member Services by logging in to your Aetna website at <a href="https://www.aetnastudenthealth.com">https://www.aetnastudenthealth.com</a> or calling the toll-free number on your ID card.</td>
<td></td>
</tr>
</tbody>
</table>
### Well woman preventive visits
Routine gynecological exams (including Pap smears)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed at a physician, obstetrician (OB), gynecologist (GYN) or OB/GYN office</td>
<td>100% (of the <strong>negotiated charge</strong>) per visit No copayment or policy year deductible applies</td>
<td>80% (of the <strong>recognized charge</strong>) per visit</td>
</tr>
<tr>
<td>Well woman routine gynecological exam maximums</td>
<td>Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per <strong>policy year</strong></td>
<td>1 visit</td>
<td></td>
</tr>
</tbody>
</table>

### Preventive screening and counseling services
In figuring the maximum visits, each session of up to 60 minutes is equal to one visit

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity and/or healthy diet counseling office visits</td>
<td>100% (of the <strong>negotiated charge</strong>) per visit No copayment or policy year deductible applies</td>
<td>80% (of the <strong>recognized charge</strong>) per visit</td>
</tr>
<tr>
<td>Obesity and/or healthy diet counseling maximum visits</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Misuse of alcohol and/or drugs counseling office visits</td>
<td>100% (of the <strong>negotiated charge</strong>) per visit No copayment or policy year deductible applies</td>
<td>80% (of the <strong>recognized charge</strong>) per visit</td>
</tr>
<tr>
<td>Misuse of alcohol and/or drugs counseling maximum visits per <strong>policy year</strong></td>
<td>5 visits</td>
<td></td>
</tr>
<tr>
<td>Use of tobacco products counseling office visits</td>
<td>100% (of the <strong>negotiated charge</strong>) per visit No copayment or policy year deductible applies</td>
<td>80% (of the <strong>recognized charge</strong>) per visit</td>
</tr>
<tr>
<td>Use of tobacco products counseling maximum visits per <strong>policy year</strong></td>
<td>8 visits</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Depression screening counseling office visits</td>
<td>100% (of the negotiated charge) per visit&lt;br&gt;No copayment or policy year deductible applies</td>
<td>80% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Depression screening counseling maximum visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted infection counseling office visits</td>
<td>100% (of the negotiated charge) per visit&lt;br&gt;No copayment or policy year deductible applies</td>
<td>80% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Sexually transmitted infection counseling maximum visits per policy year</td>
<td>2 visits</td>
<td></td>
</tr>
<tr>
<td>Genetic risk counseling for breast and ovarian cancer office visits</td>
<td>100% (of the negotiated charge) per visit&lt;br&gt;No copayment or policy year deductible applies</td>
<td>80% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Genetic risk counseling for breast and ovarian cancer age and frequency limitations</td>
<td>Not subject to any age or frequency limitations</td>
<td></td>
</tr>
</tbody>
</table>

**Routine cancer screenings**
Performed at a physician office, specialist office or facility

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine cancer screenings</td>
<td>100% (of the negotiated charge) per visit&lt;br&gt;No copayment or policy year deductible applies</td>
<td>80% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Routine cancer screening maximums</td>
<td>Subject to any age, family history and frequency guidelines as set forth in the most current:&lt;br&gt;Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF&lt;br&gt;Comprehensive guidelines supported by the Health Resources and Services Administration&lt;br&gt;For details, contact your physician or Member Services by logging in to your Aetna website at <a href="https://www.aetnastudenthealth.com">https://www.aetnastudenthealth.com</a> or calling the toll-free number on your ID card.</td>
<td></td>
</tr>
</tbody>
</table>
### Lung cancer screening maximums

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung cancer screening maximums</td>
<td>1 screening every 12 months</td>
<td></td>
</tr>
</tbody>
</table>

**Lung cancer screenings important note:**

Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.

### Prenatal care

Prenatal care services provided by a physician, obstetrician (OB), gynecologist (GYN), and/or OB/GYN

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care services only</td>
<td>100% (of the <em>negotiated charge</em>) per visit</td>
<td>80% (of the <em>recognized charge</em>) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

**Important note:**

You should review the *Maternity care* and *Well newborn nursery care* sections. They will give you more information on coverage levels for maternity care under this plan.

### Comprehensive lactation support and counseling services

Facility or office visits

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactation counseling services</td>
<td>100% (of the <em>negotiated charge</em>) per visit</td>
<td>80% (of the <em>recognized charge</em>) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactation counseling services maximum visits per <strong>policy year</strong> either in a group or individual setting</td>
<td>6 visits</td>
<td></td>
</tr>
</tbody>
</table>

**Important note:**

Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section.
### Breast feeding durable medical equipment

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast pump supplies and accessories</td>
<td>100% (of the <strong>negotiated charge</strong>) per item</td>
<td>80% (of the <strong>recognized charge</strong>) per item</td>
</tr>
<tr>
<td></td>
<td>No <strong>copayment</strong> or <strong>policy year deductible</strong> applies</td>
<td></td>
</tr>
</tbody>
</table>

**Important note:**
See the *Breast feeding durable medical equipment* section of the certificate of coverage for limitations on breast pump and supplies.

### Family planning services – female contraceptives

#### Counseling services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female contraceptive counseling services office visit</td>
<td>100% (of the <strong>negotiated charge</strong>) per visit</td>
<td>80% (of the <strong>recognized charge</strong>) per visit</td>
</tr>
<tr>
<td></td>
<td>No <strong>copayment</strong> or <strong>policy year deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td>Contraceptive counseling services maximum visits per policy year either in a group or individual setting</td>
<td>2 visits</td>
<td></td>
</tr>
</tbody>
</table>

**Important note:**
Any visits that exceed the contraceptive counseling services maximum are covered under *Physician services* office visits.

### Contraceptives (prescription drugs and devices)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit</td>
<td>100% (of the <strong>negotiated charge</strong>) per item</td>
<td>80% (of the <strong>recognized charge</strong>) per item</td>
</tr>
<tr>
<td></td>
<td>No <strong>copayment</strong> or <strong>policy year deductible</strong> applies</td>
<td></td>
</tr>
</tbody>
</table>
## Female voluntary sterilization

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient provider services</strong></td>
<td>100% (of the negotiated charge) No copayment or policy year deductible applies</td>
<td>80% (of the recognized charge)</td>
</tr>
<tr>
<td><strong>Outpatient provider services</strong></td>
<td>100% (of the negotiated charge) No copayment or policy year deductible applies</td>
<td>80% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>
2. Physicians and other health professionals

Physician and specialist services (non-surgical and non-preventive)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office hours visits (non-surgical and non-preventive care by a physician or specialist, includes telehealth consultations)</td>
<td>$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit</td>
<td>80% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

Allergy testing and treatment

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy testing performed at a physician or specialist office</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Allergy injections treatment performed at a physician or specialist office</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

Physician and specialist – inpatient surgical services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon</td>
<td>75% (of the negotiated charge)</td>
<td>55% (of the recognized charge)</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>75% (of the negotiated charge)</td>
<td>55% (of the recognized charge)</td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>75% (of the negotiated charge)</td>
<td>55% (of the recognized charge)</td>
</tr>
</tbody>
</table>

Physician and specialist – outpatient surgical services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery performed at a physician or specialist office or outpatient department of a hospital or surgery center by a surgeon</td>
<td>75% (of the negotiated charge) per visit</td>
<td>55% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>75% (of the negotiated charge) per visit</td>
<td>55% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>75% (of the negotiated charge) per visit</td>
<td>55% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>
In-hospital non-surgical physician services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-hospital non-surgical physician services</td>
<td>75% (of the negotiated charge) per visit</td>
<td>55% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

Consultant services (non-surgical and non-preventive)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office hours visits (non-surgical and non-preventive care by a consultant, includes telehealth consultations)</td>
<td>$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit</td>
<td>80% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

Second surgical opinion

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second surgical opinion</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

Alternatives to physician office visits

Walk-in clinic visits (non-emergency visit)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk-in clinic (non-emergency visit)</td>
<td>$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit</td>
<td>80% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

Important note:

Some walk-in clinics can provide preventive care and wellness services. The types of services offered will vary by the provider and location of the clinic. If you get preventive care and wellness benefits at a walk-in clinic, they are paid at the cost sharing shown in the Preventive care and wellness section.
### 3. Hospital and other facility care

#### Hospital care (facility charges)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital (room and board) and other miscellaneous services and supplies</td>
<td>75% (of the negotiated charge) per admission</td>
<td>55% (of the recognized charge) per admission</td>
</tr>
</tbody>
</table>

Subject to semi-private room rate unless intensive care unit is required

Room and board includes intensive care

For physician charges, refer to the Physician and specialist – inpatient surgical services benefit

#### Preadmission testing

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preadmission testing</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

#### Anesthesia and related facility charges for a dental procedure

Coverage is subject to certain conditions. See the benefit description in the certificate of coverage for details.

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia and related facility charges for a dental procedure</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

#### Alternatives to hospital stays

#### Outpatient surgery (facility charges)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility charges for surgery performed in the outpatient department of a hospital or surgery center</td>
<td>75% (of the negotiated charge)</td>
<td>55% (of the recognized charge)</td>
</tr>
</tbody>
</table>

For physician charges, refer to the Physician and specialist – outpatient surgical services benefit
### Home health care

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>75% (of the negotiated charge) per visit</td>
<td>55% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

### Hospice care

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient facility (room and board and other miscellaneous services and supplies)</td>
<td>75% (of the negotiated charge) per admission</td>
<td>55% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Outpatient</td>
<td>75% (of the negotiated charge) per visit</td>
<td>55% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

**Hospice care important note:**
This includes part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8-hours a day. It also includes part-time or intermittent home health aide services to care for you up to 8-hours a day.

### Skilled nursing facility

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient facility (room and board and miscellaneous inpatient care services and supplies)</td>
<td>75% (of the negotiated charge) per admission</td>
<td>55% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board includes intensive care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum days of confinement per policy year</td>
<td>150</td>
<td></td>
</tr>
</tbody>
</table>
4. Emergency services and urgent care

Emergency services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital emergency room</td>
<td>$100 copayment then the plan pays 75% (of the balance of the negotiated charge) per visit</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td>Non-emergency care in a hospital emergency room</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Emergency services important note:

- **Out-of-network providers** do not have a contract with us. The provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by the 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 your ID card, or call Member Services for an address at 1-877-626-2308 and we will resolve any payment issue with the provider. Make sure the member ID is on the bill.

- A separate hospital emergency room copayment 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 will be waived and your inpatient copayment will apply.

- **Covered benefits** that are applied to the hospital emergency room copayment cannot be applied to any other copayment under the plan. Likewise, a copayment that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment.

- Separate copayment amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment amounts may be different from the hospital emergency room copayment. They are based on the specific service given to you.

- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment amounts that are different from the hospital emergency room copayment amounts.

Urgent care

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent medical care provided by an urgent care provider</td>
<td>$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit</td>
<td>80% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Non-urgent use of urgent care provider</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
5. Pediatric dental care

Pediatric dental care

Limited to covered persons through the end of the month in which the person turns age 19

Dental benefits are subject to the medical plan’s policy year deductibles and maximum out-of-pocket limits as explained on the schedule of benefits.

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A services</td>
<td>100% (of the negotiated charge) per visit</td>
<td>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Type B services</td>
<td>70% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Type C services</td>
<td>50% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Orthodontic services</td>
<td>50% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Dental emergency services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

Diagnostic and preventive care (type A services)

Visits and images

- Office visits during regular office hours, for oral evaluation-established patient (limited to: 2 visits every 12 months)
- Comprehensive oral evaluation (limited to: 2 visits every 12 months)
- Comprehensive periodontal evaluation-new or established patient (limited to: 2 visits every 12 months)
- Problem-focused examination (limited to: 2 visits every 12 months)
- Detailed and extensive oral evaluation – problem focused, by report
- Prophylaxis (cleaning) (limited to: 2 treatments per year)
- Topical application of fluoride (limited to: 2 treatments per year)
- Topical fluoride varnish (limited to: 2 treatments every 12 months)
- Sealants (limited to: 1 application every 3 years for permanent molars only)
- Preventive resin restoration in a moderate to high caries risk patient-permanent tooth (limited to: 1 application every 3 years for permanent molars only)
- Bitewing images (limited to: 2 sets per year)
Complete image series, including bitewings if medically necessary (limited to: 1 set every 3 years)
- Panoramic images (limited to: 1 set every 3 years)
- Vertical bitewing images (limited to: 2 sets per year)
- Periapical images
- Cephalometric radiographic image
- Oral/facial photographic images
- Interpretation of diagnostic image
- Intra-oral, occlusal view, maxillary or mandibular
- Resin infiltration of lesion, 1 per tooth every 3 years
- Diagnostic models
- Emergency palliative treatment per visit

Space maintainers
- Fixed -- (unilateral)
- Fixed – bilateral, maxillary
- Fixed – bilateral, mandibular
- Removable (unilateral)
- Removable – bilateral, maxillary
- Removable – bilateral, mandibular
- Re-cementation of space maintainer
- Removal of fixed space maintainer
- Removal of fixed – bilateral, maxillary
- Removal of fixed – bilateral, mandibular

Basic restorative care (type B services)
Visits and images
- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Consultation (by other than the treating provider)
- Therapeutic drug injection, by report
- Infiltration of sustained release therapeutic drug – per quadrant (Only eligible with extraction of impacted third molar wisdom teeth)

Images and pathology
- Extra-oral first 2D projection radiographic image
- Extra-oral posterior dental radiographic image

Oral surgery
- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants (primary tooth)
  - Coronectomy
  - Removal of residual tooth roots
  - Surgical removal of erupted tooth requiring removal of bone and/or resectioning of tooth
  - Surgical access of an unerupted tooth
- Impacted teeth
  - Removal of tooth (soft tissue)
  - Removal of impacted teeth
    - Removal of tooth (partially bony)
    - Removal of tooth (completely bony)
    - Removal of tooth (completely bony with unusual surgical complications)
• Incision and drainage of abscess
• Other surgical procedures
  – Closure of oral fistula of maxillary sinus
  – Alveoplasty, in conjunction with extractions four or more teeth – per quadrant
  – Alveoplasty, in conjunction with extractions – 1 to 3 teeth or tooth spaces – per quadrant
  – Alveoplasty, not in conjunction with extraction – per quadrant
  – Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces – per quadrant
  – Excision of hyperplastic tissue
  – Excision of periocoronal gingiva
  – Removal of exostosis
  – Tooth reimplantation
  – Transplantation of tooth or tooth bud
  – Closure of oral fistula of maxillary sinus
  – Placement of device to facilitate eruption of impacted tooth
  – Frenectomy
  – Suture of small wound, less than 5 cm

Periodontics
• Occlusal adjustment (other than with an appliance or by restoration)
• Periodontal scaling and root planing, per quadrant-4 or more teeth (limited to 4 separate quadrants every 2 years)
• Periodontal scaling and root planing – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
• Periodontal maintenance procedures following active therapy (limited to 4 in 12 months combined with prophylaxis after completion of active periodontal therapy)
• Collection and application of autologous blood product (limited to 1 every 3 years)

Endodontics
• Pulp capping
• Pulpotomy
• Pulpal therapy
• Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp; does not include final restoration)

Restorative dentistry
Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface are considered as a single restoration)
• Amalgam restorations
• Protective restoration
• Resin-based composite restorations (other than for molars)
• Pins
• Pin retention – per tooth, in addition to amalgam or resin restoration
• Crowns (when tooth cannot be restored with a filling material)
  – Prefabricated stainless steel crown
  – Prefabricated resin crown (excluding temporary crowns)
• Interim therapeutic restoration-primary teeth
• Prefabricated porcelain/ceramic crown-primary teeth
• Re-cementation
  – Inlay
  – Crown
  – Fixed partial bridge
- Fabricated-prefabricated post and core
- Implant/abutment supported crown
- Implant/abutment supported fixed partial denture

**Prosthodontics**
- Dentures and partials
  - Office reline
  - Laboratory relines
  - Special tissue conditioning, per denture
  - Rebase, per denture
- Adjustment to denture (Must be more than 6 months after installation if done by the same Dentist who installed it)
  - Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth
- Adding teeth to existing partial denture
  - Each tooth
  - Each clasp
- Repairs: bridges; partial bridges

**General Anesthesia, Intravenous(IV) Sedation and Drugs**
General anesthesia and IV sedation - only when medically necessary and only when provided in conjunction with a covered dental surgical procedure
- Evaluation for moderate sedation, deep sedation or general anesthesia
- Deep sedation/general anesthesia-each 15 minute increment
- Deep sedation/general anesthesia-each subsequent 15 minute increment
- Intravenous conscious sedation/analgesia-each 15 minute increment
- Intravenous conscious sedation/analgesia-each subsequent 15 minute increment

**Major restorative care (type C services)**

**Periodontics**
- Osseous surgery, including flap and closure, 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Osseous surgery, including flap and closure, per quadrant (limited to 1 per quadrant every 3 years)
- Pedical soft tissue graft procedures
- Bone replacement graft, first site in quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy, 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure – per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Pedicle soft tissue graft procedures
- Clinical crown lengthening
- Autogenous connective tissue graft procedures (including donor site surgery)
- Non-autogenous connective soft tissue allograft
- Free soft tissue graft procedures implant or edentulous tooth position in same graft
- Full mouth debridement (limited to 1 treatment per lifetime)
Endodontics
- Apexification/recalcification
- Apicoectomy
- Root canal therapy including images:
  - Anterior tooth
  - Premolar tooth
  - Molar tooth
- Retreatment of previous root canal therapy:
  - Anterior tooth
  - Premolar tooth
  - Molar tooth
- Root amputation
- Hemisection (including any root removal)

Restorative
- Inlays, onlays, labial veneers and crowns are covered only as a treatment for decay or acute traumatic injury and only when the teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge
- Inlays/onlays (limited to 1 per tooth every 5 years)
- Veneers, non-cosmetic (limited to 1 per tooth every 5 years)
- Crowns (limited to 1 per tooth every 5 years)
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain/ceramic substrate
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - ¾ cast metallic or porcelain/ceramic
  - Titanium
- Post and core
- Core build-up
- Repair
  - Replace all teeth and acrylic on cast metal framework – upper/lower
  - Crowns, inlays, onlays, veneers

Prosthodontics
- Installation of dentures and bridges is covered only if needed to replace teeth that were not abutments to a denture or bridge less than 5 years old
- Replacement of existing bridges or dentures (limited to 1 every 5 years)
- Bridge abutments (see inlays and crowns) (limited to 1 per tooth every 5 years)
- Pontics (limited to 1 per tooth every 5 years)
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
  - Titanium
  - Removable bridge/partial denture (unilateral) (limited to 1 every 5 years)
• One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics (limited to 1 every 5 years)
• Retainer – cast metal for resin bonded fixed prosthesis (limited to 1 every 5 years)
• Retainer – porcelain/ceramic for resin bonded fixed prosthesis (limited to 1 every 5 years)
• Dentures and partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
• Complete upper denture (limited to 1 every 5 years)
• Complete lower denture (limited to 1 every 5 years)
• Immediate upper denture (limited to 1 every 5 years)
• Immediate lower denture (limited to 1 every 5 years)
• Partial upper or lower, resin base – including any conventional clasps, rests and teeth (limited to 1 every 5 years)
• Partial upper or lower, cast metal base with resin saddles – including any conventional clasps, rests and teeth (limited to 1 every 5 years)
• Implants – only if determined as a dental necessity (limited to 1 per tooth every 5 years)
• Implant supported complete denture, partial denture (limited to 1 every 5 years)
• Surgical placement of interium implant body (limited to 1 every 5 years)
• Surgical placement of transosteal implant (limited to 1 every 5 years)
• Implant Maintenance Procedures (limited to 1 every 5 years)
• Custom abutment (limited to 1 every 5 years)
• Bone graft at time of implant placement (limited to 1 every 5 years)
• Repair implant prosthesis (limited to 1 every 5 years)
• Repair implant abutment (limited to 1 every 5 years)
• Replacement of semi-precision or precision attachment (limited to 1 every 5 years)
• Debridement/osseous contouring of a peri-implant defect (limited to 1 every 5 years)
• Surgical removal of implant body (limited to 1 every 5 years)
• Implant index (limited to 1 every 5 years)
• Connecting bar
• Stress breakers
• Removable appliance therapy
• Fixed appliance therapy
• Interim partial denture (stayplate), anterior only
• Occlusal guard (Occlusal guard adjustment not eligible within first 6 months after placement of appliance)

Orthodontic services – when medically necessary

• Orthodontic treatment (includes removal of appliances, construction and placement of retainer) (interceptive orthodontic treatment is not covered)
• Limited orthodontic treatment of the primary, transitional and adolescent dentition
• Comprehensive orthodontic treatment of the transitional and adolescent dentition
• Periodic orthodontic treatment visit (as part of contract)
• Pre-orthodontic treatment visit
6. Specific conditions

