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

Schedule of Benefits

Prepared exclusively for:

Policyholder: Illinois Institute of Technology
Policyholder number: 724532
Student policy effective date: 08/10/2019
Plan effective date: 08/10/2019
Plan issue date: 07/05/2019
Actuarial value and metallic level: 83.45% - Gold

Underwritten by Aetna Life Insurance Company in the State of Illinois.

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
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 and copayments and coinsurance listed in the schedule of benefits below reflects the policy year deductibles and copayment 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 receive that are not a covered benefit.
- This plan has maximums for specific covered benefits. For example, these could be visit, day or dollar maximums. They are combined 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
  - 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.

How to contact us for help

We are here to answer your questions.

- Call Member Services at the toll-free number on your ID card 1-877-480-4161.

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.

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
**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:

<table>
<thead>
<tr>
<th>You pay your policy year deductible</th>
<th>Your physician charges</th>
<th>Your physician collects the copayment from you</th>
<th>The plan pays 80% coinsurance</th>
<th>You pay 20% coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000</td>
<td>$120</td>
<td>$20</td>
<td>$80</td>
<td>$20</td>
</tr>
</tbody>
</table>

**Plan features**

<table>
<thead>
<tr>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
</table>

**Policy year deductible**

You have to meet your policy year deductible before this plan pays for benefits.

<table>
<thead>
<tr>
<th>Student</th>
<th>$300 per policy year</th>
<th>400 per policy year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>$300 per policy year</td>
<td>$400 per policy year</td>
</tr>
<tr>
<td>Each Child</td>
<td>$300 per policy year</td>
<td>$400 per policy year</td>
</tr>
</tbody>
</table>

**Policy year deductible waiver**

The policy year deductible is waived for the following eligible health services:

- In-network care for *Preventive care and wellness*
- In-network care for *Pediatric Preventive Dental Benefits*
- In-network and out-of-network care for *victims of sexual assault or abuse, Pediatric Vision Benefits, and Prescribed Medicines Expense*

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
## Maximum out-of-pocket limits

<table>
<thead>
<tr>
<th></th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student</strong></td>
<td>$6,850 per policy year</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Spouse</strong></td>
<td>$6,850 per policy year</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Each child</strong></td>
<td>$6,850 per policy year</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$13,700 per policy year</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*See the *How to read your schedule of benefits*, *Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.*
**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**.

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Preventive care and wellness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine physical exams</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed at a physician's office</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>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. For details, contact your physician or Member Services by logging onto your Aetna secure website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or calling the toll-free number on your ID card.</td>
<td></td>
</tr>
<tr>
<td>Covered persons age 22 &amp; over: Maximum visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive care immunizations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed in a facility or at a physician's office</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><strong>Maximums</strong></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 For details, contact your physician or Member Services by logging onto your Aetna secure website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or calling the toll-free number on your ID card.</td>
<td></td>
</tr>
</tbody>
</table>

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Well woman preventive visits</th>
<th>Routine gynecological exams (including Pap smears)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performed at a physician’s, obstetrician (OB), gynecologist (GYN) or OB/GYN office</strong></td>
<td><strong>100% (of the negotiated charge) per visit</strong></td>
</tr>
<tr>
<td></td>
<td><strong>No copayment or policy year deductible applies</strong></td>
</tr>
<tr>
<td></td>
<td><strong>80% (of the recognized charge) per visit</strong></td>
</tr>
</tbody>
</table>

| **Maximums**                                      | **Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration Women’s Preventive Services Guidelines.** |
| **Maximum visits per policy year**                | **1 visit**                                      |

<table>
<thead>
<tr>
<th><strong>Preventive screening and counseling services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity and/or healthy diet counseling office visits</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

| **Maximum visits per policy year**                | **26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*** |
| **(This maximum applies only to covered persons age 22 and older)** | **5 visits***                                      |

*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.

| **Substance use disorders counseling office visits** | **100% (of the negotiated charge) per visit**     |
|                                                   | **No copayment or policy year deductible applies** |
|                                                   | **80% (of the recognized charge) per visit**     |

| **Maximum visits per policy year**                | **5 visits***                                      |