**Birthing center (facility charges)**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient <em>(room and board)</em> and other miscellaneous services and supplies</td>
<td>Paid at the same cost-sharing as hospital care.</td>
<td>Paid at the same cost-sharing as hospital care.</td>
</tr>
</tbody>
</table>

**Diabetic services and supplies (including equipment and training)**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic services and supplies (including equipment and training)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

**Family planning services – other**

**Voluntary sterilization for males**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient physician or specialist surgical services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Outpatient physician or specialist surgical services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

**Abortion**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient physician or specialist surgical services</td>
<td>75% (of the negotiated charge)</td>
<td>55% (of the recognized charge)</td>
</tr>
<tr>
<td>Outpatient physician or specialist surgical services</td>
<td>75% (of the negotiated charge)</td>
<td>55% (of the recognized charge)</td>
</tr>
</tbody>
</table>

**Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>TMJ and CMJ treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Description</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>Impacted wisdom teeth</td>
<td>75% (of the <strong>negotiated charge</strong>)</td>
<td>55% (of the <strong>recognized charge</strong>)</td>
</tr>
<tr>
<td>Accidental injury to sound natural teeth</td>
<td>75% (of the <strong>negotiated charge</strong>)</td>
<td>55% (of the <strong>recognized charge</strong>)</td>
</tr>
<tr>
<td>Dermatological treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Maternity care (includes delivery and postpartum care services in a <strong>hospital</strong> or birthing center)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Well newborn nursery care in a <strong>hospital</strong> or birthing center</td>
<td>75% (of the <strong>negotiated charge</strong>)</td>
<td>55% (of the <strong>recognized charge</strong>)</td>
</tr>
<tr>
<td>Important note:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If applicable, the per admission <strong>copayment</strong> and/or <strong>policy year deductible</strong> amounts for newborns will be waived for nursery charges for the duration of the newborn’s initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender affirming treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>
### Autism spectrum disorder

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism spectrum disorder diagnosis and testing</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Autism spectrum disorder treatment (includes <strong>physician</strong> and <strong>specialist</strong> office visits)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Applied behavior analysis</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

### Behavioral health

**Mental health treatment – inpatient**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient <strong>hospital mental health disorders</strong> treatment (room and board and other miscellaneous hospital services and supplies)</td>
<td>75% (of the negotiated charge) per admission</td>
<td>55% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Inpatient <strong>residential treatment facility mental health disorders</strong> treatment (room and board and other miscellaneous residential treatment facility services and supplies)</td>
<td>Coverage is provided under the same terms, conditions as any other illness.</td>
<td>Coverage is provided under the same terms, conditions as any other illness.</td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental health disorder room and board</strong> intensive care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Mental health treatment – outpatient

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient mental health disorders office visits to a physician or behavioral health provider (Includes telehealth consultations)</td>
<td>$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit Coverage is provided under the same terms, conditions as any other illness.</td>
<td></td>
</tr>
<tr>
<td>Other outpatient mental health disorders treatment (includes skilled behavioral health services in the home)</td>
<td>75% (of the negotiated charge) per visit</td>
<td>55% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Partial hospitalization treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive outpatient program</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Substance related disorders treatment – inpatient

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital substance related disorders detoxification (room and board and other miscellaneous hospital services and supplies)</td>
<td>75% (of the negotiated charge) per admission Coverage is provided under the same terms, conditions as any other illness.</td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital substance related disorders rehabilitation (room and board and other miscellaneous hospital services and supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient residential treatment facility substance related disorders (room and board and other miscellaneous residential treatment facility services and supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance related disorders room and board intensive care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Substance related disorders treatment – outpatient

**Detoxification and rehabilitation**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient substance related disorders office visits to a physician or behavioral health provider (Includes telehealth consultations)</td>
<td>$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit. Coverage is provided under the same terms, conditions as any other illness.</td>
<td>80% (of the recognized charge) per visit. Coverage is provided under the same terms, conditions as any other illness.</td>
</tr>
<tr>
<td>Other outpatient substance related disorder services</td>
<td>75% (of the negotiated charge) per visit. Coverage is provided under the same terms, conditions as any other illness.</td>
<td>55% (of the recognized charge) per visit. Coverage is provided under the same terms, conditions as any other illness.</td>
</tr>
</tbody>
</table>

**Obesity (bariatric) surgery**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity surgery – inpatient and outpatient facility and physician services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

**Reconstructive surgery and supplies**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconstructive surgery and supplies (includes reconstructive breast surgery)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

**Transplant services**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage (IOE facility)</th>
<th>Out-of-network coverage (Includes providers who are otherwise part of Aetna’s network but are non-IOE providers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient and outpatient transplant facility services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Inpatient and outpatient transplant physician and specialist services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Description</td>
<td>In-network coverage (IOE facility)</td>
<td>Out-of-network coverage (Includes providers who are otherwise part of Aetna’s network but are non-IOE providers)</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Human leukocyte antigen testing</td>
<td>$0 copayment, 0% coinsurance, no policy year deductible applies, up to $150</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Lifetime limit for Human leukocyte antigen laboratory testing fees</td>
<td>Once per lifetime</td>
<td></td>
</tr>
</tbody>
</table>

**Transplant services – travel and lodging**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage (IOE facility)</th>
<th>Out-of-network coverage (Includes providers who are otherwise part of Aetna’s network but are non-IOE providers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant services – travel and lodging</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Lifetime maximum</strong> payable for travel and lodging expenses for any one transplant, including tandem transplants</td>
<td>$10,000</td>
<td></td>
</tr>
<tr>
<td>Maximum payable for lodging expenses per IOE patient</td>
<td>$50 per night</td>
<td></td>
</tr>
<tr>
<td>Maximum payable for lodging expenses per companion</td>
<td>$50 per night</td>
<td></td>
</tr>
</tbody>
</table>

**Treatment of infertility**

**Basic infertility services**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient and outpatient care – basic infertility</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>
### 7. Specific therapies and tests

#### Outpatient diagnostic testing

**Diagnostic complex imaging services**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility</td>
<td>75% (of the <em>negotiated charge</em>) per visit</td>
<td>55% (of the <em>recognized charge</em>) per visit</td>
</tr>
</tbody>
</table>

**Diagnostic lab work and radiological services**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic lab work and radiological services performed in a physician’s office, the outpatient department of a hospital or other facility</td>
<td>75% (of the <em>negotiated charge</em>) per visit</td>
<td>55% (of the <em>recognized charge</em>) per visit</td>
</tr>
</tbody>
</table>

**Chemotherapy**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy</td>
<td>75% (of the <em>negotiated charge</em>) per visit</td>
<td>55% (of the <em>recognized charge</em>) per visit</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage (GCIT-designated facility/provider)</th>
<th>Out-of-network coverage (Including providers who are otherwise part of Aetna’s network but are not GCIT-designated facilities/providers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services and supplies</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

**Outpatient infusion therapy**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient infusion therapy performed in a covered person’s home, physician’s office, outpatient department of a hospital or other facility</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

**Outpatient radiation therapy**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient radiation therapy</td>
<td>75% (of the <em>negotiated charge</em>) per visit</td>
<td>55% (of the <em>recognized charge</em>) per visit</td>
</tr>
</tbody>
</table>
**Specialty prescription drugs**
Purchased and injected or infused by your **provider** in an outpatient setting

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty prescription drugs</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

**Outpatient respiratory therapy**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory therapy</td>
<td>75% (of the negotiated charge) per visit</td>
<td>55% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

**Transfusion or kidney dialysis of blood**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfusion or kidney dialysis of blood</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

**Short-term cardiac and pulmonary rehabilitation services**

**Cardiac rehabilitation**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac rehabilitation</td>
<td>75% (of the negotiated charge) per visit</td>
<td>55% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

**Pulmonary rehabilitation**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary rehabilitation</td>
<td>75% (of the negotiated charge) per visit</td>
<td>55% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

**Short-term rehabilitation and habilitation therapy services**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient physical, occupational, speech, and cognitive therapies</td>
<td>75% (of the negotiated charge) per visit</td>
<td>55% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Combined for short-term rehabilitation services and habilitation therapy services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Chiropractic services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic services</td>
<td>$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit</td>
<td>80% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Maximum visits per <strong>policy year</strong></td>
<td>40</td>
<td></td>
</tr>
</tbody>
</table>

### Diagnostic testing for learning disabilities

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic testing for learning disabilities</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>
### 8. Other services and supplies

#### Ambulance service

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency ground, air, and water ambulance</td>
<td>75% (of the negotiated charge) per trip</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td>(Includes non-emergency ambulance)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Clinical trial therapies (experimental or investigational)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical trial therapies</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

#### Clinical trials (routine patient costs)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical trial therapies</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

#### Durable medical equipment (DME)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable medical equipment</td>
<td>75% (of the negotiated charge) per item</td>
<td>55% (of the recognized charge) per item</td>
</tr>
</tbody>
</table>

#### Nutritional support

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional support</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

#### Prosthetic devices

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cochlear implants</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Prosthetic devices to replace an arm or a leg</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the negotiated charge) per item</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
</tbody>
</table>
### Hearing aids

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aids</td>
<td>75% (of the negotiated charge) per item</td>
<td>55% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Hearing aids maximum per ear</td>
<td>One hearing aid per ear every policy year</td>
<td></td>
</tr>
</tbody>
</table>

### Hearing exams

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing exams</td>
<td>75% (of the negotiated charge) per visit</td>
<td>55% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Hearing exam maximum</td>
<td>1 hearing exam every policy year</td>
<td></td>
</tr>
</tbody>
</table>

### Podiatric (foot care) treatment

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician and specialist non-routine foot care treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

### Vision care

**Pediatric vision care**

Limited to covered persons through the end of the month in which the person turns age 19

**Pediatric routine vision exams (including refraction)**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed by a legally qualified ophthalmologist or optometrist</td>
<td>100% (of the negotiated charge) per visit</td>
<td>80% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
</tbody>
</table>

**Pediatric comprehensive low vision evaluations**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed by a legally qualified ophthalmologist or optometrist</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Maximum</td>
<td>One comprehensive low vision evaluation every policy year</td>
<td></td>
</tr>
</tbody>
</table>
Pediatric vision care services and supplies

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit for fitting of contact lenses</td>
<td>100% (of the negotiated charge) per visit</td>
<td>80% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Maximum contact lens fitting visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td>Eyeglass frames, prescription lenses or prescription contact lenses</td>
<td>100% (of the negotiated charge) per item</td>
<td>80% (of the recognized charge) per item</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Maximum number of eyeglass frames per policy year</td>
<td>One set of eyeglass frames</td>
<td></td>
</tr>
<tr>
<td>Maximum number of prescription lenses per policy year</td>
<td>One pair of prescription lenses</td>
<td></td>
</tr>
<tr>
<td>Maximum number of prescription contact lenses per policy year (includes</td>
<td>Daily disposable: up to 3 month supply</td>
<td></td>
</tr>
<tr>
<td>non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)</td>
<td>Extended wear disposable: up to 6 month supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-disposable: one set</td>
<td></td>
</tr>
<tr>
<td>Optical devices</td>
<td>Covered according to the type of benefit and the place</td>
<td>Covered according to the type of benefit and the place</td>
</tr>
<tr>
<td></td>
<td>where the service is received.</td>
<td>where the service is received.</td>
</tr>
<tr>
<td>Maximum number of optical devices per policy year</td>
<td>One optical device</td>
<td></td>
</tr>
</tbody>
</table>

**Pediatric vision care important note:**
Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.

As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.
9. Outpatient prescription drugs

Plan features
Outpatient prescription drug benefits are subject to the medical plan’s maximum out-of-pocket limits as explained earlier in this schedule of benefits.

Policy year deductible and copayment waiver for risk reducing breast cancer
The outpatient prescription drug policy year deductible and the prescription drug copayment will not apply to risk reducing breast cancer prescription drugs filled at a retail or mail order in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.

Policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs
The outpatient prescription drug policy year deductible and 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 or mail order in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.

Your policy year deductible and any prescription drug copayment will apply after those two regimens per policy year have been exhausted.

Policy year deductible and copayment waiver for contraceptives
The policy year deductible and the prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy.

This means that such contraceptive methods are paid at 100% for:

- Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%.
- If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drugs or devices for that method paid at 100%.

The policy year deductible and 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.

Preferred generic prescription drugs (including specialty drugs)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30-day supply filled at a retail pharmacy</td>
<td>$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$20 copayment per supply then the plan pays 80% (of the balance of the recognized charge)</td>
</tr>
<tr>
<td>No policy year deductible applies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Preferred Generic Prescription Drugs (Including Specialty Drugs)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network Coverage</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30-day supply</td>
<td>$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$20 copayment per supply then the plan pays 80% (of the balance of the recognized charge)</td>
</tr>
<tr>
<td>supply filled at a <strong>retail pharmacy</strong></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Description</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy</td>
<td>$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$50 copayment per supply then the plan pays 80% (of the balance of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

Non-preferred generic prescription drugs (including specialty drugs)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30-day supply filled at a retail pharmacy</td>
<td>$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$60 copayment per supply then the plan pays 80% (of the balance of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy</td>
<td>$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$150 copayment per supply then the plan pays 80% (of the balance of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

Preferred brand-name prescription drugs (including specialty drugs)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30-day supply filled at a retail pharmacy</td>
<td>$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$30 copayment per supply then the plan pays 80% (of the balance of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy</td>
<td>$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$75 copayment per supply then the plan pays 80% (of the balance of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>
## Non-preferred brand-name prescription drugs (including specialty drugs)

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30-day supply filled at a <strong>retail pharmacy</strong></td>
</tr>
<tr>
<td>In-network coverage</td>
</tr>
<tr>
<td>$60 <strong>copayment</strong> per supply then the plan pays 100% (of the balance of the <strong>negotiated charge</strong>)*</td>
</tr>
<tr>
<td>No <strong>policy year deductible</strong> applies</td>
</tr>
<tr>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>$60 <strong>copayment</strong> per supply then the plan pays 80% (of the balance of the <strong>recognized charge</strong>)*</td>
</tr>
<tr>
<td>No <strong>policy year deductible</strong> applies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than a 30-day supply but less than a 90-day supply filled at a <strong>mail order pharmacy</strong></td>
</tr>
<tr>
<td>In-network coverage</td>
</tr>
<tr>
<td>$150 <strong>copayment</strong> per supply then the plan pays 100% (of the balance of the <strong>negotiated charge</strong>)*</td>
</tr>
<tr>
<td>No <strong>policy year deductible</strong> applies</td>
</tr>
<tr>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>$150 <strong>copayment</strong> per supply then the plan pays 80% (of the balance of the <strong>recognized charge</strong>)*</td>
</tr>
<tr>
<td>No <strong>policy year deductible</strong> applies</td>
</tr>
</tbody>
</table>

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## Diabetic insulin

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day supply at <strong>retail pharmacy</strong></td>
</tr>
<tr>
<td>In-network coverage</td>
</tr>
<tr>
<td>Paid according to the type of drug per the schedule of benefits above</td>
</tr>
<tr>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>Paid according to the type of drug per the schedule of benefits above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-day supply at <strong>mail order pharmacy</strong></td>
</tr>
<tr>
<td>In-network coverage</td>
</tr>
<tr>
<td>Paid according to the type of drug per the schedule of benefits above</td>
</tr>
<tr>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>Paid according to the type of drug per the schedule of benefits above</td>
</tr>
</tbody>
</table>

---

**Important note:**
Your cost share will not exceed $35 per 30 day supply of a covered **prescription insulin** drug filled at an **in-network pharmacy**. No **policy year deductible** applies for insulin.

---

## Orally administered anti-cancer prescription drugs (including specialty drugs)

<table>
<thead>
<tr>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>For each fill up to a 30-day supply filled at a <strong>specialty pharmacy</strong> or <strong>retail pharmacy</strong></td>
</tr>
<tr>
<td>In-network coverage</td>
</tr>
<tr>
<td>100% (of the <strong>negotiated charge</strong>)*</td>
</tr>
<tr>
<td>No <strong>policy year deductible</strong> applies</td>
</tr>
<tr>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>100% (of the <strong>recognized charge</strong>)*</td>
</tr>
<tr>
<td>No <strong>policy year deductible</strong> applies</td>
</tr>
</tbody>
</table>
### Contraceptives (birth control)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 12 month supply of generic and OTC drugs and devices filled at a retail pharmacy or mail order pharmacy</td>
<td>100% (of the <strong>negotiated charge</strong>)</td>
<td>100% (of the <strong>recognized charge</strong>)</td>
</tr>
<tr>
<td></td>
<td>No <strong>policy year deductible</strong> applies</td>
<td>No <strong>policy year deductible</strong> applies</td>
</tr>
<tr>
<td>For each fill up to a 12 month supply of <strong>brand-name prescription drugs</strong> and devices filled at a retail pharmacy or mail order pharmacy</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
</tr>
</tbody>
</table>

### Preventive care drugs and supplements

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care drugs and supplements filled at a retail pharmacy or mail order pharmacy</td>
<td>100% (of the <strong>negotiated charge</strong>) per <strong>prescription</strong> or <strong>refill</strong></td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
</tr>
<tr>
<td></td>
<td>No <strong>copayment</strong> or <strong>policy year deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td>For each 30-day supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive care drugs and supplements maximums</td>
<td>Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging in to your Aetna website at <a href="https://www.aetnastudenthealth.com">https://www.aetnastudenthealth.com</a> or calling the toll-free number on your ID card.</td>
<td></td>
</tr>
</tbody>
</table>

### Risk reducing breast cancer prescription drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk reducing breast cancer prescription drugs filled at a pharmacy</td>
<td>100% (of the <strong>negotiated charge</strong>) per <strong>prescription</strong> or <strong>refill</strong></td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
</tr>
<tr>
<td></td>
<td>No <strong>copayment</strong> or <strong>policy year deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td>For each 30-day supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk reducing breast cancer prescription drugs maximums</td>
<td>Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered risk reducing breast cancer <strong>prescription drugs</strong>, contact Member Services by logging in to your Aetna website at <a href="https://www.aetnastudenthealth.com">https://www.aetnastudenthealth.com</a> or calling the toll-free number on your ID card.</td>
<td></td>
</tr>
</tbody>
</table>
### Tobacco cessation prescription and over-the-counter drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco cessation <strong>prescription drugs</strong> and OTC drugs filled at a pharmacy</td>
<td>100% (of the negotiuated charge) per prescription or refill. No copayment or policy year deductible applies</td>
<td>Paid according to the type of drug per the schedule of benefits, above.</td>
</tr>
<tr>
<td>For each 30-day supply</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits.

Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging into your Aetna website at [https://www.aetnastudenthealth.com](https://www.aetnastudenthealth.com) or calling the toll-free number on your ID card.

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### Outpatient prescription drugs important note:

**Dispense As Written (DAW)**

If a **prescriber** prescribes a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If a **prescriber** does not specify DAW and you request a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **brand-name prescription drug** and the **generic prescription drug**, plus the cost sharing that applies to the **brand-name prescription drug**. The cost difference related to a **prescription drug** that is not specified as DAW is not applied towards your **policy year deductible** or maximum out-of-pocket limit.
General coverage provisions
This section provides detailed explanations about these features:

- Policy year deductibles
- Copayments
- Maximums
- Coinsurance
- Maximum out-of-pocket limits

Policy year deductible provisions
Eligible health services that are subject to the policy year deductible include covered benefits provided under the medical plan and outpatient prescription drug benefits provided under the prescription drug benefit.

Eligible health services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Eligible health services applied to the in-network policy year deductibles will not be applied to satisfy the out-of-network policy year deductibles.

The in-network and out-of-network policy year deductible may not apply to certain eligible health services. You must pay any applicable copayments for eligible health services to which the policy year deductible does not apply.

Individual
This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. See the Policy year deductibles provision at the beginning of this schedule for any exceptions to this general rule. This policy year deductible applies separately to you. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.

Copayments
In-network coverage
This is a specified dollar amount or percentage that must be paid by you when you receive eligible health services from an in-network provider. If Aetna compensates in-network providers on the basis of the negotiated charge amount, your percentage copayment is based on this amount.

Out-of-network coverage
This is a specified dollar amount or percentage that must be paid by your when you receive eligible health services from an out-of-network provider. If Aetna compensates out-of-network providers on the basis of the recognized charge amount, your percentage copayment is based on this amount.

Coinsurance
Coinsurance is both the percentage of eligible health services that the plan pays and what you pay. The specific percentage that we have to pay for eligible health services is listed earlier in the schedule of benefits. Coinsurance is not a copayment.
Maximum out-of-pocket limits provisions

Eligible health services that are subject to the maximum out-of-pocket limits include covered benefits provided under the medical plan and outpatient prescription drug benefits provided under the outpatient prescription drug benefit.

Eligible health services applied to the out-of-network maximum out-of-pocket limit will not be applied to satisfy the in-network maximum out-of-pocket limit. Eligible health services applied to the in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.

The maximum out-of-pocket limit is the maximum amount you are responsible to pay for copayments, coinsurance and policy year deductibles for eligible health services during the policy year. This plan has an individual maximum out-of-pocket limit.