*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.

| **Use of tobacco products counseling office visits** | **100% (of the negotiated charge) per visit**     |
|                                                   | **No copayment or policy year deductible applies** |
|                                                   | **80% (of the recognized charge) per visit**     |

| **Maximum visits per policy year**                | **8 visits***                                      |

*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.
<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Sharing 100% (of the negotiated charge) per visit</th>
<th>Cost Sharing 80% (of the recognized charge) per visit</th>
<th>Maximum visits per policy year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression screening counseling office visits</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
<td>1 visit*</td>
</tr>
<tr>
<td>Sexually transmitted infection counseling office visits</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
<td>2 visits*</td>
</tr>
<tr>
<td>Genetic risk counseling for breast and ovarian cancer office visits</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin cancer behavioral counseling office visits</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls prevention counseling office visits</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
<table>
<thead>
<tr>
<th>Routine cancer screenings</th>
<th>Performed at a physician’s office, specialist’s office or facility.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine cancer screenings</td>
<td>100% (of the negotiated charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>80% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximums</th>
<th>Subject to any age; family history; and frequency guidelines as set forth in the most current:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</td>
</tr>
<tr>
<td></td>
<td>• The comprehensive guidelines supported by the Health Resources and Services Administration.</td>
</tr>
<tr>
<td></td>
<td>For details, contact your physician or Member Services by logging onto your Aetna secure website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or calling the toll-free number on your ID card.</td>
</tr>
</tbody>
</table>

| Lung cancer screening maximums | 1 screening every 12 months* |

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

<table>
<thead>
<tr>
<th>Prenatal care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)</td>
</tr>
</tbody>
</table>

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

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Comprehensive lactation support and counseling services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactation counseling services - facility or office visits</td>
<td>100% (of the negotiated charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>80% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Lactation counseling services maximum visits per policy year either in a group or individual setting</td>
<td>6 visits*</td>
</tr>
<tr>
<td>*Important note: Any visits that exceed the lactation counseling services maximum are covered under the Physicians and other health professionals section.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breast feeding durable medical equipment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast pump supplies and accessories</td>
<td>100% (of the negotiated charge) per item</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>80% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Important note: See the Breast feeding durable medical equipment section of the certificate of coverage for limitations on breast pump and supplies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family planning services – female contraceptives</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female contraceptive counseling services office visit</td>
<td>100% (of the negotiated charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>80% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Contraceptive counseling services maximum visits per policy year either in a group or individual setting</td>
<td>2 visits*</td>
</tr>
<tr>
<td>Important note: Any visits that exceed the contraceptive counseling services maximum are covered under Physician services office visits.</td>
<td></td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
<table>
<thead>
<tr>
<th></th>
<th>Contraceptives (prescription drugs and devices)</th>
<th>80% (of the recognized charge) per item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female contraceptive</td>
<td>100% (of the negotiated charge per item)</td>
<td></td>
</tr>
<tr>
<td>prescription drugs and devices provided, administered, or removed, by a physician during an office visit</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% (of the recognized charge) per item</td>
<td></td>
</tr>
<tr>
<td>Female voluntary sterilization</td>
<td>100% (of the negotiated charge) per visit</td>
<td></td>
</tr>
<tr>
<td>Inpatient provider services</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% (of the recognized charge) per visit</td>
<td></td>
</tr>
<tr>
<td>Outpatient provider services</td>
<td>100% (of the negotiated charge per visit)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% (of the recognized charge) per visit</td>
<td></td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2. Physicians and other health professionals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physician and specialist services (non-surgical and non-preventive)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office hours visits (non-surgical and non-preventive care by a physician and specialist)</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Telemedicine consultation by a physician or specialist</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><strong>Allergy testing and treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy testing performed at a physician’s or specialist’s 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’s or specialist’s 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><strong>Physician and specialist – inpatient surgical services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td><strong>Physician and specialist – outpatient surgical services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery performed at a physician’s or specialist’s office or outpatient department of a hospital or surgery center by a surgeon</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