Individual

Once the amount of the copayments, coinsurance and policy year deductibles you have paid for eligible health services during the policy year meets the individual maximum out-of-pocket limits, this plan will pay:

- 100% of the negotiated charge for in-network covered benefits
- 100% of the recognized charge for out-of-network covered benefits

that apply towards the limits for the rest of the policy year for that person.

Medical and outpatient prescription drugs

In-network care

Costs that you incur that do not apply to your in-network maximum out-of-pocket limits.

Certain costs that you incur do not apply toward the maximum out-of-pocket limit. These include:

- All costs for non-covered services

Calculations; determination of recognized charge; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one policy year. Determinations regarding when benefits are covered are subject to the terms and conditions of the certificate of coverage.
Student Health Insurance

Preferred Provider Organization (PPO)
Medical and Outpatient Prescription Drug Plan

Certificate of Coverage

Prepared exclusively for:

Policyholder: Husson University
Policyholder number: 686157
Student policy effective date: 08/01/23
Plan effective date: 08/01/23
Plan issue date: 11/30/23

Underwritten by Aetna Life Insurance Company

IMPORTANT NOTICES:

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

• Sanctioned Countries:
  If coverage provided under this student policy violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for eligible health services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). Visit https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx to find out more..
Welcome

Thank you for choosing Aetna®.

This is your certificate of coverage. It is one of three documents that together describe the benefits covered by your Aetna plan.

This certificate of coverage will tell you about your covered benefits – what they are and how you get them. It is your certificate of coverage under the student policy, and it replaces all certificates of coverage describing similar coverage that were previously sent to you. The second document is the schedule of benefits. It tells you how we share expenses for eligible health services and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the student policy between Aetna Life Insurance Company ("Aetna") and the policyholder. Ask the policyholder if you have any questions about the student policy.

Sometimes, we may send you documents that are amendments, endorsements, attachments, inserts or riders. They change or add to the documents that they’re part of. When you receive these, they are considered part of your Aetna plan for coverage.

Where to next? Take a look at the Table of contents section or try the Let’s get started! section right after it. The Let’s get started! section gives you a summary of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your Aetna plan.
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- When will your coverage end?
- Why would we suspend paying claims or end your coverage?

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- Continuation of coverage for other reasons

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- Entire student policy
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- Coverage and services
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- Some other money issues
- Your health information
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Glossary

Discount programs

Schedule of benefits

Issued with your certificate of coverage
Let’s get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire certificate of coverage and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words in the certificate of coverage and schedule of benefits

- When we say “you” and “your”, we mean the covered student
- When we say “us”, “we”, and “our”, we mean Aetna
- Some words appear in bold type and we define them in the Glossary section

Sometimes we use technical medical language that is familiar to medical providers.

What your plan does – providing covered benefits

Your plan provides covered benefits. These are eligible health services for which your plan has the obligation to pay.

This plan provides covered benefits for medical and pharmacy services.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after the eligibility and enrollment process is completed. To learn more see the Who the plan covers section.

Your coverage typically ends when you are no longer a student. To learn more see the When coverage ends section.

Ending coverage under the plan doesn’t necessarily mean you lose coverage with us. See the Special coverage options after your plan coverage ends section.

Eligible health services

Physician and hospital services are the foundation for many other services. You’ll probably find the preventive care, emergency services and urgent condition coverage especially important. But the plan won’t always cover the services you want. Sometimes it doesn’t cover health care services your physician will want you to have.

So what are eligible health services? They are health care services that meet these three requirements:

- They are listed in the Eligible health services and exclusions section.
- They are not carved out in the What your plan doesn’t cover – general exclusions section.
- They are not beyond any limits in the schedule of benefits.

Paying for eligible health services – the general requirements

There are several general requirements for the plan to pay any part of the expense for an eligible health service. They are:

- The eligible health service is medically necessary
- You get the eligible health service from an in-network provider or out-of-network provider
- You or your provider precertifies the eligible health service when required

You will find details on medical necessity and precertification requirements in the Medical necessity and precertification requirements section.
Paying for eligible health services – sharing the expense
Generally your plan and you will share the expense of your eligible health services when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense and sometimes you will. For more information see the What the plan pays and what you pay section, and see the schedule of benefits.

Disagreements
We know that people sometimes see things differently.

The plan tells you how we will work through our differences. And if we still disagree, an independent group of experts called an “external review organization” or ERO for short, will make the final decision for us.

For more information see the When you disagree - claim decisions and appeals procedures section.

How your plan works while you are covered for in-network coverage
Your in-network coverage helps you:
• Get and pay for a lot of – but not all – health care services
• Pay less cost share when you use an in-network provider

Generally your in-network coverage will pay only when you get care from an in-network provider.

School health services
School health services can give you some of the care that you need. Contact them first before seeking care.

School health services will generally provide your routine care and send you to other providers when you need specialized care or services that school health services cannot provide.

You don’t have to access care through school health services. You may go directly to in-network providers for eligible health services. Your plan often will pay a bigger share for eligible health services that you get through school health services.

For more information about in-network providers and the role of school health services, see the Who provides the care section.

Aetna’s network of providers
Aetna’s network of physicians, hospitals and other health care providers is there to give you the care that you need. You can find in-network providers and see important information about them most easily on our online provider directory. Just log in to your Aetna website at https://www.aetnastudenthealth.com.

If you can’t find an in-network provider for a service or supply that you need, call Member Services at the toll-free number on your ID card. We will help you find an in-network provider. If we can’t find one, we may give you a pre-approval to get the service or supply from an out-of-network provider. When you get a pre-approval for an out-of-network provider, covered benefits are paid at the in-network coverage level of benefits.
How your plan works while you are covered for out-of-network coverage

The section above told you how your plan works while you are covered for in-network coverage. You also have coverage when:

- You want to get your care from providers who are not part of the Aetna network

It’s called out-of-network coverage. Your out-of-network coverage helps you get and pay for a lot of – but not all – health care services.

Your out-of-network coverage:
- Means you can get care from providers who are not part of the Aetna network.
- Means you will have to pay for services at the time that they are provided. You will be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of eligible health services that you paid directly to a provider.
- Means that when you use out-of-network coverage, it is your responsibility to start the precertification process with providers.
- Means you may pay a higher cost share when you use an out-of-network provider.

You will find details on:
- Precertification requirements in the Medical necessity and precertification requirements section.
- Out-of-network providers and any exceptions in the Who provides the care section.
- Cost sharing in the What the plan pays and what you pay section, and your schedule of benefits.
- Claim information in the When you disagree - claim decisions and appeals procedures section.

Surprise bill

There may be times when you unknowingly receive services or don’t consent to receive services from an out-of-network provider, even when you try to stay in the network for your eligible health services. You may get a bill at the out-of-network rate that you didn’t expect. This is called a surprise bill.

An out-of-network provider can’t balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirements, such as deductibles, copayments and coinsurance for the following services:
- Emergency services provided by an out-of-network provider and ancillary services initiated from your emergency service
- Non-emergency services provided by an out-of-network provider at an in-network facility, except when the out-of-network provider has given you the following:
  - The out-of-network notice for your signature
  - The estimated charges for the items and services
  - Notice that the provider is an out-of-network provider
- Out-of-network air ambulance services

The out-of-network provider must get your consent to be treated and balance billed by them.

Ancillary services mean any professional services including:
- Anesthesiology
- Hospitalist services
- Items and services related to emergency medicine
- Laboratory services
- Neonatology
• Pathology
• Radiology
• Services provided by an **out-of-network provider** because there was no **in-network provider** available to perform the service

A facility in this instance means an institution providing health care related services, or a health care setting. This includes the following:

- Hospitals and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- Skilled nursing facilities
- Residential treatment facilities
- Diagnostic, laboratory, and imaging centers
- Rehabilitation facilities
- Other therapeutic health settings

A surprise bill claim is paid based on the median contracted rate for all plans offered by us in the same insurance market for the same or similar item or service that is all of the following:

- Provided by a **provider** in the same or similar specialty or facility of the same or similar facility type
- Provided in the geographic region in which the item or service is furnished

The median contracted rate is subject to additional adjustments as specified in federal regulations.

Any cost share paid with respect to the items and services will apply toward your in-network **deductible** and **maximum out-of-pocket limit** if you have one.

It is not a surprise bill when you knowingly choose to go out-of-network and have signed a consent notice for these services. In this case, you are responsible for all charges.

If you receive a surprise bill or have any questions about what a surprise bill is, contact us.

**How to contact us for help**

We are here to answer your questions. You can contact us by:

- Calling our Member Services at the toll-free number on your ID card 1-877-626-2308
- Writing us at Aetna Life Insurance Company, 151 Farmington Ave, Hartford, CT 06156
- Visiting [https://www.aetnastudenthealth.com](https://www.aetnastudenthealth.com) to register and access your Aetna website.

Aetna’s online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

**Your ID card**

We issued to you a digital ID card which you can view or print by going to the website at [https://www.aetnastudenthealth.com](https://www.aetnastudenthealth.com). When visiting **physicians**, **hospitals**, and other **providers**, you don't need to show them an ID card. Just provide your name, date of birth and either your digital ID card or social security number. The **provider** office can use that information to verify your eligibility and benefits.

Remember, only you can use your digital ID card. If you misuse your card by allowing someone else to use it, that is fraud and we may end your coverage. See the **Honest mistakes and intentional deception** section for details.

If you don’t have internet access, call Member Services at the toll-free number in the **How to contact us for help** section. You can also access your ID card when you’re on the go. To learn more, visit us at [https://www.aetnastudenthealth.com](https://www.aetnastudenthealth.com).
Who the plan covers

The **policyholder** decides and tells us who is eligible for health care coverage.

You will find information in this section about:
- Who is eligible?
- When you can join the plan
- Special times you can join the plan

Who is eligible?
You are eligible if you are a:
- Full-time student

Medicare eligibility
You are not eligible for health coverage under this **student policy** if you have **Medicare** at the time of enrollment in this student plan.

If you obtain **Medicare** after you enrolled in this student plan, your health coverage under this plan will not end.

As used here, “have **Medicare**” means that you are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

When you can join the plan
As a student you can enroll yourself:
- During the enrollment period
- At other special times during the year (see the **Special times you can join the plan** section below)

If you do not enroll yourself when you first qualify for medical benefits, you may have to wait until the next enrollment period to join.

Notification of change in status
It is important that you notify us and the **policyholder** of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us and the **policyholder** as soon as possible of status changes such as:
- Change of address or phone number
- Change in marital status
- Enrollment in **Medicare**
- You enroll in any other health plan

Special times you can join the plan
You can enroll in these situations:
- When you did not enroll in this plan before because:
  - You were covered by another health plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
- You become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.
- When you are a victim of domestic abuse or spousal abandonment and you don’t want to be enrolled in the perpetrator’s health plan.
We must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

**Effective date of coverage**

**Enrollment**

**Student coverage**

If you enrolled on or before the effective date of the student policy and you were eligible for health benefits at the time, your coverage will take effect as of the effective date of the student policy. Your coverage will take effect on this date if we received your completed enrollment application or you did not submit a waiver form to waive automatic enrollment in the student plan and you paid any required **premium** contribution.

If you enroll after the effective date of the student policy and you are eligible for health benefits at the time, your coverage will take effect as of that date as long as:

- We agree
- We receive your completed request for enrollment
- You pay any **premium** contribution.

**Late enrollment**

If we receive your enrollment application and **premium** contribution more than 31 days after the date you become eligible, coverage will only become effective if, and when:

- We agree to enroll you
- You enroll during the policyholder’s late enrollment period, or
- You enroll because you lost coverage for any reason under another health plan with similar health coverage.
Medical necessity and precertification requirements

The starting point for covered benefits under your plan is whether the services and supplies are eligible health services. See the Eligible health services and exclusions and General exclusions sections plus the schedule of benefits.

Your plan pays for its share of the expense for eligible health services only if the general requirements are met. They are:

- The eligible health service is medically necessary
- You or your provider precertifies the eligible health service when required

This section addresses the medical necessity and precertification requirements.

Medically necessary; medical necessity

As we said in the Let's get started! section, medical necessity is a requirement for you to receive a covered benefit under this plan.

The medical necessity requirements are stated in the Glossary section, where we define "medically necessary, medical necessity". That is where we also explain what our medical directors or their physician designees consider when determining if an eligible health service is medically necessary.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

Precertification

You need precertification from us for some eligible health services.

Precertification for medical services and supplies

In-network care

Your in-network physician is responsible for obtaining any necessary precertification before you get the care. If your in-network physician doesn't get a required precertification, we won't pay the provider who gives you the care. You won't have to pay either if your in-network physician fails to ask us for precertification. If your in-network physician requests precertification and we refuse it, you can still get the care but the plan won't pay for it. You will find details on requirements in the What the plan pays and what you pay - Important exceptions – when you pay all section.

Out-of-network care

When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify, your benefits may be reduced, or the plan may not pay any benefits. Refer to your schedule of benefits for this information. The list of services and supplies requiring precertification appears later in this section.
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. This must be made for:

<table>
<thead>
<tr>
<th>Type of Admission</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-emergency admissions</td>
<td>You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.</td>
</tr>
<tr>
<td>An emergency admission</td>
<td>You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>An urgent admission</td>
<td>You, your physician or the facility will need to call before you are scheduled to be admitted. 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.</td>
</tr>
<tr>
<td>Outpatient non-emergency services requiring precertification</td>
<td>You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.</td>
</tr>
</tbody>
</table>

Notification calls for certain medical conditions

You must notify us for certain medical conditions within the timeframe specified below. No penalty will apply if you fail to notify us. To notify us, call the Member Services toll-free number on your ID card.

<table>
<thead>
<tr>
<th>Type of Notification</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification call for an emergency medical condition</td>
<td>You, your physician or the facility must call us within 24 hours or as soon as reasonably possible after receiving emergency outpatient care, treatment or procedure.</td>
</tr>
</tbody>
</table>

Written notification of precertification decisions

We will provide a written notification to you and your physician of the precertification decision within 72 hours or 2 business days, whichever is less, where required by state law and within the timeframe specified by state law. If your precertified services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

Inpatient and outpatient precertification

When you have an inpatient admission to a facility, we will notify you, your physician and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days will need to be precertified. You, your physician, or the facility will need to call us at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. We will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

When you have an outpatient service or supply that requires precertification, we will notify you, your physician and the facility about your precertified outpatient service or supply. If your physician recommends that your outpatient service or supply benefits be extended, the additional outpatient benefits will need to be precertified. You, your physician, or the facility will need to call us at the number on your ID card as soon as reasonably possible, but no later than the final day of the authorized outpatient service or supply. We will review and process the request for the extended outpatient benefits. You and your physician will receive a notification of an approval or denial.

If precertification determines that the stay or outpatient services and supplies are not covered benefits, the notification will explain why and how you can appeal our decision. You or your provider may request a review of the precertification decision. See the When you disagree - claim decisions and appeals procedures section.
What if you don't obtain the required precertification?
If you don’t obtain the required precertification:
• You will be responsible for the unpaid balance of the bills.
• Any additional out-of-pocket expenses incurred will not count toward your out-of-network policy year deductibles or maximum out-of-pocket limits.

What types of services and supplies require precertification?
Precertification is required for the following types of services and supplies:

<table>
<thead>
<tr>
<th>Inpatient services and supplies</th>
<th>Outpatient services and supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Affirming Treatment</td>
<td>Applied behavior analysis</td>
</tr>
<tr>
<td>Gene-based, cellular and other innovative therapies (GCIT)</td>
<td>ART Services</td>
</tr>
<tr>
<td>Obesity (bariatric) surgery</td>
<td>Certain prescription drugs and devices*</td>
</tr>
<tr>
<td>Stays in a hospice facility</td>
<td>Complex imaging</td>
</tr>
<tr>
<td>Stays in a hospital</td>
<td>Comprehensive infertility services</td>
</tr>
<tr>
<td>Stays in a rehabilitation facility</td>
<td>Cosmetic and reconstructive surgery</td>
</tr>
<tr>
<td>Stays in a residential treatment facility for treatment of mental health disorders and substance related disorders</td>
<td>Gender Affirming Treatment</td>
</tr>
<tr>
<td>Stays in a skilled nursing facility</td>
<td>Gene-based, cellular and other innovative therapies (GCIT)</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
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<tr>
<td></td>
<td>Hospice services</td>
</tr>
<tr>
<td></td>
<td>Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)*</td>
</tr>
<tr>
<td></td>
<td>Kidney dialysis</td>
</tr>
<tr>
<td></td>
<td>Knee surgery</td>
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<tr>
<td></td>
<td>Non-emergency transportation by airplane</td>
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<tr>
<td></td>
<td>Outpatient back surgery not performed in a physician’s office</td>
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<tr>
<td></td>
<td>Partial hospitalization treatment – mental health disorder and substance related disorders treatment</td>
</tr>
<tr>
<td></td>
<td>Private duty nursing services</td>
</tr>
<tr>
<td></td>
<td>Sleep studies</td>
</tr>
<tr>
<td></td>
<td>Transcranial magnetic stimulation (TMS)</td>
</tr>
<tr>
<td></td>
<td>Wrist surgery</td>
</tr>
</tbody>
</table>

*For a current listing of the prescription drugs and medical injectable drugs that require precertification, contact Member Services by calling the toll-free number on your ID card or by logging in to the Aetna website at https://www.aetnastudenthealth.com.

Sometimes you or your provider may want us to review a service that doesn’t require precertification before you get care. This is called a predetermination, and it is different from precertification. Predetermination means that you or your provider requests the pre-service clinical review of a service that does not require precertification.
Precertification for prescription drugs and devices
Certain prescription drugs and devices are covered under the medical plan when they are given to you by your physician or health care facility and not obtained at a pharmacy. The following precertification information applies to these prescription drugs and devices.

For certain prescription drugs and devices, your prescriber or your pharmacist needs to get approval from us before we will agree to cover the prescription drug or device for you. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain prescription drugs and devices and makes sure there is a medically necessary need for the prescription drug or device. For the most up-to-date information, call Member Services at the toll-free number on your ID card or log in to your Aetna website at https://www.aetnastudenthealth.com.

For the prescription of at least one drug for each therapeutic class of medication used in medication-assisted treatment for opioid disorder, precertification is not required. A precertification request for a drug guide medication prescribed to assess or treat a serious mental illness will be approved.

Step therapy
There is another type of precertification for prescription drugs, and that is step therapy. Step therapy is a type of precertification where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. However, step therapy is not required for a prescription drug prescribed to assess or treat a serious mental illness.

You can obtain the most up-to-date information about step therapy prescription drugs by calling Member Services at the toll-free number on your ID card or by logging in to your Aetna website at https://www.aetnastudenthealth.com. Your physician can find additional details about the step therapy prescription drugs in our clinical policy bulletins.

How can I request a medical exception?
Sometimes you or your provider may ask for a medical exception for prescription drugs that are not covered or for which coverage was denied. You, someone who represents you or your provider can contact us. You will need to provide us with the required clinical documentation. Any exception granted is based upon an individual and is a case by case decision that will not apply to other covered persons.

For directions on how you can submit a request for a review:
• Contact Member Services at the toll-free number on your ID card 1-877-626-2308
• Go online at https://www.aetnastudenthealth.com
• Submit the request in writing to CVS Health, ATTN: Aetna PA, 1300 E Campbell Road, Richardson, TX 75081

You, someone who represents you or your provider may seek a quicker medical exception when the situation is urgent. It’s an urgent situation when you have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug. We will make a coverage decision within 24 hours after we receive your request. We will tell you, someone who represents you, or your provider of our decision.
Eligible health services and exclusions

The information in this section is the first step to understanding your plan's eligible health services. These services are:

- Described in this section
- Not listed as exclusions in this section or the General exclusions section
- Not beyond any limitations in the schedule of benefits

Your plan covers many kinds of health care services and supplies, such as physician care and hospital stays. But sometimes those services are not covered at all or are covered only up to a limit.

For example:

- Physician care generally is covered but physician care for cosmetic surgery is never covered. This is an exclusion.
- Home health care is generally covered but it is a covered benefit only up to a set number of visits a year. This is a limitation.

We explain eligible health services and exclusions in this section. You can find out about general exclusions in the General exclusions section and about limitations in the schedule of benefits.

We've grouped the health care services below to make it easier for you to find what you're looking for.

**Important note:**

Sex-specific eligible health services are covered when medically appropriate, regardless of identified gender.

1. Preventive care and wellness

This section describes the eligible health services and supplies available under your plan when you are well. Your plan pays the entire expense for all covered benefits under the Preventive care and wellness section.
Important notes:

1. You will see references to the following recommendations and guidelines in this section:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
   - United States Preventive Services Task Force
   - Health Resources and Services Administration
   - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

   These recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the calendar year, one year after the updated recommendation or guideline is issued.

2. Diagnostic testing for the treatment or diagnosis of a medical condition will not be covered under the preventive care and wellness benefit. For those types of tests and treatment, you will pay the cost sharing specific to eligible health services for diagnostic testing and treatment.