*See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefits.
| In-hospital non-surgical physician services | 80% (of the negotiated charge) per admission | 60% (of the recognized charge) per admission |
| Consultant services (non-surgical and non-preventive) | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Consultant office visits | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Telemedicine consultation by a consultant | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Second surgical opinion | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Alternatives to physician office visits | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Walk-in clinic visits (non-emergency visit) | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

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.*

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage**</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Hospital and other facility care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital care (facility charges)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital (room and board) and other miscellaneous services and supplies</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board intensive care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For physician charges, refer to the Physician and specialist-inpatient surgical services benefit</td>
<td></td>
<td></td>
</tr>
<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>
<tr>
<td>Anesthesia and related facility charges for a dental procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage is subject to certain conditions. See the benefit description in the certificate of coverage for details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia and related facility charges for a dental procedure</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Alternatives to hospital stays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery (facility charges)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility charges for surgery performed in the outpatient department of a hospital or surgery center</td>
<td>80% (of the negotiated charge)</td>
<td>60% (of the recognized charge)</td>
</tr>
<tr>
<td>For physician charges, refer to the Physician and specialist-outpatient surgical services benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>80% (of the negotiated charge)</td>
<td>60% (of the recognized charge)</td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
**Hospice care**

<table>
<thead>
<tr>
<th>Inpatient facility (room and board and other miscellaneous services and supplies)</th>
<th>80% (of the negotiated charge) per admission</th>
<th>60% (of the recognized charge) per admission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong></td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

**Outpatient private duty nursing**

<table>
<thead>
<tr>
<th>Outpatient private duty nursing</th>
<th>80% (of the negotiated charge) per visit</th>
<th>60% (of the recognized charge) per visit</th>
</tr>
</thead>
</table>

**Skilled nursing facility**

<table>
<thead>
<tr>
<th>Inpatient facility (room and board) and miscellaneous inpatient care services and supplies</th>
<th>80% (of the negotiated charge) per admission</th>
<th>60% (of the recognized charge) per admission</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
### 4. Emergency services and urgent care

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital emergency room</td>
<td>80% (of the negotiated charge) per visit</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td>Emergency services resulting from a criminal sexual assault or abuse</td>
<td>100% (of the negotiated charge) per visit</td>
<td>Paid the same as in-network coverage</td>
</tr>
</tbody>
</table>

**Important note:**
- As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment and coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- 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>Eligible health services</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>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

**See the cost-sharing that applies to these covered benefits in this schedule of benefits.**

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Pediatric dental care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to covered persons through the end of the month in which the person turns age 19</td>
<td></td>
<td></td>
</tr>
<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 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 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>

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.

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
**Pediatric dental care schedule**

### Diagnostic and preventive care (type A services)

#### Dental service or supply

**Visits and images**

- Office visit during regular office hours for oral exam, limited to 2 visits every 12 months
- Routine comprehensive or recall examination, limited to 2 visits every 12 months
- Problem-focused examination
- Oral examination performed in school setting, limited to 2 visits every 12 months
- Prophylaxis (cleaning) (office or school setting), limited to 2 treatments per year
- Topical application of fluoride (office or school setting, limited to 2 applications of treatment per year
- Topical application of fluoride varnish, limited to 3 treatments per year
- Sealant, per tooth, limited to 1 application every 3 years for permanent molars and premolar only
- Prophylaxis (office or school setting), limited to 2 treatments per year
- Complete image series, including bitewings if medically necessary or panoramic image, limited to 1 sets per 36 months
- Vertical bitewing images, limited to 1 set every 36 months
- Periapical images
- Intra-oral, occlusal view, maxillary or mandibular
- Emergency palliative treatment, per visit

**Space maintainers**

- Space maintainers are covered only when needed to preserve space resulting from premature loss of primary teeth (Includes all adjustments within 6 months after installation)
- Space maintainers - Fixed (unilateral or bilateral)
- Space maintainers - Removable (unilateral or bilateral)
- Re-cementation of space maintainer
- Removal of fixed space maintainer

### Basic restorative care (type B services)

#### Dental service or supply

**Visits and images**

- Consultation by other than the treating provider
- Professional visit after hours (payment will be made on the basis of services rendered or the charge for the after-hours visit, whichever is greater)

**Images, pathology and prescription drugs**

- Extra-oral radiographic image

**Oral surgery**

- Extraction, coronal remnants
- Extraction, erupted tooth or exposed root
- Extractions, surgical removal of erupted tooth/root tip
- Impacted teeth, removal of tooth (soft tissue)
- Odontogenic cysts and neoplasms, removal of odontogenic cyst or tumor
- Other surgical procedures, alveoplasty, in conjunction with extractions per quadrant
- Other surgical procedures, alveoplasty, not in conjunction with extraction
- Other surgical procedures, alveoplasty, not in conjunction with extractions – 1 to 3 teeth or tooth

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Type</th>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodontics</td>
<td>Excision of hyperplastic tissue, Removal of exostosis, Tooth reimplantation, Transplantation of tooth or tooth bud, Closure of oral fistula or maxillary sinus, Crown exposure to aid eruption, Frenectomy</td>
</tr>
<tr>
<td>Endodontics</td>
<td>Occlusal adjustment (other than with an appliance or by restoration), Periodontal scaling and root planing, per quadrant, limited to 4 separate quadrants every 2 years, Periodontal scaling and root planing – 1 to 3 teeth per quadrant; limited to 4 separate quadrant every 2 years, Gingivectomy, per quadrant, limited to 1 per quadrant every 24 months, Gingivectomy, 1 to 3 teeth per quadrant, limited to 1 per site every 24 months, Gingival flap procedure, per quadrant, limited to 1 per quadrant every 24 months, Gingival flap procedure-1 to 3 teeth per quadrant, limit to 1 per site every 24 months, Periodontal maintenance procedures following active therapy</td>
</tr>
<tr>
<td>Restorative dentistry</td>
<td>Pulp capping, Pulpotomy, Pulpal therapy, Pulpal regeneration, Apexification/recalcification, Apicoectomy, Root canal therapy including medically necessary images: Anterior, Bicuspid</td>
</tr>
<tr>
<td></td>
<td>(Multiple restorations in 1 surface are considered as a single restoration)</td>
</tr>
<tr>
<td>Pins</td>
<td>Pin retention – per tooth, in addition to amalgam or resin restoration</td>
</tr>
<tr>
<td>Crowns</td>
<td>Prefabricated stainless steel, Prefabricated resin crown (excluding temporary crowns)</td>
</tr>
<tr>
<td>Re-cementation</td>
<td>Inlay, Crown, Bridge</td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
**Major restorative care (type C services)**

**Dental service or supply**

**Oral surgery**

- Surgical removal of impacted teeth:
  - Removal of tooth (partially bony)
  - Removal of tooth (completely bony)

**Periodontics**

- Osseous surgery, including flap and closure, 1 to 3 teeth per quadrant, limited to 1 per site every 24 months
- Osseous surgery, including flap and closure per quadrant, limited to 1 per quadrant every 24 months
- Soft tissue graft procedure
- Clinical crown lengthening
- Full mouth debridement, 2 per year

**Endodontics**

- Molar root canal therapy including medically necessary images
- Retreatment of previous root canal therapy including medically necessary images:

**Restorative**

(Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.)