3. Gender-specific preventive care and wellness benefits include eligible health services described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your physician or contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or by calling the toll-free number on your ID card. This information can also be found at the https://www.healthcare.gov website.

Routine physical exams

Eligible health services include office visits to your physician or other health professional for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- 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
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
  - Screening for gestational diabetes for women
  - High-risk Human Papillomavirus (HPV) DNA testing for women age 30 and older
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial hospital checkup
Preventive care immunizations

Eligible health services include immunizations provided by your physician or other health professional for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

The following is not covered under this benefit:
- Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment

COVID-19 diagnosis and prevention

Covered services include:
- Screening
- Testing
- Immunizations

Well woman preventive visits

Eligible health services include your routine:
- Well woman preventive exam office visit to your physician, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes Pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury.
- Preventive care breast cancer (BRCA) gene blood testing by a physician and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.

Preventive screening and counseling services

Eligible health services include screening and counseling by your health professional for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting.

Here is more detail about those benefits:
- **Obesity and/or healthy diet counseling**
  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**
  Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment
• **Use of tobacco products**
  **Eligible health services** include the following screening and counseling services to help you to stop the use of tobacco products:
  - Preventive counseling visits

  Tobacco product means a substance containing tobacco or nicotine such as:
  - Cigarettes
  - Cigars
  - Smoking tobacco
  - Snuff
  - Smokeless tobacco
  - Candy-like products that contain tobacco

• **Sexually transmitted infection counseling**
  **Eligible health services** include the counseling services to help you prevent or reduce sexually transmitted infections.

• **Genetic risk counseling for breast and ovarian cancer**
  **Eligible health services** include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

**Routine cancer screenings**

**Eligible health services** include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies (includes:
  - Bowel preparation medications
  - Anesthesia
  - Removal of polyps performed during a screening procedure
  - Pathology exam on any removed polyps)
- Lung cancer screenings
- Colorectal cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration
**Prenatal care**

*Eligible health services* include your routine prenatal physical exams as *Preventive Care and wellness*, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height
- Preeclampsia screening

You can get this care at your physician's, OB's, GYN's, or OB/GYN's office.

**Important note:**
You should review the benefit under *Eligible health services and exclusions – Maternity care and Well newborn nursery care* section of this certificate of coverage for more information on coverage for pregnancy expenses under this plan.

**Comprehensive lactation support and counseling services**

*Eligible health services* include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast-feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support provider.

**Breast feeding durable medical equipment**

*Eligible health services* include renting or buying *durable medical equipment* you need to pump and store breast milk as follows:

**Breast pump**

*Eligible health services* include:

- Renting a hospital grade electric pump while your newborn child is confined in a hospital
- The buying of:
  - An electric breast pump (non-hospital grade, cost is covered by your plan once every 12 months) or
  - A manual breast pump (cost is covered by your plan once per pregnancy)

If an electric breast pump was purchased within the previous 12 months period, the purchase of another electric breast pump will not be covered until a 12 month period has elapsed since the last purchase.

**Breast pump supplies and accessories**

*Eligible health services* include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose. Including the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.
Family planning services – female contraceptives

Eligible health services include family planning services such as:

Counseling services
Eligible health services include counseling services provided by a provider on contraceptive methods. These will be covered when you get them in either a group or individual setting.

Contraceptives
Eligible health services include contraceptive prescription drugs and devices (including any related services or supplies) when they are provided by, administered, or removed by a provider.

Voluntary sterilization
Eligible health services include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

Important note:
See the following sections for more information:
- Family planning services - other
- Maternity care
- Well newborn nursery care
- Treatment of infertility
- Outpatient prescription drugs

The following are not covered under this benefit:
- Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a provider
2. Physicians and other health professionals

Physician and specialist services (non-surgical and non-preventive)

Eligible health services include services provided by your physician to treat an illness or injury such as radiological supplies, services and tests. You can get those services:
- At the physician’s or specialist’s office
- In your home
- From any other inpatient or outpatient facility
- By way of telehealth

Important note:
Your student policy covers telehealth. All in-person physician or specialist office visits that are covered benefits are also covered if you use telehealth instead.

Telehealth provided by a physician or specialist may have different cost sharing than other outpatient services. See the schedule of benefits for more information.

Allergy testing and treatment

Eligible health services include the services and supplies that your physician or specialist may provide for:
- Allergy testing
- Allergy injections treatment

The following are not covered under this benefit:
- Allergy sera and extracts administered via injection

Physician and specialist – inpatient surgical services

Eligible health services include the services of:
- The surgeon who performs your surgery while you are confined in a hospital or birthing center
- Your surgeon who you visit before and after the surgery

When your surgery requires two or more surgical procedures:
- Using the same approach and at the same time or
- Right after each other

we will pay for the one that costs the most.

Coverage includes eligible health services provided by a licensed mid-wife.

Anesthetist

Covered benefits for your surgery include the services of an anesthetist who is not employed or retained by the hospital where the surgery is performed.
Surgical assistant
Covered benefits for your surgery include the services of a surgical assistant. A “surgical assistant” is a health professional trained to assist in surgery and during the periods before and after surgery. A surgical assistant is under the supervision of a physician.

The following are not covered under this benefit:
- The services of any other physician who helps the operating physician
- A stay in a hospital (Hospital stays are covered in the Eligible health services and exclusions – Hospital and other facility care section)
- Services of another physician for the administration of a local anesthetic

Physician and specialist – outpatient surgical services
Eligible health services include the services of:
- The surgeon who performs your surgery in the outpatient department of a hospital or surgery center
- Your surgeon who you visit before and after the surgery

Covered benefits include hospital or surgery center services provided within 24 hours of the surgical procedure.

Anesthetist
Covered benefits for your surgery include the services of an anesthetist who is not employed or retained by the hospital or surgery center where the surgery is performed.

Surgical assistant
Covered benefits for your surgery include the services of a surgical assistant. A “surgical assistant” is a health professional trained to assist in surgery and during the periods before and after surgery. A surgical assistant is under the supervision of a physician.

The following are not covered under this benefit:
- The services of any other physician who helps the operating physician
- A stay in a hospital (Hospital stays are covered in the Eligible health services and exclusions – Hospital and other facility care section)
- A separate facility charge for surgery performed in a physician’s office
- Services of another physician for the administration of a local anesthetic

In-hospital non-surgical physician services
During your stay in a hospital for surgery, eligible health services include the services of physician employed by the hospital to treat you. The physician does not have to be the one who performed the surgery.
Consultant services (non-surgical and non-preventive)

Eligible health services include the services of a consultant to confirm a diagnosis made by your physician or to determine a diagnosis. Your physician or specialist must make the request for the consultant services.

Covered benefits by a physician or specialist include treatment by the consultant.

The consultation may happen by way of telehealth.

Important note:

Your student policy covers telehealth. All in-person consultant office visits provided by a physician or specialist that are covered benefits are also covered if you use telehealth instead.

Telehealth provided by a physician or specialist may have different cost sharing than other outpatient services. See the schedule of benefits for more information.

Second surgical opinion

Eligible health services include a second surgical opinion by a specialist to confirm your need for a surgery. The specialist must be board-certified in the medical field for the surgery that is being proposed by your physician.

Covered benefits include diagnostic lab work and radiological services ordered by the specialist.

We must receive a written report from a specialist on the second surgical opinion.

Alternatives to physician and specialist office visits

Walk-in clinic (non-emergency visit)

Eligible health services include, but are not limited to, health care services provided at walk-in clinics for:

- Scheduled and unscheduled visits for illnesses and injuries that are not emergency medical conditions
- Preventive care immunizations administered within the scope of the clinic’s license
3. Hospital and other facility care

Hospital care (facility charges)
Eligible health services include inpatient and outpatient hospital care.

The types of hospital care services that are eligible for coverage include:
- Room and board charges up to the hospital's semi-private room rate.
- Services of health professionals employed by the hospital
- Operating and recovery rooms
- Intensive care units of a hospital
- Administration of blood and blood derivatives, but not the expense of the blood or blood product
- Radiation therapy
- Inhalation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a hospital

Preadmission testing
Eligible health services include pre-admission testing on an outpatient basis before a scheduled surgery.

For your preadmission testing to be eligible for coverage, the following conditions must be met:
- The testing is related to the scheduled surgery
- The testing is done within the 7 days before the scheduled surgery and
- The testing is not repeated in, or by, the hospital or surgery center where the surgery is done

Anesthesia and related facility charges for a dental procedure
Eligible health services include:
- General anesthesia
- Charges made by an anesthetist
- Related hospital or surgery center charges

for your dental procedure.

The following conditions must be met:
- Your dental provider cannot safely perform the oral surgery in a dental office setting

All other non-facility charges are covered under the Pediatric dental care section if you are eligible for that coverage.

Alternatives to hospital stays

Outpatient surgery (facility charges)
Eligible health services include facility services provided and supplies used in connection with outpatient surgery performed in a surgery center or a hospital's outpatient department.
Important note:
Some surgeries can be done safely in a physician’s office. For those surgeries, your plan will pay only for physician services and not a separate facility fee.

The following are not covered under this benefit:
- The services of any other physician who helps the operating physician
- A stay in a hospital (See the Hospital care – facility charges benefit in this section)
- A separate facility charge for surgery performed in a physician’s office
- Services of another physician for the administration of a local anesthetic, except as specifically covered in connection with another eligible health service as described in this student policy

Home health care
Eligible health services include home health care services provided by a home health care agency in the home, but only when all of the following criteria are met:
- You are homebound
- Your physician orders them
- The services take the place of your needing to stay in a hospital or a skilled nursing facility, or needing to receive the same services outside your home
- The services are part of a home health care plan
- The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a physician or social worker

Short-term physical, speech and occupational therapy provided in the home are subject to the conditions and limitations imposed on therapy provided outside the home. See the Short-term rehabilitation services and Habilitation therapy services sections and the schedule of benefits.

Home health care services do not include custodial care.

The following are not covered under this benefit:
- Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Homemaker or housekeeper services
- Food or home delivered services
- Maintenance therapy

Hospice care
Eligible health services include inpatient and outpatient hospice care when given as part of a hospice care program because your physician diagnoses you with a terminal illness.

The types of hospice care services that are eligible for coverage include:
- Room and board
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a hospital
• Part-time or intermittent nursing care by a R.N. or L.P.N. for up to eight hours a day
• Part-time or intermittent home health aide services to care for you up to eight hours a day
• Medical social services under the direction of a physician such as:
  - Assessment of your social, emotional and medical needs, and your home and family situation
  - Identification of available community resources
  - Assistance provided to you to obtain resources to meet your assessed needs
• Respite care

Hospice care services provided by the providers below may be covered, even if the providers are not an employee of the hospice care agency responsible for your care:
• A physician for consultation or case management
• A physical or occupational therapist
• A home health care agency for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient prescription drugs
  - Psychological counseling
  - Dietary counseling

The following are not covered under this benefit:
• Funeral arrangements
• Counseling
• Bereavement counseling
• Financial or legal counseling which includes estate planning and the drafting of a will
• Homemaker or caretaker services that are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

Skilled nursing facility
Eligible health services include inpatient skilled nursing facility care.

The types of skilled nursing facility care services that are eligible for coverage include:
• Room and board, up to the semi-private room rate
• Services and supplies that are provided during your stay in a skilled nursing facility

For your stay in a skilled nursing facility to be eligible for coverage, the following conditions must be met:
• The skilled nursing facility admission will take the place of:
  - An admission to a hospital or sub-acute facility or
  - A continued stay in a hospital or sub-acute facility.
• There is a reasonable expectation that your condition will improve enough to go home within a reasonable amount of time
• The illness or injury is severe enough to require constant or frequent skilled nursing care on a 24-hour basis
4. Emergency services and urgent care

Eligible health services include services and supplies for the treatment of an emergency medical condition or an urgent condition.

Emergency services coverage for an emergency medical condition includes your use of:

- An ambulance
- The emergency room facilities
- The emergency room staff physician services
- The hospital nursing staff services
- The staff radiologist and pathologist services

As always, you can get emergency services from in-network providers. However, you can also get emergency services from out-of-network providers.

Your coverage for emergency services will continue until the following conditions are met:

- You are evaluated and your condition is stabilized
- Your attending physician determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another provider if you need more care

For follow-up care, you are covered when:

- Your in-network physician provides the care.
- You use an out-of-network provider to provide the care. If you use an out-of-network provider to receive follow-up care, you may be subject to a higher out-of-pocket expense.

In case of a medical emergency

When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance assistance. If possible, call your physician but only if a delay will not harm your health.

Non-emergency condition

If you go to an emergency room for what is not an emergency medical condition, the plan will not cover your expenses. See the schedule of benefits for specific plan details.

Examples of non-emergency care are:

- Routine or preventive care (including immunizations)
- Follow-up care
- Physical therapy
- Elective treatment
- Any diagnostic lab work and radiological services which are not related to the treatment of the emergency medical condition

The following are not covered under this benefit:

- Non-emergency services in a hospital emergency room facility
In case of an urgent condition

Urgent condition
If you need care for an urgent condition, you should first seek care through your physician or school health services. If your physician or school health services is not reasonably available to provide services, you may access urgent care from an urgent care facility.

Non-urgent care
If you go to an urgent care facility for what is not an urgent condition, the plan will not cover your expenses. See the schedule of benefits for specific plan details.

Examples of non-urgent care are:

- Routine or preventive care (this includes immunizations)
- Follow-up care
- Physical therapy
- Elective treatment
- Any diagnostic lab work and radiological services which are not related to the treatment of the urgent condition

The following is not covered under this benefit:

- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)
5. Pediatric dental care

Eligible health services include dental services and supplies provided by a dental provider as found in the Pediatric dental care section of the schedule of benefits.

Dental emergencies

Eligible health services also include dental services provided for a dental emergency. Services and supplies provided for a dental emergency will be covered even if services and supplies are provided by an out-of-network provider.

If you have a dental emergency, you should consider calling your in-network dental provider who may be more familiar with your dental needs. If you cannot reach your in-network dental provider, you may get treatment from any dentist. The care received from an out-of-network provider must be for the temporary relief of the dental emergency until you can be seen by your in-network dental provider. Services given for other than the temporary relief of the dental emergency by an out-of-network provider can cost you more. To get the maximum level of benefits, services should be provided by your in-network dental provider.

If you get treatment from an out-of-network provider for a dental emergency, the plan pays a benefit at the in-network cost-sharing level of coverage.

Follow-up care will be paid at the cost-sharing level that applies to the type of provider that gives you the care.

Orthodontic treatment?

Orthodontic treatment is covered for a severe, dysfunctional, disabling condition, such as:

- Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement
- The following craniofacial anomalies:
  - Hemifacial microsomia
  - Craniosynostosis syndromes
  - Cleidocranial dental dysplasia
  - Arthrogryposis
  - Marfan syndrome
- Anomalies of facial bones and/or oral structures
- Facial trauma resulting in functional difficulties

If you suffer from one of these conditions, the orthodontic services that are eligible for coverage include:

- Pre-orthodontic treatment visit
- Comprehensive orthodontic treatment
- Orthodontic retention (removal of appliances, construction and placement of retainers(s)
Replacements
The plan’s “replacement rule” applies to:

- Crowns
- Inlays
- Onlays
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

The “replacement rule” means that replacements of, or additions to, these dental services are covered only when:

- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay, onlay and veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be fixed.
- You had a tooth (or teeth) extracted. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Missing teeth that are not replaced
The plan covers installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years.

Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Getting an advance claim review
This only applies to out-of-network coverage. The purpose of the advance claim review is to determine, in advance, what we will pay for proposed services. Knowing ahead of time which services are covered and the benefit amount payable, helps you and your dental provider make informed decisions about the care you are considering.

Important note:
The advance claim review is not a guarantee of coverage and payment, but rather an estimate of the amount or scope of benefits to be paid.
When to get an advance claim review

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $350. Here are the steps to get an advance claim review:

1. Ask your dental provider to write down a full description of the treatment you need, using either an Aetna claim form or an American Dental Association (ADA) approved claim form
2. Before treating you, your dental provider should send the form to us
3. We may request supporting images and other diagnostic record.
4. Once all of the information has been gathered, we will review the proposed treatment plan and provide you and your dental provider with a statement outlining the benefits payable
5. You and your dental provider can then decide how to proceed

The advance claim review is voluntary. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, we will take into account alternate procedures, services, or courses of dental treatment for the dental condition in question in order to accomplish the anticipated result. See the When does your plan cover other treatment? section below.

What is a course of dental treatment?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more dentists to treat a dental condition that was diagnosed by the attending dentist during an oral examination. A course of treatment starts on the date your dentist first renders a service to correct or treat the diagnosed dental condition.

Pediatric dental care exclusions

The following are not covered under this benefit:

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

Birthing center (facility charges)

Eligible health services include prenatal (non-preventive care) and postpartum care and obstetrical services from a birthing center.

A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care.

Refer to the Eligible health services and exclusions-Maternity care and Well newborn nursery care sections for more information.

Diabetic services and supplies (including equipment and training)

Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Insulin preparations
  - Hypodermic needles and syringes used for the treatment of diabetes
  - Injection aids for the blind
  - Diabetic test agents
  - Lancets/lancing devices
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Injectable glucagons
  - Glucagon emergency kits
- Equipment
  - External insulin pumps
  - Blood glucose meters without special features, unless required due to blindness
- Training
  - Self-management training provided by a health care provider certified in diabetes self-management training

“Self-management training” is a day care program of educational services and self-care designed to instruct you in the self-management of diabetes (including medical nutritional therapy). The program must be under the supervision of a health professional whose scope of practice includes diabetic education or management.

This coverage includes the treatment of insulin dependent (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy.

Family planning services – other

Eligible health services include certain family planning services provided by your physician such as:

- Voluntary sterilization for males
- Abortion

The following are not covered under this benefit:

- Reversal of voluntary sterilization procedures, including related follow-up care
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care
Temporomandibular joint dysfunction treatment (TMJ) and craniomandibular joint dysfunction treatment (CMJ)

Eligible health services include:

- Diagnostic or therapeutic services including treatment of associated myofascial pain
- Medical and dental surgical treatment
- Medical and dental non-surgical treatment including prosthesis placed directly on the teeth

for TMJ and CMJ by a provider.

The following are not covered under this benefit:

- Dental implants

Impacted wisdom teeth

Eligible health services include the services and supplies of a dental provider for the removal of one or more impacted wisdom teeth.

Accidental injury to sound natural teeth

Eligible health services include the services and supplies of a dental provider to treat an injury to sound natural teeth.

The following are not covered under this benefit:

- The care, filling, removal or replacement of teeth and treatment of diseases of the teeth
- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Bony impacted teeth
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

Dermatological treatment

Eligible health services include the diagnosis and treatment of skin disorders by a physician or specialist.

The following are not covered under this benefit:

- Acne treatment
- Cosmetic treatment and procedures

Maternity care

Eligible health services include prenatal (non-preventive care), delivery, postpartum care, and other obstetrical services, and postnatal visits. Coverage includes eligible health services provided by a licensed mid-wife.

After your child is born, eligible health services include:

- 48 hours of inpatient care in a hospital or birthing center after a vaginal delivery
- 96 hours of inpatient care in a hospital or birthing center after a cesarean delivery
• A shorter stay if the attending physician, with the consent of the mother, discharges the mother or newborn earlier
• The mother could be discharged earlier. If so, the plan will pay for 2 post-delivery home visits by a health care provider

Routine newborn care services are part of the mother’s benefit. The mother and newborn will be considered as one person when calculating the deductible, coinsurance, and any applicable copayments.

The following are not covered under this benefit:
• Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Well newborn nursery care
Eligible health services include routine care of your well newborn child in a hospital or birthing center such as:
• Well newborn nursery care during the mother’s stay but for not more than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery and
• Hospital or birthing center visits and consultations for the well newborn by a physician but for not more than 1 visit per day

Gender affirming treatment
Eligible health services include certain services and supplies for gender affirming (sometimes called sex change) treatment.

Important note:
As a reminder, gender affirming treatment requires precertification by Aetna. Your in-network provider is responsible for obtaining precertification. You are responsible for obtaining precertification when you use an out-of-network provider. Visit https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html for detailed information about this benefit, including eligibility and medical necessity requirements. You can also call Member Services at the toll-free number on your ID card.

Autism spectrum disorder
Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.

Eligible health services include the services and supplies provided by a physician or behavioral health provider for the diagnosis, testing and treatment of autism spectrum disorders. We will only cover this treatment if a physician or behavioral health provider orders it as part of a treatment plan.

We will cover certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:
• That systematically change behavior
• That are responsible for observable improvements in behavior

Important note:
As a reminder, applied behavior analysis requires precertification by Aetna. Your in-network provider is responsible for obtaining precertification. You are responsible for obtaining precertification when you use an out-of-network provider.
Early childhood intervention
Eligible health services include early intervention services for members ages birth to 36 months of age with an identified developmental disability or delay. A referral from the child’s provider is required.

Behavioral health
Mental health treatment
Eligible health services include the treatment of mental health disorders provided by a general medical hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider as follows:

- Inpatient room and board at the semi-private room rate. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Other services and supplies related to your condition that are provided during your stay in a general medical hospital, psychiatric hospital, or residential treatment facility.
- Outpatient treatment received while not confined as an inpatient in a general medical hospital, psychiatric hospital, or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor, or a pastoral, marriage or family therapist (includes telehealth consultations)
  - Individual, group and family therapies for the treatment of mental health
  - Other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      ▪ You are homebound
      ▪ Your physician orders them
      ▪ The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home
      ▪ The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - Observation
    - Peer counseling support by a peer support specialist (including telehealth consultation)
      ▪ A peer support specialist serves as a role model, mentor, coach, and advocate. Peer support must be supervised by a behavioral health provider.
Substance related disorders treatment

Eligible health services include the treatment of substance related disorders provided by a general medical hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider as follows:

- **Inpatient room and board** at the semi-private room rate. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Other services and supplies that are provided during your stay in a general medical hospital, psychiatric hospital or residential treatment facility.
- Outpatient treatment received while not confined as an inpatient in a general medical hospital, psychiatric hospital or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor, or a pastoral, marriage or family therapist (includes telehealth consultations)
  - Individual, group and family therapies for the treatment of substance related disorders
  - Other outpatient substance related disorders treatment such as:
    - Outpatient detoxification
    - Partial hospitalization treatment provided in a facility or program for treatment of substance related disorders provided under the direction of a physician
    - Intensive outpatient program provided in a facility or program for treatment of substance related disorders provided under the direction of a physician
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your physician orders them
      - The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
    - Ambulatory detoxification which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Treatment of withdrawal symptoms
    - Observation
    - Peer counseling support by a peer support specialist (including telehealth consultation)
      - A peer support specialist serves as a role model, mentor, coach, and advocate. Peer support must be supervised by a behavioral health provider.

**Important note:**

Your student policy covers telehealth for mental health disorders and substance related disorders. All in-person physician or behavioral health provider office visits that are covered benefits are also covered if you use telehealth provided by a physician or behavioral health provider instead.

Telehealth provided by a physician or behavioral health provider may have different cost sharing than other outpatient services. See the schedule of benefits for more information.
Obesity (bariatric) surgery and services

Eligible health services include obesity surgery, which is also known as “weight loss surgery.” Obesity surgery is a type of procedure performed on people who are morbidly obese, for the purpose of losing weight.

Obesity is typically diagnosed based on your body mass index (BMI). To determine whether you qualify for obesity surgery, your physician will consider your BMI and any other condition or conditions you may have. In general, obesity surgery will not be approved for any covered person with a BMI less than 35.

Your physician will request approval from us in advance of your obesity surgery. We will cover charges made for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient prescription drug benefits included under the Outpatient prescription drugs section
- Other related outpatient services

The following are not covered under this benefit:

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described above and in the Eligible health services and exclusions – Preventive care and wellness section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Reconstructive surgery and supplies

Eligible health services include all stages of reconstructive surgery by your provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your surgery reconstructs the breast where a necessary mastectomy was performed. Services and supplies include:
  - An implant
  - Areolar and nipple reconstruction
  - Areolar and nipple re-pigmentation
  - Surgery on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema and prosthetic devices
- Your surgery is to implant or attach a covered prosthetic device
- Your surgery corrects a gross anatomical defect present at birth. The surgery will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - The purpose of the surgery is to improve function
- Your surgery is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part and your surgery will improve function.
Transplant services

Eligible health services include transplant services provided by a physician and hospital. This includes human leukocyte antigen testing for bone marrow transplants.

This includes the following transplant types:
- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy for FDA-approved treatments
- Thymus tissue for FDA-approved treatments

Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as Institutes of Excellence™ (IOE) facilities in your provider directory.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the IOE facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the in-network copayment, coinsurance, policy year deductible, maximum out-of-pocket and limits, unless stated differently in this certificate and the schedule of benefits. You may also get transplant services at a non-IOE facility, but your cost share will be higher. Transplant services received from a non-IOE facility are subject to the out-of-network copayment, coinsurance, policy year deductible, maximum out-of-pocket and limits, unless stated differently in this certificate and the schedule of benefits.

Important note:

If there are no IOE facilities assigned to perform your transplant type in your network, it’s important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don’t get your transplant services at the facility we designate your cost share will be higher.

Many pre and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. If your transplant care is being coordinated by the National Medical Excellence Program® (NME), all medical services must be managed through the NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the eligible health service is not directly related to your transplant.

Travel and lodging expenses

If an IOE patient lives 100 or more miles from the IOE facility, eligible health services include travel and lodging expenses for the IOE patient and a companion to travel between the IOE patient’s home and the IOE facility. Eligible health services will be reimbursed by the plan and include coach class round-trip air, train, or bus travel and lodging costs.

The following are not covered under this benefit:
- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness
Treatment of infertility
Basic infertility services
Eligible health services include seeing a physician or infertility specialist:

- To diagnose and evaluate the underlying medical cause of infertility.
- To do surgery to treat the underlying medical cause of infertility. Examples are endometriosis surgery or, for men, varicocele surgery.

The following are not covered under the infertility treatment benefit:

- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father
  - Cryopreservation (freezing) and storage of eggs, embryos, sperm or reproductive tissue
  - Thawing of cryopreserved (frozen) eggs, sperm or reproductive tissue
  - The care of the donor in a donor egg cycle which includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which the person is not genetically related
  - Obtaining sperm for ART services
  - Home ovulation prediction kits or home pregnancy tests
  - The purchase of donor embryos, donor oocytes, or donor sperm
  - Reversal of voluntary sterilizations, including follow-up care
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)
7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services
Eligible health services include complex imaging services by a provider, including:
- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans

Diagnostic lab work and radiological services
Eligible health services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests.

Chemotherapy
Eligible health services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your hospital benefit covers the initial dose of chemotherapy after a cancer diagnosis during a hospital stay. Covered benefits for chemotherapy include anti-nausea prescription drugs.

Gene-based, cellular and other innovative therapies (GCIT)
Eligible health services include GCIT provided by a physician, hospital or other provider.

Key Terms
Here are some key terms we use in this section. These will help you better understand GCIT.

Gene
A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Molecular
Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Therapeutic
Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

GCIT are defined as any services that are:
- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. We call these “GCIT services.”
Eligible health services for GCIT include:
- Cellular immunotherapies.
- Genetically modified viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for treatment of certain conditions.
- All human gene therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza® (Nusinersen).
  - siRNA.
  - mRNA.
  - microRNA therapies.

Facilities/providers for gene-based, cellular and other innovative therapies
We designate facilities to provide GCIT services or procedures. GCIT physicians, hospitals and other providers are GCIT-designated facilities/providers for Aetna and CVS Health.

Important note:
You must get GCIT eligible health services from a GCIT-designated facility/provider. If there are no GCIT-designated facilities/providers assigned in your network, it’s important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don’t get your GCIT services at the facility/provider we designate, they will not be eligible health services.

Outpatient infusion therapy
Eligible health services include infusion therapy you receive in an outpatient setting including but not limited to:
- A free-standing outpatient facility
- The outpatient department of a hospital
- A physician in their office
- A home care provider in your home

You can access the list of preferred infusion locations by contacting Member Services at the toll-free number on your ID card or by logging in to your Aetna website at https://www.aetnastudenthealth.com.

Infusion therapy is the parenteral (e.g. intravenous) administration of prescribed medications or solutions.

Certain infused medications may be covered under the outpatient prescription drug coverage. You can access the list of specialty prescription drugs by contacting Member Services at the toll-free number on your ID card or by logging in to your Aetna website at https://www.aetnastudenthealth.com to determine if coverage is under the outpatient prescription drug benefit of this certificate of coverage.

The following are not covered under this benefit:
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan
- Enteral nutrition
- Blood transfusions and blood products
- Dialysis
Outpatient radiation therapy

Eligible health services include the following radiology services provided by a health professional:

- Radiological services
- Gamma ray
- Accelerated particles
- Mesons
- Neutrons
- Radium
- Radioactive isotopes

Specialty prescription drugs

Eligible health services include specialty prescription drugs when they are:

- Purchased by your provider
- Injected or infused by your provider in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a hospital
  - A physician in his/her office
  - A home care provider in your home
- Listed on our specialty prescription drug list as covered under this certificate of coverage

You can access the list of specialty prescription drugs by contacting Member Services at the toll-free number on your ID card in the How to contact us for help section or by logging in to your Aetna website at https://www.aetnastudenthealth.com to determine if coverage is under the outpatient prescription drug benefit of this certificate of coverage.

Certain injected and infused medications may be covered under the outpatient prescription drug coverage. You can access the list of specialty prescription drugs by contacting Member Services at the toll-free number on your ID card in the How to contact us for help section or by logging in to your Aetna website at https://www.aetnastudenthealth.com to determine if coverage is under the outpatient prescription drug benefit of this certificate of coverage.

Outpatient respiratory therapy

Eligible health services include outpatient respiratory therapy services you receive at a hospital, skilled nursing facility or physician's office but only if those services are part of a treatment plan determined by your risk level and ordered by your physician.

Transfusion or kidney dialysis of blood

Eligible health services include services and supplies for the transfusion or kidney dialysis of blood. Covered benefits include:

- Whole blood
- Blood components
- The administration of whole blood and blood components
Short-term cardiac and pulmonary rehabilitation services
Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation
Eligible health services include cardiac rehabilitation services you receive at a hospital, skilled nursing facility or physician’s office, but only if those services are part of a treatment plan determined by your risk level and ordered by your physician.

Pulmonary rehabilitation
Eligible health services include pulmonary rehabilitation services as part of your inpatient hospital stay if it is part of a treatment plan ordered by your physician.

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a hospital, skilled nursing facility, or physician’s office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your physician.

Short-term rehabilitation and habilitation therapy services

Short-term rehabilitation therapy services
Short-term rehabilitation therapy services help you restore or develop skills and functioning for daily living.

Eligible health services include short-term rehabilitation therapy services your physician prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A hospital, skilled nursing facility, or hospice facility
- A home health care agency
- A physician

Short-term rehabilitation therapy services have to follow a specific treatment plan, ordered by your physician.

Outpatient cognitive rehabilitation, physical, occupational and speech therapy
Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury or surgical procedure
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions you lost as a result of an acute illness, injury or surgical procedure or
  - Relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to:
  - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute illness, injury or surgical procedure or
  - Improve delays in speech function development caused by a gross anatomical defect present at birth

Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one’s thoughts with spoken words.
• Cognitive rehabilitation therapy associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Short-term habilitation therapy services
Short-term habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn’t walking or talking at the expected age).

Eligible health services include short-term habilitation therapy services your physician prescribes. The services have to be performed by:
  • A licensed or certified physical, occupational or speech therapist
  • A hospital, skilled nursing facility, or hospice facility
  • A home health care agency
  • A physician

Short-term habilitation therapy services have to follow a specific treatment plan, ordered by your physician.

Outpatient physical, occupational, and speech habilitation therapy
Eligible health services include:
  • Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function.
  • Occupational therapy (except for vocational rehabilitation or employment counseling or services provided in an educational or training setting), if it is expected to develop any impaired function.
  • Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to develop speech function as a result of delayed development. Speech function is the ability to express thoughts, speak words and form sentences.

Chiropractic services
Eligible health services include spinal therapeutic, adjustive, and manipulative services to correct a muscular or skeletal problem.

Your provider (including chiropractor, allopathic, or osteopathic doctor) must establish or approve a treatment plan that details the treatment, and specifies frequency and duration.

Diagnostic testing for learning disabilities
Eligible health services include diagnostic testing for:
  • Attention deficit disorder
  • Attention deficit hyperactive disorder
  • Dyslexia

Once you are diagnosed with one of these conditions, the treatment is covered under the Mental health treatment section.
8. Other services

Ambulance service

Eligible health services include transport by professional ambulance services.

For emergency services:
- To the first hospital to provide emergency services
- From one hospital to another hospital if the first hospital cannot provide the emergency services you need

For non-emergency services:
- From hospital to your home or to another facility if an ambulance is the only safe way to transport you.
- From your home to a hospital if an ambulance is the only safe way to transport you. Transport is limited to 200 miles

Your plan also covers transportation to a hospital by professional air or water ambulance when:
- Professional ground ambulance transportation is not available
- Your condition is unstable, and requires medical supervision and rapid transport
- You are traveling from one hospital to another and
  - The first hospital cannot provide the emergency services you need
  - The two conditions above are met

The following are not covered under this benefit:
- Ambulance services for routine transportation to receive outpatient or inpatient care

Clinical trial therapies (experimental or investigational)

Eligible health services include experimental or investigational drugs, devices, treatments or procedures from a provider under an “approved clinical trial” only when you have cancer or terminal illnesses and all of the following conditions are met:
- Standard therapies have not been effective or are not appropriate
- You are eligible to join according to the trial protocol (with respect to treatment of that illness)
- Your participation in the trial offers meaningful potential for significant clinical benefit
- Your referring physician determines that taking part in the trial would be appropriate according to the above conditions

An "approved clinical trial" is a clinical research study or clinical investigation that meets all of these criteria:
- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- The clinical trial is approved and funded by the United States Department of Health and Human Services (HHS), National Institutes of Health (NIH) or a cooperative group of the Center of the National Institutes of Health.
- You are treated in accordance with the protocols of that study.
Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred by you from a provider in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening illness or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

The following are not covered under this benefit:
- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)

Durable medical equipment (DME)

Eligible health services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. Your plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase DME, that purchase is only eligible for coverage if you need it for long-term use.

Coverage includes:
- One item of DME for the same or similar purpose.
- Repairing DME due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new DME item you need because your physical condition has changed. It also covers buying a new DME item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.
- The fitting and adjustment of such DME items.

We:
- Assume no responsibility
- Make no express or implied warranties

concerning the outcome of any covered DME items.

We reserve the right to limit the payment of charges up to the most cost-efficient and least restrictive level of service or item that can be safely and effectively provided. It is our decision whether to rent or purchase the DME item.

Coverage is limited to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment that you purchase or rent for personal convenience or mobility.

Your plan only covers the same type of DME that Medicare covers. But there are some DME items Medicare covers that your plan does not.

The following are not covered under this benefit:
- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
• Over bed tables
• Elevators
• Communication aids
• Vision aids
• Telephone alert systems
• Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a **physician**

**Nutritional support**

**Eligible health services** include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

The following are not covered under this benefit:

- Any food item, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as described above

**Infant formula**

**Eligible health services** include amino acid-based elemental infant formula when your **physician** has submitted documentation that the amino-acid based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas, have been tried and have failed or are contraindicated.

Coverage is provided when your **physician** has diagnosed and documented one of the following:

- Symptomatic allergic colitis or proctitis
- Laboratory-proven or biopsy-proven allergic or eosinophilic gastroenteritis
- A history of anaphylaxis
- Gastroesophageal reflux disease that is nonresponsive to standard medical therapies
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical **provider**
- Cystic fibrosis
- Malabsorption of cow milk-based or soy-milk based formula

Coverage of amino acid-based elemental infant formula will be provided without regard to the method of the delivery of the formula.

**Inborn errors of metabolism**

**Eligible health services** include coverage for metabolic formula and special modified low-protein food products that have been prescribed by your **physician** for an inborn error of metabolism.
**Prosthetic devices**

**Eligible health services** include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

Prosthetic device means:
- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of **illness** or **injury** or congenital defects
- Cochlear implants

Coverage includes:
- The prosthetic device
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- The fitting, instruction and other services (such as attachment or insertion) so you can properly use the device

The following are not covered under this benefit:
- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft
- Communication aids

**Hearing aids**

**Eligible health services** include prescribed hearing aids and hearing aid services as described below.

Hearing aid means:
- Any wearable, non-disposable instrument or device designed to aid impaired human hearing
- Parts, attachments, or accessories

Hearing aid services are:
- Audiometric hearing exam and evaluation for a hearing aid **prescription** performed by:
  - A **physician** certified as an otolaryngologist or otologist
  - An audiologist who is legally qualified in audiology, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select and adjust or fit a hearing aid
Hearing aids alternate treatment rule
Sometimes there are several types of hearing aids that can be used to treat a medical condition, all of which provide acceptable results. When alternate hearing aids can be used, the plan’s coverage may be limited to the cost of the least expensive device that is:

- Customarily used nationwide for treatment and
- Deemed by the medical profession to be appropriate for treatment of the condition in question. The device must meet broadly accepted standards of medical practice for your physical condition.

You should review the differences in the cost of alternate treatment with your physician. Of course, you and your physician can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover for hearing aids.

The following are not covered under this benefit:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 12 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist

Hearing exams
Eligible health services include hearing exams for evaluation and treatment of illness, injury or hearing loss when performed by a hearing specialist.

The following are not covered under this benefit:

- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay

Podiatric (foot care) treatment
Eligible health services include non-routine foot care for the treatment of illness or injury of the feet by physicians and health professionals.

Non-routine treatment means:

- It would be hazardous for you if someone other than a physician or health professional provided the care
- You have an illness that makes the non-routine treatment essential
- The treatment is routine foot care but it’s part of an eligible health service (e.g., debriding of a nail to expose a subungual ulcer, or treatment of warts)
- The treatment you need might cause you to have a change in your ability to walk.

The following are not covered under this benefit:

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet
Telehealth
Eligible health services include telehealth consultations when provided by a physician, specialist, behavioral health provider acting within the scope of their license.

Vision care
Pediatric vision care
Routine vision exams
Eligible health services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.

Vision care services and supplies
Eligible health services include:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, prescription lenses or prescription contact lenses that are identified as preferred by a vision provider
- Eyeglass frames, prescription lenses or prescription contact lenses that are identified as non-preferred by a vision provider
- Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses
- Aphakic prescription lenses prescribed after cataract surgery has been performed
- Low vision services including comprehensive low vision evaluations and prescribed optical devices, such as high-power spectacles, magnifiers, and telescopes

In any one policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.

The following are not covered under this benefit:

- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes
9. Outpatient prescription drugs

What you need to know about your outpatient prescription drug benefits

Read this section carefully so that you know:

- How to access in-network pharmacies
- How to access out-of-network pharmacies
- Eligible health services under your outpatient prescription drug benefit
- What outpatient prescription drugs are covered
- Other services
- How you get an emergency prescription filled
- Where your schedule of benefits fits in
- What precertification requirements apply
- How do I request a medical exception

Some prescription drugs may not be covered or coverage may be limited. This does not keep you from getting prescription drugs that are not covered benefits. You can still fill your prescription, but you have to pay for it yourself. For more information see the Where your schedule of benefits fits in section, and see the schedule of benefits.

A pharmacy may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled. In this situation, the pharmacist will call the prescriber for guidance.

Your plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication’s FDA-approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

How to access in-network pharmacies

How do you find an in-network pharmacy?

You can find an in-network pharmacy in two ways:

- **Online:** By logging in to your Aetna website at [https://www.aetnastudenthealth.com](https://www.aetnastudenthealth.com).
- **By phone:** Call Member Services at the toll-free number on your ID card. During regular business hours, a Member Services representative can assist you. Our automated telephone assistant can give you this information 24 hours a day.

You may go to any in-network pharmacies.

The in-network pharmacy will submit your claim. You will pay any cost sharing directly to the in-network pharmacy.

How to access out-of-network pharmacies

You can directly access an out-of-network pharmacy to get covered outpatient prescription drugs.

If you use an out-of-network pharmacy to obtain outpatient prescription drugs, you are subject to a higher out-of-pocket expense and are responsible for:

- Your out-of-network copayment
- Your out-of-network coinsurance
- Any charges over our recognized charge
- Submitting your own claims
Eligible health services under your outpatient prescription drug benefit

What does your outpatient prescription drug benefit cover?

Eligible health services under your outpatient prescription drug benefit include:

Any pharmacy service that meets these three requirements:
- They are described in this section
- They are not listed as exclusions in this section or the General exclusions section
- They are not beyond any limits in the schedule of benefits

Your plan benefits are covered when you follow the plan's general rules:
- You need a prescription from your prescriber
- Your drug needs to be medically necessary for your illness or injury. See the Medical necessity and precertification requirements section
- You need to show your ID card to the pharmacy when you get a prescription filled

Your outpatient prescription drug benefit is based on drugs in the preferred drug guide. The preferred drug guide includes both brand-name prescription drugs and generic prescription drugs. Your out-of-pocket costs may be higher if your prescriber prescribes a prescription drug not listed in the preferred drug guide.

If we remove a drug or device from the drug guide, we will give you 60 days advance written notice.

Generic prescription drugs may be substituted by your pharmacist for brand-name prescription drugs. Your out-of-pocket costs may be less if you use a generic prescription drug when available.

Prescription drugs covered by this plan are subject to misuse, waste, and/or abuse utilization review by us, your provider, and/or your in-network pharmacy. The outcome of this review may include limiting coverage of the applicable drug(s) to one prescribing provider and/or one in-network pharmacy, limiting the quantity, dosage, day supply, requiring a partial-fill or denial of coverage.