- Inlay/onlays, limited to 1 per tooth every 5 years

**Crowns**

- Resin, limited to 1 per tooth every 5 years
- Resin with noble metal, limited to 1 per tooth every 5 years
- Resin with base metal, limited to 1 per tooth every 5 years
- Porcelain/ceramic substrate, limited to 1 per tooth every 5 years
- Porcelain with noble metal, limited to 1 per tooth every 5 years
- Porcelain with base metal, limited to 1 per tooth every 5 years
- Porcelain with noble metal, limited to 1 tooth every 5 years
- Base metal (full cast), limited to 1 per tooth every 5 years
- Noble metal (full cast), limited to 1 per tooth every 5 years
- Titanium, limited to 1 tooth every 5 years
- ¾ cast metallic or porcelain/ceramic, limited to 1 per tooth every 5 years
- Core build-up
- Post and core

**Repairs:**

**Prosthodontics**

- Dentures and partial dentures:
  - Replacement of existing dentures or bridges, limited to 1 every 5 years
  - Installation of dentures and bridges is covered only if needed to replace teeth which were not abutments to a denture or bridge less than 5 years old.
- Bridg abutments (see inlays and crowns)

**Pontics**

- Full cast base metal, limited to 1 every 5 years
- Full cast noble metal, limited to 1 every 5 years

*See the *How to read your schedule of benefits*, *Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.*
- Porcelain with noble metal, limited to 1 every 5 years
- Porcelain with base metal, limited to 1 every 5 years
- Resin with noble metal, limited to 1 every 5 years
- Resin with base metal, limited to 1 every 5 years
- Resin with noble metal, limited to 1 every 5 years
- Titanium, limited to 1 every 5 years
- Removable bridge (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

### 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/immediate upper partial denture, limited to 1 every 5 years
- Immediate lower denture/immediate lower partial 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 with resin saddles (including any conventional clasps, rest and teeth), limited to 1 every 5 years
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Office reline
- Laboratory relines
- Special tissue conditioning, per denture
- Rebase, per denture
- Adjustment to denture (more than 6 months after installation)
- 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: crowns and bridges
- Occlusal guard (for bruxism only)
- Occlusal guard adjustment, not eligible within first 6 months after placement of appliance

### General anesthesia and intravenous sedation

Only when medical necessary and only when provided in conjunction with a covered dental surgical procedure

- Nitrous oxide/analgesia
- Therapeutic drug injection, limited to medical necessity
- Non-intravenous conscious sedation
- Other drugs or medicaments, by report

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Orthodontic services</th>
<th>(Medically necessary comprehensive treatment.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All comprehensive orthodontic services require precertification to ensure treatment is medically necessary. To qualify for coverage, your severe, dysfunctional, handicapping malocclusion may be evaluated using the Modified Salzmann Index where coverage would need to score 42 points or greater.</td>
<td></td>
</tr>
<tr>
<td>• Orthodontic waiting period, none</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Specific conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birthing center (facility charges)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(room and board 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>
<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>
<tr>
<td>Family planning services – other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary sterilization for males</td>
<td></td>
<td></td>
</tr>
<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>
<tr>
<td>Abortion</td>
<td></td>
<td></td>
</tr>
<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>
<tr>
<td>Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (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>Impacted wisdom teeth</td>
<td>80% (of the negotiated charge)</td>
<td>80% (of the recognized charge)</td>
</tr>
</tbody>
</table>

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### Accidental injury to sound natural teeth

| Accidental injury to sound natural teeth | 80% (of the negotiated charge) | 80% (of the recognized charge) |

### Dermatological treatment

| Dermatological treatment | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

### Maternity care

| Maternity care (includes delivery and postpartum care services in a hospital or birthing center) | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

### Well newborn nursery care

<table>
<thead>
<tr>
<th>Well newborn nursery care in a hospital or birthing center</th>
<th>80% (of the negotiated charge)</th>
<th>60% (of the recognized charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

*Note: If applicable, the per admission copayment and/or policy year deductible 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.*

### Pregnancy complications

<table>
<thead>
<tr>
<th>Inpatient (room and board and other miscellaneous services and supplies)</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject to semi-private room rate unless intensive care unit required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board includes intensive care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Gender reassignment (sex change) treatment

| Surgical, hormone replacement therapy, and counseling treatment | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th><strong>Autism spectrum disorder</strong></th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</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 physician and specialist 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>

| **Mental health treatment** | | |
|-----------------------------|-----------------------------|
| Mental health treatment – inpatient | | |
| Inpatient hospital mental disorders treatment (room and board and other miscellaneous hospital services and supplies) | 80% (of the negotiated charge) per admission | 60% (of the recognized charge) per admission |
| Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies) | | |
| Subject to semi-private room rate unless intensive care unit is required | | |
| Mental disorder room and board intensive care | | |
## Mental health treatment – outpatient