What outpatient prescription drugs are covered?

Your prescriber may give you a prescription in different ways, including:
- Writing out a prescription that you then take to a pharmacy
- Calling or e-mailing a pharmacy to order the medication
- Submitting your prescription electronically to a pharmacy

Once you receive a prescription from your prescriber, you may fill the prescription at an in-network retail, mail order or specialty or out-of-network pharmacy.

Prescription drug synchronization

If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, your in-network pharmacy may be able to coordinate that for you. We will apply a prorated daily cost share rate to a partial fill of a maintenance drug, if needed, to synchronize your prescription drugs.
Types of pharmacies

Retail pharmacy
Generally, retail pharmacies may be used for up to a 30 day supply of prescription drugs. You should show your ID card to the in-network pharmacy every time you get a prescription filled.

You do not have to complete or submit claim forms. The in-network pharmacy will take care of claim submission. You may have to complete or submit claim forms when you use an out-of-network pharmacy.

Mail order pharmacy
Generally, the drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition.

Outpatient prescription drugs are covered when dispensed by an in-network mail order pharmacy. A mail order pharmacy may be used for up to a 90-day supply of prescription drugs. Prescriptions for less than a 30-day supply or more than a 90-day supply are not eligible for coverage when dispensed by an in-network mail order pharmacy.

Prescription refills after the initial fill can be filled at an in-network mail order pharmacy.

Specialty pharmacy
Specialty prescription drugs often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. A specialty pharmacy may be used for up to a 30 day supply of prescription drugs. You can access the list of specialty prescription drugs by contacting Member Services at the toll-free number on your ID card or by logging in to your Aetna website at https://www.aetnastudenthealth.com.

Specialty prescription drugs are covered when dispensed through an in-network specialty pharmacy or in-network retail pharmacy.

See the schedule of benefits for details on supply limits and cost sharing.

Other services

Preventive contraceptives
For females who are able to reproduce, your outpatient prescription drug plan covers certain prescription drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing. Your outpatient prescription drug plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive prescription drugs by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.

We cover over-the-counter (OTC) and generic prescription drugs and devices for each of the methods identified by the FDA at no cost share. If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug for that method at no cost share.

Important Note:
You may qualify for a medical exception if your provider determines that the contraceptives covered standardly as preventive are not medically appropriate. Your prescriber may request a medical exception and submit the exception to us.
Diabetic supplies
Eligible health services include but are not limited to the following diabetic supplies upon prescription by a prescriber:
- Injection devices including insulin syringes, needles and pens
- Test strips - blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs
- Continuous glucose monitors
- Insulin infusion disposable pumps

See the Diabetic services and supplies (including equipment and training) section for medical eligible health services.

Early refills of prescription eye drops
Eligible health services include one early refill of a prescription of eye drops if the following criteria are met:
- You request the refill no earlier than the date on which 70% of the days of use authorized by the provider have elapsed
- The provider indicated on the original prescription that a specific number of refills are authorized
- The refill you request does not exceed the number of refills indicated on the original prescription
- The prescription has not been refilled more than once during the period authorized by the provider prior to the request for an early refill
- The prescription eye drops are a covered benefit under the plan

Immunizations
Under the outpatient prescription drugs benefit, eligible health services include preventive immunizations for infectious diseases as required by the federal Affordable Care Act (ACA) guidelines when administered at an in-network pharmacy.

You should contact:
- Member Services at the toll-free number on your ID card to find a participating in-network pharmacy

You should contact the pharmacy for availability as not all pharmacies will stock all available vaccines.

Your medical plan also provides coverage for preventive immunizations as required by the federal Affordable Care Act (ACA) guidelines. For details, refer to the Preventive care and wellness section.

Orally administered anti-cancer drugs, including chemotherapy drugs
Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

Over-the-counter drugs
Eligible health services include certain over-the-counter medications, as determined by the plan. Coverage of the selected over-the-counter medications requires a prescription. You can access the list by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling Member Services at the toll-free number on your ID card.
Preventive care drugs and supplements

**Eligible health services** include preventive care drugs and supplements (including over-the-counter drugs and supplements) as required by the Affordable Care Act (ACA) guidelines when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Risk-reducing breast cancer prescription drugs

**Eligible health services** include **prescription drugs** used to treat people who are at:

- Increased risk for breast cancer
- Low risk for adverse medication side effects

Tobacco cessation prescription and over-the-counter drugs

**Eligible health services** include FDA-approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Outpatient prescription drugs exclusions

The following are not covered under the outpatient prescription drugs benefit:

- Abortion drugs
- Allergy sera and extracts administered via injection
- Any services related to the dispensing, injecting or application of a drug
- Biological sera unless specified on the **preferred drug guide**
- Compounded prescriptions containing bulk chemicals not approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones
- **Cosmetic** drugs including medications and preparations used for cosmetic purposes
- Devices, products and appliances, except those that are specially covered
- Dietary supplements including medical foods
- Drugs or medications
  - Administered or entirely consumed at the time and place it is prescribed or provided
  - Which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written except as specifically provided above
  - That are therapeutically equivalent or therapeutically alternative to a covered **prescription drug** (unless a medical exception is approved)
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while an inpatient of a healthcare facility
  - Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by our Pharmacy and Therapeutics Committee
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
  - 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
  - That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
  - 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 (e.g. two antihistamine drugs)
• Genetic care
  - Any treatment, device, drug, service or supply to alter the body’s genes, genetic make-up, or the expression of the body’s genes except for the correction of congenital birth defects
• Immunizations related to 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 provided above
• Infertility
  - Prescription drugs used primarily for the treatment of infertility
• Injectables
  - Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us.
  - 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. This exception does not apply to Depo Provera and other injectable drugs used for contraception.
• Off-label drug use except for indications recognized through peer-reviewed medical literature (FDA-approved prescription drugs used for purposes not specified on their labels except for the diagnosis of cancer, HIV, or AIDS)
• 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 preferred drug guide.
  - 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.
• Replacement of lost or stolen prescriptions
• Test agents except diabetic test agents
• Tobacco cessation drugs, unless recommended by the United States Preventive Services Task Force (USPSTF)
• We reserve the right to exclude:
  - A manufacturer’s product when the same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the preferred drug guide
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on our preferred drug guide
How you get an emergency prescription filled
You may not have access to an in-network pharmacy in an emergency or urgent care situation. If you must fill a prescription in either situation, we will reimburse you as shown in the table below.

<table>
<thead>
<tr>
<th>Type of pharmacy</th>
<th>Your cost share</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network pharmacy</td>
<td>• You pay the copayment.</td>
</tr>
<tr>
<td>Out-of-network pharmacy</td>
<td>• You pay the pharmacy directly for the cost of the prescription. Then you fill out and send a prescription drug refund form to us, including all itemized pharmacy receipts.</td>
</tr>
<tr>
<td></td>
<td>• Submission of a claim doesn’t guarantee payment. If your claim is approved, you will be reimbursed the cost of your prescription less your copayment.</td>
</tr>
</tbody>
</table>

Where your schedule of benefits fits in
You are responsible for paying your part of the cost sharing. The schedule of benefits shows any benefit limitations and any out-of-pocket costs you are responsible for. Keep in mind that you are responsible for costs not covered under this plan.

Your outpatient prescription drug costs are based on:
• The type of prescription drug you are prescribed
• Where you fill your prescription

The plan may, in certain circumstances, make some preferred brand-name prescription drugs available to covered persons at the generic prescription drug copayment level.

How your copayment works
Your copayment is the amount you pay for each prescription fill or refill. Your schedule of benefits shows you which copayments you need to pay for specific prescription fill or refill. You will pay any cost sharing directly to the in-network pharmacy.

What precertification requirements apply?
Precertification
For certain drugs, you, your prescriber or your pharmacist needs to get approval from us before we will cover the drug. This is called “precertification”. The requirement for getting approval in advance guides appropriate use of precertified drugs and makes sure they are medically necessary. For the most up-to-date information, call Member Services at the toll-free number on your ID card or by logging in to your Aetna website at https://www.aetnastudenthealth.com.

Step therapy
There is another type of precertification for prescription drugs, and that is step therapy. Step therapy is a type of precertification where we require you to first try certain prescription drugs to treat your medical condition before we will cover another prescription drug for that condition.

You will find the step therapy prescription drugs on the preferred drug guide. For the most up-to-date information, call Member Services at the toll-free number on your ID card in the How to contact us for help section or log in to your Aetna website at https://www.aetnastudenthealth.com.
Medical exceptions
Sometimes you or your provider may ask for a medical exception for prescription drugs that are not covered or for which coverage was denied. You, someone who represents you or your provider can contact us. You will need to provide us with the required clinical documentation. Any exception granted is based upon an individual and is a case by case decision that will not apply to other covered persons.

For directions on how you can submit a request for a review:
- Contact Member Services at the toll-free number on your ID card
- Go online at https://www.aetnastudenthealth.com
- Submit the request in writing to CVS Health, ATTN: Aetna PA, 1300 E Campbell Road, Richardson, TX 75081

You, someone who represents you or your provider may seek a quicker medical exception when the situation is urgent. It's an urgent situation when you have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug.

Prescribing units
Some outpatient prescription drugs are subject to quantity limits. These quantity limits help your prescriber and pharmacist check that your outpatient prescription drug is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these quantity limits.

Any outpatient prescription drug that has duration of action extending beyond one (1) month shall require the number of copayments per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) copayments.

Continuity of prescription drugs
We reserve the right to request a review of your previous insurance carrier’s prescription drug prior authorization with your prescribing provider. If your provider participates in the review and requests that the prior authorization be continued, we will honor the previous insurance carrier’s prior authorization for a period not to exceed 6 months beginning with your effective date of coverage with us.
What your plan doesn’t cover – General exclusions

We already told you about the many health care services and supplies that are eligible for coverage under your plan in the Eligible health services and exclusions section. In that section we also told you that some health care services and supplies have exceptions and some are not covered at all (exclusions).

In this section we tell you about the general exclusions that apply to your plan. And just a reminder, you'll find coverage limitations in the schedule of benefits.

General exclusions

The following are not eligible health services under your plan except as described in:

- The Eligible health services and exclusions section of this certificate of coverage or
- A rider or amendment issued to you for use with this certificate of coverage

Acupuncture

- Acupuncture
- Acupressure

Air or space travel

- Traveling in, on or descending from any aircraft, including a hang glider, while the aircraft is in flight. This includes descending by a parachute, wingsuit or any other similar device.

This exclusion does not apply if:
- You are traveling solely as a fare-paying passenger
- You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
- You are traveling solely in a civil aircraft with a current valid “Standard Federal Aviation Agency Airworthiness Certificate” and:
  - The civil aircraft is piloted by a person with a current valid pilot’s certificate with proper ratings for the type of flight and aircraft involved
  - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the policyholder performing duties for the policyholder

Alternative health care

- Services and supplies given by a provider for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and traditional Chinese medicine.

Armed forces

- Services and supplies received from a provider as a result of an injury sustained, or illness contracted, while in the service of the armed forces of any country. When you enter the armed forces of any country, we will refund any unearned pro-rata premium.
Behavioral health treatment
  • Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:
    - Stay in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
    - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
    - Services provided in conjunction with school, vocation, work or recreational activities
    - Transportation
    - Sexual deviations and disorders except as described in the Eligible health services and exclusions section
    - Tobacco use disorders except as described in the Eligible health services and exclusions – Preventive care and wellness section

Beyond legal authority
  • Services and supplies provided by a health professional or other provider that is acting beyond the scope of its legal authority

Blood, blood plasma, synthetic blood, blood derivatives or substitutes
Examples of these are:
  • The provision of blood to the hospital, other than blood derived clotting factors
  • The services of blood donors, apheresis or plasmapheresis
  • For autologous blood donations, only administration and processing expenses are covered

Clinical trial therapies (experimental or investigational)
  • Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the Eligible health services and exclusions - Clinical trial therapies (experimental or investigational) section

Cornea or cartilage transplants
  • Cornea (corneal graft with amniotic membrane)
  • Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

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.

This exclusion does not apply to:
  • Surgery after an accidental injury when performed as soon as medically feasible. (Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.)
  • Coverage that may be provided under the Eligible health services and exclusions - Gender affirming treatment 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/changing containers and clamping tubing)
- Watching or protecting you
- **Respite care**, adult (or child) day care or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training
- 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

This exception does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.
Educational services
Examples of these services are:
- Any service or supply for education, training or retraining services or testing, except where described in the Eligible health services and exclusions – Diabetic services and supplies (including equipment and training) section. 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 are, examinations to get or keep a job, or examinations required under a labor agreement or other contract
- Because a law requires it
- 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 or investigational
- Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs). See the Eligible health services and exclusions – Other services section.

Facility charges
For care, services or supplies provided in:
- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons’ main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Felony
- Services and supplies that you receive as a result of an injury due to your commission of a felony

Gene-based, cellular and other innovative therapies (GCIT)
The following are not eligible health services unless you receive prior written approval from us:
- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the Medical necessity precertification requirements section.
Genetic care
• Any treatment, device, drug, service or supply to alter the body’s genes, genetic make-up, or the expression of the body’s genes except for the correction of congenital birth defects

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

Incidental surgeries
• Charges made by a physician for incidental surgeries. These are non-medically necessary surgeries performed during the same procedure as a medically necessary surgery.

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

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

J udgment or settlement
• Services and supplies for the treatment of an injury or illness to the extent that payment is made as a judgment or settlement by any person deemed responsible for the injury or illness (or their insurers)

Mandatory no-fault laws
• Treatment for an injury to the extent benefits are payable under any state no-fault automobile coverage.

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. See the Eligible health services and exclusions – Habilitation therapy services section

Medical supplies – outpatient disposable
• Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Syringes
  - Blood or urine testing supplies
  - Other home test kits
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient
Medicare

- Services and supplies available under Medicare, if you are entitled to premium-free Medicare Part A or enrolled in Medicare Part B, or if you are not entitled to premium-free Medicare Part A or enrolled in Medicare Part B because you refused it, dropped it, or did not make a proper request for it

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

- Outpatient prescription drugs or non-prescription drugs and medicines provided by the policyholder
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan

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

Riot

- Services and supplies that you receive from providers as a result of an injury from your “participation in a riot”. This means when you take part in a riot in any way such as inciting, or conspiring to incite, the riot. It does not include actions that you take in self-defense as long as they are not against people who are trying to restore law and order.

Routine exams

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

Services provided by a family member

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

Sexual dysfunction and enhancement

- Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Not eligible for coverage are prescription drugs in 60 day supplies

Specialty prescription drugs

- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug benefit
Strength and performance
- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - 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

Telehealth
- Services given when you are not present at the same time as the provider
- Services including:
  - Telephone calls
  - Telehealth 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 modality
- Sensory or auditory 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, except to the extent 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

Wilderness treatment programs
See Educational services within this section
Work related illness or injuries

- Coverage available to you under worker’s compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be 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.
Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are eligible health services, the foundation for getting covered care is through our network of providers. This section tells you about in-network and out-of-network providers. This section also tells you about the role of school health services.

School health services
School health services can give you some of the care that you need. Contact them first before seeking care from other providers.

In-network providers
We have contracted with providers to provide eligible health services to you. These providers make up the network for your plan. For you to receive the in-network level of benefits you must use in-network providers for eligible health services. There are some exceptions:

- Emergency services – refer to the description of emergency services and urgent care in the Eligible health services and exclusions section
- Urgent care – refer to the description of emergency services and urgent care in the Eligible health services and exclusions section
- Transplants – see the description of transplant services in the Eligible health services and exclusions – Specific conditions section

You may select an in-network provider from the directory through your Aetna website at https://www.aetnastudenthealth.com. You can search our online directory for names and locations of providers or contact Member Services at the toll-free number on your ID card.

You will not have to submit claims for treatment received from in-network providers. Your in-network provider will take care of that for you. And we will directly pay the in-network provider for what the plan owes.

Out-of-network providers
You also have access to out-of-network providers. This means you can receive eligible health services from an out-of-network provider. If you use an out-of-network provider to receive eligible health services, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network policy year deductible
- Your out-of-network coinsurance
- Any charges over our recognized charge
- Submitting your own claims and getting precertification
Keeping a provider you go to now (continuity of care)
You may have to find a new provider when:

- You join the plan and the provider you have now is not in the network
- You are already covered under another Aetna plan and your provider stops being in our network

But, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

If this situation applies to you, contact us for details. As long as the provider did not leave the network based on fraud, lack of quality standards, or our termination of the provider, you’ll be able to receive transitional care from your provider for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

If you are pregnant and have entered your second trimester, transitional care will be through the time required for postpartum care directly related to the delivery.

You will not be responsible for an amount that exceeds the cost share that would have applied had your provider remained in the network.
What the plan pays and what you pay

Who pays for your eligible health services – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your policy year deductible
- Your copayments
- Your coinsurance
- Your maximum out-of-pocket limit

We also remind you that sometimes you will be responsible for paying the entire bill – for example, if you get care that is not an eligible health service.

The general rule

When you get eligible health services:

- You pay for the entire expense up to any policy year deductible limit

And then

- The plan and you share the expense up to any maximum out-of-pocket limit. The schedule of benefits lists how much your plan pays and how much you pay for each type of health care service.

And then

- The plan pays the entire expense after you reach your maximum out-of-pocket limit

When we say “expense” in this general rule, we mean the negotiated charge for an in-network provider, and recognized charge for an out-of-network provider. See the Glossary section for what these terms mean.

See the schedule of benefits for any exceptions to this general rule.

Important exception – when your plan pays all

Under the in-network level of coverage, your plan pays the entire expense for all eligible health services under the Preventive care and wellness benefit.

Important exceptions – when you pay all

You pay the entire expense for an eligible health service:

- When you get a health care service or supply that is not medically necessary. See the Medical necessity and precertification requirements section.
- When your plan requires precertification, your physician requested it, we refused it, and you get an eligible health service without precertification. See the Medical necessity and precertification requirements section.

In all these cases, the provider may require you to pay the entire charge. Any amount you pay will not count towards your policy year deductible or towards your maximum out-of-pocket limit.
One more important exception – when you go to the emergency room
When you have to visit an emergency room for emergency services, the general rule described earlier doesn’t apply.

Instead:
- You pay your initial share, a copayment, for each visit. The copayment amount is shown in the schedule of benefits.

And then
- If you haven’t satisfied your policy year deductible, you pay any remaining expense for the visit, up to the amount of your policy year deductible.

And then
- Once the policy year deductible has been satisfied, the plan and you share the remaining expense up to any maximum out-of-pocket limit. The schedule of benefits lists what percentage of this remaining amount your plan pays. Your share is called coinsurance.

And then
- The plan pays any remaining expense after you reach your maximum out-of-pocket limit.

As with the general rule, when we say “expense” we mean the negotiated charge for an in-network provider, and recognized charge for an out-of-network provider.

Special financial responsibility
You are responsible for the entire expense of:
- Cancelled or missed appointments

Neither you nor we are responsible for:
- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the negotiated charge for in-network covered benefits
- Standby charges made by a physician

Where your schedule of benefits fits in
How your policy year deductible works
Your policy year deductible is the amount you need to pay for eligible health services per policy year before your plan begins to pay for eligible health services. Your schedule of benefits shows the policy year deductible amounts for your plan.

How your copayment works
Your copayment is the amount you pay for eligible health services after you have paid your policy year deductible. Your schedule of benefits shows you which copayments you need to pay for specific eligible health services.

How your maximum out-of-pocket limit works
You will pay your policy year deductible, copayments, and coinsurance up to the maximum out-of-pocket limit for your plan. Your schedule of benefits shows the maximum out-of-pocket limits that apply to your plan. Once you reach your maximum out-of-pocket limit, your plan will pay for covered benefits for the remainder of that policy year.

Important note:
See the schedule of benefits for any policy year deductibles, copayments, coinsurance, maximum out-of-pocket limit and maximum age, visits, days, hours, admissions that may apply.
When you disagree - claim decisions and appeals procedures

In the previous section, we explained how you and we share responsibility for paying for your eligible health services.

When a claim comes in, we decide and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures
For claims involving out-of-network providers:

<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit a claim</td>
<td>• You should notify and request a claim form from the <strong>policyholder</strong>.</td>
<td>• You must send us notice and proof as soon as reasonably possible, but not later than 20 days after the loss.</td>
</tr>
<tr>
<td></td>
<td>• When we receive your notice of claim, we will send you a claim form for filing proof of loss within 15 days.</td>
<td>• Notice given to us by you or on your behalf at Aetna Life Insurance Company, 151 Farmington Ave., Hartford, CT 06156, or to any Aetna agent, with information to identify you, will be deemed notice to us.</td>
</tr>
<tr>
<td></td>
<td>• The claim form will provide instructions on how to complete and where to send the form(s).</td>
<td>• If you are unable to complete a claim form, you may send us:</td>
</tr>
<tr>
<td></td>
<td>• If you are unable to</td>
<td>- A description of services</td>
</tr>
<tr>
<td></td>
<td>complete a claim form, you may send us:</td>
<td>- Bill of charges</td>
</tr>
<tr>
<td></td>
<td>• You must send us notice and proof as soon as reasonably possible, but not later than 20 days after the loss.</td>
<td>- Any medical documentation you received from your provider</td>
</tr>
<tr>
<td>Proof of loss (claim)</td>
<td>• A completed claim form and any additional information required by us.</td>
<td>You or your <strong>provider</strong> must send us notice and proof within 12 months of the date you received services, unless you are legally unable to notify us.</td>
</tr>
<tr>
<td>Benefit payment</td>
<td>• Written proof must be provided for all benefits within 30 days after the period for which we are liable.</td>
<td>• Benefits will be paid as soon as the necessary proof to support the claim is received, but no later than 30 days after we receive proof of loss.</td>
</tr>
<tr>
<td></td>
<td>• If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss.</td>
<td></td>
</tr>
</tbody>
</table>
Types of claims and communicating our claim decisions
You or your provider is required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the provider or to you as appropriate.

There are different types of claims. The amount of time that we have to tell you about our decision on a claim, after receiving or obtaining all of the necessary information, depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim
An urgent claim is one for which the physician treating you decides that a delay in getting medical care, could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim
A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we precertify them.

Post-service claim
A post service claim is a claim that involves health care services you have already received.

Concurrent care claim extension
A concurrent care claim extension occurs when you ask us to approve more services than we already have approved. Examples are extending a hospital stay or adding a number of visits to a provider.

Concurrent care claim reduction or termination
A concurrent care claim reduction or termination occurs when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as copayments, coinsurance and deductibles that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.
The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

We may need to tell your physician about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the hospital.

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Urgent care claim</th>
<th>Pre-service claim</th>
<th>Post-service claim</th>
<th>Concurrent care claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial determination (us)</td>
<td>24 hours</td>
<td>72 hours or 2 business days, whichever is less</td>
<td>30 days</td>
<td>1 working day*</td>
</tr>
<tr>
<td>Extensions</td>
<td>None</td>
<td>2 days</td>
<td>15 days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Additional information request (us)</td>
<td>48 hours</td>
<td>2 days</td>
<td>30 days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Response to additional information request (you)</td>
<td>48 hours</td>
<td>2 days</td>
<td>45 days</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

*We have to receive the request at least 24 hours before the previously approved health care services end. All decisions will be made within the specified time after receiving or obtaining all the necessary information.

Adverse benefit determinations
We pay many claims at the full rate negotiated charge with an in-network provider and the recognized charge with an out-of-network provider, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an “adverse benefit determination” or “adverse decision”. It is also an “adverse benefit determination” if we rescind your coverage entirely.

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal
A Complaint
You may not be happy about a provider or an operational issue, and you may want to complain. You can call Member Services at the toll-free number on your ID card or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

An Appeal
You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us by calling Member Services at the toll-free number on your ID card.

Utilization review disclosure requirements
We will give you a clear and understandable description of the utilization review process, including:

- The process for obtaining review of adverse benefit determinations
- A statement of your rights and responsibilities with respect to those procedures in the group policy
- Your right to request in writing and receive copies of any clinical review criteria used to make any adverse health care treatment decision
- A toll-free telephone number to call for utilization review decisions on our ID cards
Requests for reconsideration of an adverse utilization review determination
For an initial or concurrent review determination, the provider rendering the service can request, by telephone, fax or in writing, a reconsideration on your behalf. The reconsideration will occur within 1 day of the receipt of the request and will be conducted between the provider rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer, if the reviewer cannot be available within 1 working day.

If the reconsideration process does not resolve the difference of opinion, the adverse determination may be appealed by you or your provider. A reconsideration is not required before appealing an adverse determination.

Appeals of adverse benefit determinations
You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination, unless there are special circumstances that prevented you from filing within the 180 calendar day timeframe.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination or by calling Member Services at the toll-free number on your ID card. For a written appeal, you need to include:
- Your name
- The policyholder's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by calling Member Services at the toll-free number on your ID card. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision, unless there are special circumstances that prevented you from filing within the 60 calendar day timeframe.

Urgent care or pre-service claim appeals
If your claim is an urgent claim or a pre-service claim, your provider may appeal for you without having to fill out a form.

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.
Timeframes for deciding appeals

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Urgent care claim</th>
<th>Pre-service claim</th>
<th>Post-service claim</th>
<th>Concurrent care claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal determinations at each level (us)</td>
<td>36 hours</td>
<td>15 days</td>
<td>30 days</td>
<td>As appropriate to type of claim</td>
</tr>
<tr>
<td>Extensions</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

First level appeal

We'll let you know within 3 working days of the day we receive your appeal. The notice will include:

- The person’s name taking care of your appeal. This is the appeal coordination (coordinator)*
- The coordinator’s phone number

*The coordinator will be a clinical peer health care professional if the appeal concerns:

- Medical necessity
- Appropriateness
- Health care setting
- Level of care, or
- Effectiveness

Notice of the final decision will contain:

- The names, titles and qualifying credentials of the person(s) involved in the review
- A statement of the coordinator’s understanding of the appeal and all the pertinent facts
- The coordinator’s basis for the decision in clear terms
- A reference to the evidence or documentation used as the basis for the decision, and instructions for requesting copies of those materials
- A notice of your right to contact the Maine Bureau of Insurance, including the address and telephone number for the Bureau
- A description of the process to request a level two appeal (including the rights, procedures and timeframes for that appeal)
- A description of the process to request an expedited review of an urgent care claim
- The telephone number you can call for help with an appeal or a request for reconsideration
- The availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act
- Notice of your right to file a complaint with the Bureau of Insurance after exhausting any appeals under our internal review process
- Any other information required pursuant to the federal Affordable Care Act

You can waive your right to a second level appeal and request an external review instead.

If any appeal under the grievance procedure relies upon a medical condition regarding a health condition as the material issue, you are entitled to an independent second opinion by a provider of a similar specialty, at our expense.
Second level appeal
If we uphold an adverse benefit determination at the first appeal level, you or your authorized representative have the right to a second level appeal.

The appeal decision will be by an appeals committee (committee). This applies to urgent care appeals and medical necessity, appropriateness, health care setting, level of care or effectiveness appeals. The appeal decision must have the concurrence of the majority of clinical peer health care professionals.

The committee must:
- Be made up of one or more clinical peer health care professionals who were not previously involved in the appeal
- Not be a subordinate of a person involved in the appeal
- Not have a financial or other personal interest in the outcome of the review

For a level two appeal concerning all other appeals, the majority of the committee will be made up of our staff, who were not previously involved with the appeal. However, a person who was previously involved with the appeal may be a member of the committee. You will receive a decision within 30 calendar days.

You may also appear before the committee to present information or answer questions. If you request to appear before the committee, we will hold a hearing within 45 calendar days from the day we receive your request. The committee will notify you in writing 15 days in advance of the hearing date. The notice will tell you:
- If an attorney will be present to argue our case against you
- Your right to obtain legal representation

In the hearing, you and we may present witnesses, but it is an informal process:
- It will be held during regular business hours
- If you cannot attend the hearing, you may participate by conference call or other available technology at our expense
- You may also request that we consider a postponement or rescheduling of the hearing

In addition, you may:
- Ask us to give you all relevant information that is not confidential or privileged
- Be helped or represented at the hearing by the person of your choice
- Submit supporting material. This may be done both before and during the hearing
- Ask questions of any of our representatives
- Ask your representative to attend

An adverse benefit determination you receive from us will describe:
- The external review process and the procedure to follow if you wish to pursue external review
- Your right to get assistance from us to request external review
- Your right to attend the external review
- The names, titles and qualifying credentials of the person(s) involved in the review
- A statement of the coordinator’s understanding of the appeal and all the pertinent facts
- The specific plan provisions upon which the decision is based
- The coordinator’s basis for the decision in clear terms
- A reference to the evidence or documentation used as the basis for the decision, and instructions for requesting copies of such materials
- A description of the process to request an expedited review of an urgent care claim
- The telephone number you can call for help with an appeal or a request for reconsideration
• A notice of your right to contact the Maine Bureau of Insurance, including the address and telephone number of the Bureau
• The availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act
• Notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under our internal review process
• Any other information required pursuant to the federal Affordable Care Act

You may be allowed to provide evidence or testimony during the appeals process in accordance with the guidelines established by the United States Department of Health and Human Services (HHS). We will make our decision within 5 business days of the day the hearing is completed.

If any appeal under the grievance procedure relies upon a medical opinion regarding a health condition as the material issue, you are entitled to an independent second opinion by a provider of a similar specialty, at our expense.

“Clinical peer” means a physician or other licensed health care practitioner who holds a nonrestricted license in a state of the United States, is board certified in the same or similar specialty as typically manages the medical condition, procedure or treatment under review and whose compensation does not depend, directly or indirectly, upon the quantity, type, or cost of the medical condition, procedure or treatment that the physician or other licensed health care practitioner approves or denies on behalf of a carrier.

**Exhaustion of appeals process**

In most situations you must complete the appeal process with us before you can take these other actions:

• Contact the Maine Bureau of Insurance to request an investigation of a complaint or appeal
• File a complaint or appeal with the Maine Bureau of Insurance
• Appeal through an external review process
• Pursue arbitration, litigation or other type of administrative proceeding

But sometimes you do not have to complete the appeals process before you may take other actions. These situations are:

• We have failed to make a decision of an appeal within the time period required
• You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.
• We did not follow all of the claim determination and appeal requirements of the Maine Bureau of Insurance or the United States Department of Health and Human Services (HHS). But you will not be able to proceed directly to external review unless you have exhausted all levels of the appeals process
• You and us mutually agree to bypass the appeals process
• The life or health of the covered person is in serious jeopardy
• The covered person has died
• The adverse healthcare treatment decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the claimant has received emergency services but has not been discharged from the facility that provided the emergency
External review

External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO).

You have a right to external review only if:

- Our claim decision involved medical judgment
- We decided the service or supply is not medically necessary or not appropriate
- We decided the service or supply is experimental or investigational
- You have received an adverse determination

You may also request external review if you want to know if the federal surprise bill law applies to your situation.

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To the Maine Bureau of Insurance
- Within 4 months of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

You will pay for any information that you send and want reviewed by the ERO. We will pay for information we send to the ERO plus the cost of the review.

The Maine Bureau of Insurance will:

- Contact the ERO that will conduct the review of your claim
- The ERO will:
  - Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
  - Consider appropriate credible information that you sent
  - Follow our contractual documents and your plan of benefits
  - Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the ERO makes, unless we can show conflict of interest, bias or fraud.

**How long will it take to get an ERO decision?**

We will tell you of the ERO decision not more than 30 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

But sometimes you can get a faster external review decision. Your provider must call us or send us a Request for External Review Form.

There are two scenarios when you may be able to get a faster external review:
For initial adverse determinations
You or your provider tells the Maine Bureau of Insurance that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function or
- Be much less effective if not started right away (in the case of experimental or investigational treatment)

For final adverse determinations
You or your provider tells the Maine Bureau of Insurance that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of experimental or investigational treatment) or
- The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision from the Maine Bureau of Insurance within 72 hours of us getting your request.

Recordkeeping
We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses
We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.
Coordination of benefits (COB)

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms
Here are some key terms we use in this section. These terms will help you understand this COB section.

Allowable expense means:
- A health care expense that any of your health plans cover to any degree. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, cosmetic surgery generally is not an allowable expense under this plan.

In this section when we talk about “other plans” through which you may have other coverage for health care expenses, we mean:
- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Different rules apply if you have Medicare. See the How COB works with Medicare section below for those rules.

Here’s how COB works
- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid
- We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable submitted expenses

Determining who pays
Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

<table>
<thead>
<tr>
<th>If you are:</th>
<th>Primary plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered under this plan as a student or dependent</td>
<td>The plan covering you as a student.</td>
<td>The plan covering you as a dependent.</td>
</tr>
</tbody>
</table>
How are benefits paid?

<table>
<thead>
<tr>
<th></th>
<th>Primary plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary plan</td>
<td>The primary plan pays your claims as if there is no other health plan involved.</td>
<td>The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that was not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.</td>
</tr>
<tr>
<td>Secondary plan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How COB works with Medicare

This section explains how the benefits under this plan interact with benefits available under Medicare. Keep in mind, if you have Medicare, you are not eligible to enroll in this plan. But you might get Medicare after you are already enrolled in this plan, so these rules will apply.

You have Medicare when you are entitled to premium-free Medicare Part A or enrolled in Medicare Part B or Premium Part A, or both, by reason of:

- Age
- Disability
- ALS / Lou Gehrig’s disease or
- End stage renal disease

You also have Medicare even if you are not entitled to premium-free Medicare Part A or enrolled in Medicare Part B or Premium Part A if you:

- Refused it
- Dropped it or
- Did not make a proper request for it

When you have Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. In the case of someone who is eligible but not covered, the plan may pay as if you are covered by Medicare and coordinates benefits with the benefits Medicare would have paid had you enrolled in Medicare. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid had you been covered.

<table>
<thead>
<tr>
<th>If you have Medicare because of:</th>
<th>Primary plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Medicare</td>
<td>This plan</td>
</tr>
<tr>
<td>Disability</td>
<td>Medicare</td>
<td>This plan</td>
</tr>
<tr>
<td>ALS / Lou Gehrig’s disease</td>
<td>Medicare</td>
<td>This plan</td>
</tr>
<tr>
<td>End stage renal disease (ESRD)*</td>
<td>This plan will pay first for the first 3 months unless you take a self-dialysis course, there is no Medicare waiting period and Medicare becomes primary payer on the first month of dialysis. Also, if a transplant takes place within the 3-month waiting period,</td>
<td>Medicare</td>
</tr>
</tbody>
</table>
Medicare becomes primary payer on the first of the month in which the transplant takes place.

*Note regarding ESRD: If you have Medicare due to age and then later have it due to ESRD, Medicare will remain your primary plan and this plan will be secondary.

This plan is secondary to Medicare in all other circumstances.

<table>
<thead>
<tr>
<th>How are benefits paid?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>We are primary</td>
<td>We pay your claims as if there is no Medicare coverage.</td>
</tr>
<tr>
<td>Medicare is primary</td>
<td>We calculate our benefit as if there were no Medicare coverage and reduce our benefit so that when combined with the Medicare payment, the total payment is no more than 100% of the allowable expense.</td>
</tr>
</tbody>
</table>

Other health coverage updates – contact information
You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly:
- **Online:** Log in to your Aetna member website at [https://www.aetnastudenthealth.com](https://www.aetnastudenthealth.com). Select Find a Form, then select Your Other Health Plans.
- **By phone:** Call Member Services at the toll-free number on your ID card.

Right to receive and release needed information
We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier
Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery
If we pay more than we should have under the COB rules, we may recover the excess from:
- Any person we paid or for whom we paid or
- Any other plan that is responsible under these COB rules
When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends and when you may still be able to continue coverage.

When will your coverage end?
Your coverage under this plan will end on the date of the first event to occur:
- This plan is discontinued
- The student policy ends
- You are no longer eligible for coverage
- The last day for which any required premium contribution has been paid
- The date you are no longer in an eligible class
- We end your coverage
- You become covered under another medical plan offered by the policyholder
- The date you withdraw from the school because of entering the armed forces of any country

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

Why would we suspend paying claims or end your coverage?
We will give you 30 days advance written notice if we suspend paying your claims because:
- You do not cooperate or give facts that we need to administer the COB provisions.

We may immediately end your coverage if:
- You commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage.
  You can refer to the General provisions – other things you should know- Honest mistakes and intentional deception section for more information on rescissions.

On the date your coverage ends, we will refund to the policyholder any prepayments for periods after the date your coverage ended.
Notice of cancellation
In the event your coverage is cancelled for not paying the **premium**, we will send you and the **policyholder** a notice of cancellation.

You have the right to designate another person to receive notice of cancellation of this **student policy** if it is cancelled for not paying the premium.

To designate or change the person you designate to receive the notice of cancellation, you must fill out a Third Party Notice Request Form. You can obtain the Third Party Notice Request Form by contacting us or the **policyholder**.

We will send the notice to you and the person you designate to the last address you provided us at least 10-45 calendar days before cancellation.
Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Continuation of coverage for other reasons
You can request an extension of coverage as we explain below, by calling Member Services at the toll-free number on your ID card.

How can you extend coverage if you are totally disabled when coverage ends?
Your coverage may be extended if you are totally disabled when coverage ends. Only the medical condition which caused the total disability is covered during your extension.

You are “totally disabled” if you cannot engage in most normal activities of a healthy person of the same age and gender.

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:
- When you are no longer totally disabled
- When you become covered by another health benefits plan or
- 6 months of coverage

How can you extend coverage when getting inpatient care when coverage ends?
Your coverage may be extended if you are getting inpatient care in a hospital or skilled nursing facility when coverage ends.

Benefits are extended for the condition that caused the hospital or skilled nursing facility stay or for complications from the condition. Benefits aren’t extended for other medical conditions.

You can continue to get care for this condition until the first to occur of:
- When you are discharged. Coverage will not end if you are transferred to another hospital or a skilled nursing facility.
- When you no longer need inpatient care.
- When you become covered by another health benefits plan.
- 3 months of coverage.
General provisions – other things you should know

Entire student policy
The student policy consists of several documents taken together. These documents are:
- The policyholder’s application
- Your enrollment form, if the policyholder requires one
- The student policy
- The certificate(s) of coverage
- The schedule of benefits
- Any riders, endorsement, inserts, attachments, and amendments to the student policy, the certificate of coverage, and the schedule of benefits

Administrative provisions
How you and we will interpret this certificate of coverage
We prepared this certificate of coverage according to federal laws and state laws that apply. You and we will interpret it according to these laws.

How we administer this plan
We apply policies and procedures we’ve develop to administer this plan.

Who’s responsible to you
We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your providers. Even in-network providers are not our employees or agents.

Coverage and services
Your coverage can change
Your coverage is defined by the student policy. This document may have amendments or riders too. Under certain circumstances, we or the policyholder or the law may change your plan according to requirements of the student policy. When an emergency or epidemic is declared, we may modify or waive precertification, prescription quantity limits or your cost share if you are affected. Only Aetna may waive a requirement of your plan. No other person – including the policyholder or provider – can do this.

If your student status changes the amount of your coverage or benefit levels, the change will take effect on the date of the status change and the amount of coverage or benefit level will be changed to the new amount.

A retroactive change in your student status will not cause a retroactive change in your coverage.

Legal action
You must complete the appeal process before you take any legal action against us for any expense or bill. See the When you disagree – claim decisions and appeals procedures section. You cannot take any action until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.
Physical examinations and evaluations and autopsies

At our expense, we have the right to have a physician of our choice examine you. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. We have the right and opportunity to conduct an autopsy in case of death where it is not prohibited by law.

Records of expenses
You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:
- Names of physicians, dental providers and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception
Honest mistakes
You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception
If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:
- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage as follows:
- We will give you 30 days advanced written notice of any rescission of coverage
- You have the right to an Aetna appeal
- You have the right to a third-party review conducted by an independent external review organization

Some other money issues
Assignment of benefits
When you see an in-network provider they will usually bill us directly. When you see an out-of-network provider, we may choose to pay you or to pay the provider directly. You may choose to assign benefits. To request assignment you must complete an assignment form. The assignment form is available from the policyholder. The completed form must be sent to us for consent.

Grace period
You will be allowed a grace period of 31 days after the due date for the payment of each contribution due after the first contribution payment. If contributions are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period.
Payment of premiums
The first premium payment for this policy is due on or before your effective date of coverage. Your next premium payment will be due the 1st of each month (“premium due date”). Each premium payment is to be paid to us on or before the premium due date.

Recovery of overpayments
We sometimes pay too much for eligible health services or pay for something that this plan doesn’t cover. If we do, we can require the person we paid – you or your provider – to return what we paid. If we don’t do that, we have the right to reduce any future benefit payments by the amount we paid by mistake.

When you are injured
If someone else caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money. We are entitled to that money, up to the amount we pay for your care. We have that right no matter who the money comes from – for example, the other driver, the policyholder, any workers’ compensation or disability award or settlement, or another insurance company. This process is called subrogation.

To help us get paid back, you are doing these things now:
- By accepting plan coverage, you agree your signed application for coverage is your authorization of our right of subrogation
- You are agreeing to let us know promptly in writing when you are aware of notice given to any party of the intention to investigate or pursue a claim to cover damages
- You are agreeing to repay us from money you receive because of your injury.
- You are giving us a right to seek money in your name, from any person who causes you injury and from your own insurance. We can seek money only up to the amount we paid for your care.
- You are agreeing to cooperate with us so we can get paid back in full. For example, you’ll tell us within 30 days of when you seek money for your injury or illness. You’ll hold any money you receive until we are paid in full. And you’ll give us the right to money you get, ahead of everyone else.
- You are agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money.
- At the appropriate time, you are agreeing to give us written approval to allow such payments to be made to us only on a just and equitable basis and not on the basis of a priority lien. A just and equitable basis recognizes factors that diminish the potential value of your claim. The factors that may reduce the potential value of your claim include, but are not limited to:
  - Legal defenses
  - Exigencies of trial and/or
  - Limits of coverage

If benefits are paid by us and we determine you received workers’ compensation benefits for the same incident, we have the right to recover as described in the subrogation provision. You agree that in consideration for the coverage provided by this student policy, you will notify us of any workers’ compensation claim you make and that you agree to reimburse us as described above.