<table>
<thead>
<tr>
<th>Service</th>
<th>80% (of the negotiated charge) per visit</th>
<th>60% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient mental disorder treatment office visits to a physician or behavioral health provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other outpatient mental disorders treatment (includes skilled behavioral health services in the home)</td>
<td></td>
<td></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 use disorder related treatment - inpatient

### Detoxification – inpatient

<table>
<thead>
<tr>
<th>Service</th>
<th>80% (of the negotiated charge) per admission</th>
<th>60% (of the recognized charge) per admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital substance use disorder detoxification (room and board and other miscellaneous hospital services and supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital substance use disorder rehabilitation (room and board and other miscellaneous hospital services and supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient residential treatment facility substance use disorder (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 use disorder room and board intensive care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Substance use disorder related treatment-outpatient: detoxification and rehabilitation</th>
<th>80% (of the negotiated charge) per visit</th>
<th>60% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient substance use disorder office visits to a physician or behavioral health provider</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Other outpatient substance use disorder services</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (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>
<tr>
<td><strong>Obesity (bariatric) surgery</strong></td>
<td></td>
<td></td>
</tr>
<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>
<tr>
<td><strong>Reconstructive surgery and supplies</strong></td>
<td></td>
<td></td>
</tr>
<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>

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network (IOE facility)</td>
<td>Network (Non-IOE facility)</td>
<td>Network Non-IOE facility and out-of-network facility</td>
</tr>
</tbody>
</table>

### Transplant services

<table>
<thead>
<tr>
<th>Inpatient and outpatient transplant facility services</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<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>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

### Transplant services-travel and lodging

<table>
<thead>
<tr>
<th>Transplant services-travel and lodging</th>
<th>Covered</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Lifetime Maximum Benefit payable for Travel and Lodging Expenses for any one transplant, including tandem transplants</th>
<th>$10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Benefit payable for Lodging Expenses per IOE patient</td>
<td>$50 per night</td>
</tr>
<tr>
<td>Maximum Benefit payable for Lodging Expenses per companion</td>
<td>$50 per night</td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment of infertility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic infertility services</strong></td>
<td></td>
<td></td>
</tr>
<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>
<tr>
<td><strong>Comprehensive infertility services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient and outpatient care - comprehensive infertility 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>Maximum number of ovulation induction cycles with menotropins per lifetime</td>
<td>6 attempts</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Does not apply toward the plan maximum out-of-pocket limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Advanced reproductive technology (ART) service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient and outpatient care – ART 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>Maximum number of cycles per lifetime</td>
<td>6 attempts</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Does not apply toward the plan maximum out-of-pocket limit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefits.
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
</table>

7. Specific therapies and tests

**Outpatient diagnostic testing**

<table>
<thead>
<tr>
<th>Diagnostic complex imaging services</th>
<th>80% (of the negotiated charge) per visit</th>
<th>60% (of the recognized charge) per visit</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Diagnostic lab work and radiological services</th>
<th>80% (of the negotiated charge) per visit</th>
<th>60% (of the recognized charge) per visit</th>
</tr>
</thead>
</table>

**Chemotherapy**

<table>
<thead>
<tr>
<th>Chemotherapy</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
</table>

**Outpatient infusion therapy**

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

**Outpatient radiation therapy**

<table>
<thead>
<tr>
<th>Outpatient radiation therapy</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
</table>

**Specialty prescription drugs**

(Purchased and injected or infused by your provider in an outpatient setting)

<table>
<thead>
<tr>
<th>Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting</th>
<th>Covered according to the type of benefit or the place where the service is received.</th>
<th>Covered according to the type of benefit or the place where the service is received.</th>
</tr>
</thead>
</table>