We don’t have to reduce the amount we’re due for any reason, even to help pay your lawyer or pay other costs you incurred to get a recovery.
**Your health information**
We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your providers’ claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call Member Services at the toll-free number on your ID card.

When you accept coverage under this plan, you agree to let your providers share information with us. We need information about your physical and mental condition and care.

**Effect of benefits under other plans**
Effect of a Health Maintenance Organization plan (an HMO Plan) or a Preferred Provider Organization plan (PPO plan) on coverage

If you have coverage under another group medical plan (such as an HMO or PPO plan) and that other plan denies coverage of benefits because you received the services or supplies outside of the plan’s network geographic area, this student plan will cover those denied benefits as long as they are covered benefits under this plan. Covered benefits will be paid at the applicable level of benefits under the student plan.

**Effect of prior coverage - transferred business**
Prior coverage means:
- Any plan of student coverage that has been replaced by coverage under part or all of this plan.
- The plan must have been sponsored by the policyholder (e.g., transferred business).
- If you are eligible, the replacement can be complete, or in part for your eligible class. Any such plan is prior coverage if provided by another student contract or any benefit section of this plan.

If your coverage under any part of this plan replaces any prior coverage, any benefits provided under such prior coverage may reduce benefits payable under this plan. See the General coverage provisions section of the schedule of benefits.
Glossary A-M

Accident or accidental
An injury to you that is not planned or anticipated. An illness does not cause or contribute to an accident.

Aetna®
Aetna Life Insurance Company, an affiliate, or a third-party vendor under contract with Aetna.

Ambulance
A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Behavioral health provider
An individual professional that is licensed or certified to provide diagnostic and/or therapeutic services for mental health disorders and substance related disorders under the laws of the jurisdiction where the individual practices.

Brand-name prescription drug
An FDA-approved prescription drug marketed with a specific name or trademark name by the company that manufactures it, usually by the company which develops and patents it.

Calendar year
A period of 12 months beginning January 1st and ending on December 31st.

Clinical related injury
As used within the Blood and body fluid exposure covered benefit, this is any incident which exposes you, acting as a student in a clinical capacity, to an illness that requires testing and treatment. Incident means unintended:
- Needlestick pricks
- Exposure to blood and body fluid
- Exposure to highly contagious pathogens

Coinsurance
Coinsurance is both the percentage of eligible health services that the plan pays and what you pay. The specific percentage that we have to pay for eligible health services is listed in the schedule of benefits.

Copayments
The specific dollar amount or percentage you have to pay for a health care service listed in the schedule of benefits.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible health services that meet the requirements for coverage under the terms of this plan, including:
- They are medically necessary
- You received precertification, if required
Covered person
A covered student for whom all of the following applies:
• The person is eligible for coverage as defined in the certificate of coverage
• The person has enrolled for coverage and paid any required premium contribution
• The person’s coverage has not ended

Covered student
A student who is insured under the student policy.

Craniomandibular joint dysfunction (CMJ)
This is a disorder of the jaw joint.

Custodial care
Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be custodial care even if it prescribed by a physician or given by trained medical personnel.

Dental emergency
Any dental condition that:
• Occurs unexpectedly
• Requires immediate diagnosis and treatment in order to stabilize the condition, and
• Is characterized by symptoms such as severe pain and bleeding

Dental emergency services
Services and supplies given by a dental provider to treat a dental emergency.

Dental provider
Any individual legally qualified to provide dental services or supplies. This may be any of the following:
• Any dentist
• Independent practice dental hygienist
• Group
• Organization
• Dental facility
• Other institution or person

Dentist
A legally qualified dentist licensed to do the dental work he or she performs.

Detoxification
The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:
• Intoxicating alcohol or drug
• Alcohol or drug-dependent factors
• Alcohol in combination with drugs

This can be done by metabolic or other means as determined by a physician or a nurse practitioner working within the scope of their licenses. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.
The list of in-network providers for your plan. The most up-to-date directory for your plan appears at https://www.aetnastudenthealth.com. When searching from our online provider directory, you need to make sure that you are searching for providers that participate in your specific plan. In-network providers may only be considered for certain Aetna plans. When searching for in-network dental providers, you need to make sure you are searching under Pediatric Dental plan.

**Durable medical equipment (DME)**

Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an illness or injury
- Suited for use in the home
- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

**Effective date of coverage**

The date your coverage begins under this certificate of coverage as noted in Aetna’s records.

**Eligible health services**

The health care services and supplies and outpatient prescription drugs listed in the Eligible health services and exclusions section and not carved out or limited in the General exclusions section of this certificate of coverage or in the schedule of benefits.

**Emergency admission**

An admission to a hospital or treatment facility ordered by a physician within 24 hours after you receive emergency services.

**Emergency medical condition**

The sudden and, at the time, unexpected onset of a physical or mental health condition, including severe pain, manifesting itself by the symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe:

- That the absence of immediate medical attention for an individual could reasonably be expected to result in:
  - Placing the physical or mental health of the individual or, with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy
  - Serious impairment of a bodily function or
  - Serious dysfunction of any organ or body part
- With respect to a woman who is having contractions, that there is:
  - Inadequate time to effect a safe transfer of the woman to another hospital before delivery; or
  - A threat to the health or safety of the woman or unborn child if the woman were to be transferred to another hospital

**Emergency services**

A health care item or service furnished or required to evaluate and treat an emergency medical condition that is provided in an emergency facility or setting.
**Experimental or investigational**
A drug, device, procedure, or treatment that we find is experimental or investigational because:
- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility provider state that it is experimental or investigational.

**Formulary exclusions list**
A list of prescription drugs not covered under the plan. This list is subject to change.

**Generic prescription drug**
An FDA-approved drug with the same intended use as the brand-name product. It is considered to be as effective as the brand-name product and offers the same:
- Dosage
- Safety
- Strength
- Quality
- Performance

**Health professional**
A person who provides covered services within the scope of their practice and is licensed, certified or otherwise authorized by law to provide health care services to the public. Examples of health professionals include, but are not limited to, physicians, nurses, physician and registered nurse first assistants, dental providers, vision care providers, midwives and certified nurse midwives, and physical therapists.

**Home health aide**
A health professional that provides services through a home health care agency. The services that they provide are not required to be performed by an R.N., L.P.N., or L.V.N. A home health aide primarily aids you in performing the normal activities of daily living while you recover from an injury or illness.

**Home health care agency**
An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

**Home health care plan**
A plan of services prescribed by a physician (or other health professional) to be provided in the home setting. These services are usually provided after your discharge from a hospital or if you are homebound.
Homebound
This means that you are confined to your home because:

- Your physician has ordered that you stay at home because of an illness or injury
- The act of transport would be a serious risk to your life or health

You are not homebound if:

- You do not often travel from home because you are feeble or insecure about leaving your home
- You are confined to a wheelchair but you can be transported by a vehicle that can safely transport you in a wheelchair

Hospice benefit period
A period that begins on the date your physician certifies that you have a terminal illness. It ends after 12 months (or later for which your treatment is certified) or on your death; if sooner.

Hospice care
Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure.

Hospice care agency
An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care. These services may be available in your home or inpatient setting.

Hospice care program
A program prescribed by a physician or other health professional to provide hospice care and supportive care to their families.

Hospice facility
An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care.

Hospital
An institution licensed as a hospital by applicable state and federal laws, and is accredited as a hospital by The Joint Commission (TJC).

Hospital does not include a:

- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- Psychiatric hospital
- Residential treatment facility for substance related disorders
- Residential treatment facility for mental health disorders
- Extended care facility
- Intermediate care facility
- Skilled nursing facility

Hospital stay
This is your stay of 18 or more hours in a row as a resident bed patient in a hospital.
**Illness or illnesses**
Poor health resulting from disease of the body or mind.

**In-network dental provider**
A dental provider listed in the directory for your plan.

**In-network pharmacy**
A retail pharmacy, mail order pharmacy or specialty pharmacy that has contracted with Aetna, an affiliate, or a third-party vendor, to provide outpatient prescription drugs to you.

**In-network provider**
A provider listed in the directory for your plan. However, a NAP provider listed in the NAP directory is not an in-network provider.

**Infertile or infertility**
A disease defined by the failure to become pregnant:
- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart
  - For an individual or their partner who has been clinically diagnosed with gender dysphoria

**Injectable drug(s)**
These are prescription drugs when an oral alternative drug is not available.

**Injury or injuries**
Physical damage done to a person or part of their body.

**Institutes of Excellence™ (IOE) facility**
A facility designated by Aetna in the provider directory as Institutes of Excellence in-network provider for specific services or procedures.

**Intensive care unit**
A ward, unit, or area in a hospital which is set aside to provide continuous specialized or intensive care services to your because your illness or injury is severe enough to require such care.
Intensive outpatient program (IOP)
The clinical treatment provided must be:
- No more than 5 days per week
- No more than 19 hours per week
- A minimum of 2 hours each treatment day

Services must be medically necessary and delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a mental health disorder or substance related disorder and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder
This is:
- A disorder of the jaw joint
- A Myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

L.P.N.
A licensed practical nurse or a licensed vocational nurse.

Lifetime maximum
This is the most this plan will pay for eligible health services incurred by a covered person during their lifetime. Lifetime maximums do not apply to essential health benefits as classified by the Affordable Care Act (ACA) unless permitted.

Mail order pharmacy
A pharmacy where prescription drugs are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit
The maximum out-of-pocket amount for payment of copayments and coinsurance including any policy year deductible, to be paid by you per policy year for eligible health services.

Medically necessary/Medical necessity
Health care services or supplies that prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are all of the following, as determined by us within our discretion:
- Consistent with “generally accepted standards of medical practice”
- Clinically appropriate, in terms of type, frequency, extent, site and duration
- Demonstrated through scientific evidence to be effective in improving health
- Representative of “best practices” in the medical profession, and
- Not primarily for the convenience of the member, physician, or other health care provider

Generally accepted standards of medical practice means:
- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and
- Following the standards set forth in our clinical policies and applying clinical judgment
Important note:
We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is experimental or investigational. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact us. See the How to contact us for help section.

Medicare
As used in this plan, Medicare means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

Mental health disorder
A mental health disorder is, in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of mental health disorder is in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.
Negotiated charge

*Health coverage*

This is either:

- The amount an in-network provider has agreed to accept
- The amount we agree to pay directly to an in-network provider or third-party vendor (including any administrative fee in the amount paid)

for providing services, prescription drugs or supplies to covered persons in the plan. This does not include prescription drug services from an in-network pharmacy.

For surprise billing, calculations will be made based on the median contracted rate.

We may enter into arrangements with in-network providers or others related to:

- The coordination of care for covered persons
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing

These arrangements will not change the negotiated charge under this plan.

*Prescription drug coverage from an in-network pharmacy*

In-network pharmacy

The amount we established for each prescription drug obtained from an in-network pharmacy under this plan. This negotiated charge may reflect amounts we agreed to pay directly to the in-network pharmacy or to a third-party vendor for the prescription drug, and may include a rebate, an additional service or risk charge set by us.

We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may change the negotiated charge under this plan.

Non-preferred drug

A prescription drug or device that may have a higher out-of-pocket cost than a preferred drug.

Out-of-network dental provider

A dental provider who is not an in-network dental provider and does not appear in the directory for your plan.

Out-of-network pharmacy

A pharmacy that is not an in-network pharmacy, a National Advantage Program (NAP) provider and does not appear in the directory for your plan.

Out-of-network provider

A provider who is not an in-network provider or National Advantage Program (NAP) provider and does not appear in the directory for your plan.
Partial hospitalization treatment
Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. Services must be medically necessary and provided by a behavioral health provider with the appropriate license or credentials. Services are designed to address a mental health disorder or substance related disorder issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Care is delivered according to accepted medical practice for the condition of the person.

Pharmacy
An establishment where prescription drugs are legally dispensed. This includes an in-network retail pharmacy, mail order pharmacy and specialty pharmacy. It also includes an out-of-network retail pharmacy and mail order pharmacy.

Physician
A skilled health professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy, naturopathy or dentistry.

Policyholder
The school named on the front page of the student policy and your certificate of coverage and schedule of benefits for the purpose of coverage under the student policy.

Policy year
This is the period of time from anniversary date to anniversary date of the student policy except in the first year when it is the period of time from the effective date to the first anniversary date.

Policy year deductible
The amount you pay for eligible health services per policy year before your plan starts to pay as listed in the schedule of benefits.

Precertification, precertify
A requirement that you or your physician contact Aetna before you receive coverage for certain services. This may include a determination by us as to whether the service is medically necessary and eligible for coverage.

Preferred drug
A prescription drug or device that may have a lower out-of-pocket cost than a non-preferred drug.

Preferred drug guide
A list of prescription and over-the-counter (OTC) drugs and devices established by Aetna or an affiliate. It does not include all prescription and OTC drugs and devices. This list can be reviewed and changed by Aetna or an affiliate. A copy of the preferred drug guide is available at your request. You can also find it on the Aetna website at https://www.aetnastudenthealth.com.

Preferred in-network pharmacy
A network retail pharmacy that Aetna has identified as a preferred in-network pharmacy.
Premium
The amount you or the policyholder are required to pay to Aetna to continue coverage.

Prescriber
Any provider acting within the scope of his or her license, who has the legal authority to write an order for outpatient prescription drugs.

Prescription
As to hearing care:
A written order for the dispensing of prescription electronic hearing aids by otolaryngologist, otologist or audiologist.

As to prescription drugs:
A written order for the dispensing of a prescription drug or device by a prescriber. If it is a verbal order, it must promptly be put in writing by the in-network pharmacy.

As to vision care:
A written order for the dispensing of prescription lenses or prescription contact lenses by an ophthalmologist or optometrist.

Prescription drug
An FDA approved drug or biological which can only be dispensed by prescription.

Provider(s)
A physician, other health professional, hospital, skilled nursing facility, home health care agency, pharmacy, or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric hospital
An institution specifically licensed as a psychiatric hospital by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of substance related disorders and mental health disorders.

Psychiatrist
A psychiatrist generally provides evaluation and treatment of mental, emotional, or behavioral disorders.
Recognized charge

The amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The recognized charge depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the recognized charge for specific services or supplies:

<table>
<thead>
<tr>
<th>Service or supply</th>
<th>Recognized charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional services and other services or</td>
<td>105% of the Medicare allowed rate</td>
</tr>
<tr>
<td>supplies not mentioned below</td>
<td></td>
</tr>
<tr>
<td>Services of hospitals and other facilities</td>
<td>140% of the Medicare allowed rate</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>100% of the average wholesale price (AWP)</td>
</tr>
<tr>
<td>Dental expenses</td>
<td>80% of the prevailing charge rate</td>
</tr>
</tbody>
</table>

Important note: If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a prescription drug listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by Aetna).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other providers charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply
  - When the recognized charge is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to providers under Medicare programs.
- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.
Our reimbursement policies
We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the recognized charge. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider

Our reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits
We have online tools to help you decide whether to get care and if so, where. Log in to your Aetna website at https://www.aetnastudenthealth.com. The website contains additional information that can help you determine the cost of a service or supply.

R.N.
A registered nurse.

Residential treatment facility (mental health disorders)

- An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by Aetna or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating mental health disorders:

- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)
Residential treatment facility (substance related disorders)
An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for substance related disorders residential treatment programs. And is credentialed by Aetna or accredited by one of the following agencies, commissions or committees for the services being provided:
- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for substance related disorders residential treatment programs:
- A behavioral health provider or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a physician
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)

In addition to the above requirements, for substance related detoxification programs within a residential setting:
- An R.N. must be onsite 24 hours per day for 7 days a week within a residential setting
- Residential care must be provided under the direct supervision of a physician

Respite care
This is care provided to you when you have a terminal illness for the sole purpose of providing temporary relief to your family (or other care givers) from the daily demands of caring for you.

Retail pharmacy
A community pharmacy that dispenses outpatient prescription drugs.

Room and board
A facility’s charge for your overnight stay and other services and supplies expressed as a daily or weekly rate.

School health services
The policyholder’s school’s student health center or a provider or organization that is identified as a school health services provider.

Self-injectable Drug(s)
These are prescription drugs that are intended for you to self-administer by injection to a specific part of your body to treat certain chronic medical conditions.

Semi-private room rate
An institution’s room and board charge for most beds in rooms with 2 or more beds. If there are no such rooms, Aetna will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.
Skilled nursing facility
A facility specifically licensed as a skilled nursing facility by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation hospitals, and portions of a rehabilitation hospital and a hospital designated for skilled or rehabilitation therapy services.

Skilled nursing facility does not include institutions that provide only:
- Minimal care
- Custodial care services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of mental health disorders or substance related disorders.

Skilled nursing services
Services provided by an R.N. or L.P.N. within the scope of his or her license.

Sound natural teeth
These are natural teeth. If there is a filling in a tooth, the major portion of the tooth must be present. A tooth cannot be decayed, abscessed, or defective. Sound natural teeth are not capped teeth, implants, crowns, bridges, or dentures.

Specialist
A physician who practices in any generally accepted medical or surgical sub-specialty and is board-certified.

Specialty pharmacy
A pharmacy that fills prescriptions for specialty drugs.

Specialty prescription drug
An FDA-approved prescription drug that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:
- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

Stay
A full-time inpatient confinement for which a room and board charge is made.

Step therapy
A form of precertification where you must try one or more required drug(s) before a step therapy drug is covered. The required drugs have FDA approval, may cost less and treat the same condition. If you don’t try the appropriate required drug first, you may need to pay full cost for the step therapy drug.
Student policy
The student policy consists of several documents taken together. The list of documents can be found in the Entire student policy section of this certificate of coverage.

Substance related disorder
A substance related disorder, addictive disorder, or both, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

Surgery center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient surgery services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Surgery, surgeries or surgical procedures
The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as:
- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution or
- Otherwise physically changing body tissues and organs

Telehealth
A consultation between you and a physician, specialist, behavioral health provider, or telehealth provider who is performing a clinical medical or behavioral health service by means of electronic communication.

Temporomandibular joint dysfunction (TMJ)
This is a disorder of the jaw joint.

Terminal illness
A medical prognosis that you are not likely to live more than 12 months.

Urgent admission
This is an admission to the hospital due to an illness or injury that is severe enough to require a stay in a hospital within 2 weeks from the date the need for the stay becomes apparent.
Urgent care facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an urgent condition.

Urgent condition
An illness or injury that requires prompt medical attention but is not an emergency medical condition.

Walk-in clinic
A health care facility that provides limited medical care on a scheduled and unscheduled basis. A walk-in clinic may be located in, near, or within a:
- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a walk-in clinic:
- Ambulatory surgical center
- Emergency room
- Hospital
- Outpatient department of a hospital
- Physician’s office
- Urgent care facility
Discount programs

Discount arrangements
We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third-party service providers”. These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don’t pay the third party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

Wellness and Other Incentives
Covered students only

We may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services, and to continue your participation in the Aetna plan through incentives. You and your physician can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, including but not limited to financial wellness programs, we may provide incentives based on your participation.

Incentives may include but are not limited to:
- Modifications to copayment, coinsurance, or policy year deductible amounts
- Premium discounts or rebates
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards or
- Any combination of the above.

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon your health status.
Assistive Technology

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

Smartphone or Tablet

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

Non-Discrimination

Aetna is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

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

Language accessibility statement

**Interpreter services are available for free.**

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

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-480-4161** (TTY: **711**).
Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).
Aetna Life Insurance Company Rider

Travel and Lodging Reimbursement

Rider effective date: 08/01/2023

This rider is added to the Eligible health services and exclusions section of your certificate of coverage. This rider is subject to all other requirements described in your certificate, including general exclusions and defined terms.

Eligible health services and exclusions

Travel and lodging expenses
We will reimburse you for travel and lodging expenses when you need to travel at least 100 miles to access eligible health services for abortion because a law or regulation where you are located prohibits eligible health services for abortion. 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 for abortion when you submit your travel and lodging claim form.

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

We will reimburse your covered travel and lodging expenses as described in the schedule of benefits below.

See your certificate of coverage for information on eligible health services for abortion. Your schedule of benefits describes the policy year deductibles, copayments or coinsurance, if any, that apply for abortion eligible health services.

Exclusions
The following are not covered travel and lodging expenses under this rider:

- Expenses for more than one travel companion
- 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

Schedule of benefits
This rider is subject to the requirements described in your medical plan schedule of benefits unless otherwise noted below.

Travel and lodging expenses

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel and lodging reimbursement</td>
<td>100% No policy year deductible applies</td>
</tr>
<tr>
<td>Limit per policy year</td>
<td>$3000</td>
</tr>
</tbody>
</table>

This rider does not apply to the continuation of coverage plan. See the Special coverage options after your plan coverage ends section of the certificate.