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Outpatient respiratory therapy</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory therapy</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>

<table>
<thead>
<tr>
<th>Transfusion or kidney dialysis of blood</th>
<th></th>
<th></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>

<table>
<thead>
<tr>
<th>Short-term cardiac and pulmonary rehabilitation services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac rehabilitation</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>Pulmonary rehabilitation</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>

<table>
<thead>
<tr>
<th>Short-term rehabilitation and habilitation therapy services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient physical, occupational, speech, and cognitive therapies</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (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>

<table>
<thead>
<tr>
<th>Spinal manipulation services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal manipulation services</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic testing for learning disabilities</th>
<th></th>
<th></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>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
## Eligible health services | In-network coverage* | Out-of-network coverage
--- | --- | ---
### 8. Other services and supplies
#### Acupuncture in lieu of anesthesia
Acupuncture in lieu of anesthesia | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received.  
#### Ambulance service
Emergency ground, air or water ambulance | 80% (of the negotiated charge) per trip | Paid the same as in-network coverage  
#### Clinical trial therapies (experimental or investigational)
Clinical trial therapies | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received.  
#### Clinical trials (routine patient costs)
Clinical trial (routine patient costs) | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received.  
#### Durable medical equipment (DME)
Durable medical equipment | 100% (of the negotiated charge) per item | 80% (of the recognized charge) per item  
#### Enteral formulas and nutritional supplements
Enteral formulas and nutritional supplements | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received.  
#### Osteoporosis (non-preventive care)
Physician’s or specialist’s office visits | 100% (of the negotiated charge) per visit | 80% (of the recognized charge) per visit  
#### Orthotic devices
Orthotic devices | 100% (of the negotiated charge) per item | 80% (of the recognized charge) per item  

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
## Prosthetic and customized orthotic devices

<table>
<thead>
<tr>
<th>Service</th>
<th>Prosthetic and customized orthotic devices</th>
<th>100% (of the negotiated charge) per item</th>
<th>80% (of the recognized charge) per item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetic devices</td>
<td></td>
<td>100% (of the negotiated charge) per item</td>
<td>80% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>Hearing aids</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Covered persons under age 18</td>
<td></td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Hearing aids maximum</td>
<td>One hearing aid per ear every 12 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Hearing aids and exams

<table>
<thead>
<tr>
<th>Service</th>
<th>Hearing aid exams</th>
<th>80% (of the negotiated charge) per visit</th>
<th>60% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aid exam maximum</td>
<td>One hearing exam every 12 month consecutive period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing aids</td>
<td>Hearing aids</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Hearing aids maximum per ear</td>
<td>One hearing aid per ear every 12 month consecutive period</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Podiatric (foot care) treatment

<table>
<thead>
<tr>
<th>Service</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician and Specialist non-routine foot care treatment</td>
<td></td>
<td></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

<table>
<thead>
<tr>
<th>Service</th>
<th>Covered routine vision exams (including refraction)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed by a legally qualified ophthalmologist or optometrist</td>
<td>100% (of the negotiated charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>80% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>1 visit</td>
</tr>
</tbody>
</table>

---

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Pediatric comprehensive low vision evaluations</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum</td>
<td>One comprehensive low vision evaluation every 5 years</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatric vision care services and supplies</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<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 non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)</td>
<td>Daily disposables: up to 3-month supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extended wear disposable: up to 6-month supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-disposable lenses: one set</td>
<td></td>
</tr>
<tr>
<td>Optical devices</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 number of optical devices per policy year</td>
<td>One optical device</td>
<td></td>
</tr>
</tbody>
</table>

*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.

Coverage does not include the office visit for the fitting of prescription contact lenses.

*See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
</table>

9. Outpatient prescription drugs

**Plan features**

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

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

**Policy year deductible and copayment waiver for risk reducing breast cancer**

The policy year deductible will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.

**Policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs**

The 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 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 drug or device 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.

*See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Preferred generic prescription drugs</th>
<th>$12 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</th>
<th>No policy year deductible applies</th>
<th>Not covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-preferred generic prescription drugs</td>
<td>$55 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>No policy year deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preferred brand-name prescription drugs</td>
<td>$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>No policy year deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Non-preferred brand-name prescription drugs</td>
<td>$55 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>No policy year deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Copayment is the greater of 150% or 20% (of the negotiated charge) but will be no more than $250 per supply</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
<table>
<thead>
<tr>
<th>Orally administered anti-cancer prescription drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventive care drugs and supplements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care drugs and supplements filled at a retail pharmacy</td>
</tr>
<tr>
<td>For each 30-day supply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.</td>
</tr>
<tr>
<td>For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by calling the toll-free number on your ID card.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk reducing breast cancer prescription drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk reducing breast cancer prescription drugs filled at a retail pharmacy</td>
</tr>
<tr>
<td>For each 30-day supply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximums:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.</td>
</tr>
<tr>
<td>For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, contact Member Services by calling the toll-free number on your ID card.</td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
**Tobacco cessation prescription and over-the-counter drugs**

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

**Maximums**

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 above.

Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.

For details on the guidelines and the current list of covered tobacco cessation prescription drugs, contact Member Services by calling the toll-free number on your ID card.

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.*
General coverage provisions

This section provides detailed explanations about the:
- Policy year deductibles
- Copayments
- Coinsurance
- Maximum out-of-pocket limits

that are listed in the first part of this schedule of benefits.

<table>
<thead>
<tr>
<th>Policy year deductible provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible health services</strong> applied to the out-of-network <strong>policy year deductibles</strong> will be applied to satisfy the in-network <strong>policy year deductibles</strong>. Eligible health services applied to the in-network <strong>policy year deductibles</strong> will be applied to satisfy the out-of-network <strong>policy year deductibles</strong>.</td>
</tr>
</tbody>
</table>

The in-network and out-of-network **policy year deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments, coinsurance 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 and each of your covered dependents. 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 you 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.

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *important notices* sections of this schedule of benefits.*
### Maximum out-of-pocket limits provisions

<table>
<thead>
<tr>
<th>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 prescription drug benefit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 and 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.</td>
</tr>
<tr>
<td>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 and family maximum-out-of-pocket limit. As to the individual maximum out-of-pocket limit each of you must meet your maximum out-of-pocket limit separately.</td>
</tr>
</tbody>
</table>
| 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 for the rest of the policy year for that person. |
| Family
Once the amount of the copayments, coinsurance and policy year deductibles you and each of your covered dependents 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 for the rest of the policy year for that person. |
| To satisfy this family maximum out-of-pocket limit for the rest of the policy year, the following must happen:
- The family maximum out-of-pocket limit is a cumulative maximum out-of-pocket limit for all family members. The family maximum out-of-pocket limit can be met by a combination of family members with no single individual within the family contributing more than the individual maximum out-of-pocket limit amount in a policy year. |
| The maximum out-of-pocket limit may not apply to certain eligible health services. If the maximum out-of-pocket limit does not apply to a covered benefit, your copayment, coinsurance for that covered benefit will not count toward satisfying the maximum out-of-pocket limit amount. |

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
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
- All costs for non-emergency use of the emergency room
- All costs incurred for non-urgent use of an urgent care provider
- All costs for non-emergency ambulance services
- Any out of pocket costs for outpatient prescription drugs
- All costs for tracheal shave and electrolysis of face and neck given as part of gender reassignment treatment

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

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:
- Amounts you pay toward a deductible
- Amounts you pay toward a copayment/coinsurance
- Charges, expenses or costs in excess of the recognized charge
- Any out of pocket costs for durable medical equipment
- Any out of pocket costs for prosthetics
- Any out of pocket costs for comprehensive and ART infertility
- Any out of pocket costs for private duty nursing
- Any out of pocket costs for transplants
- Any out of pocket costs for obesity surgery
- All costs for non-covered services
- Any out of pocket costs for non-emergency use of the emergency room
- Any out of pocket costs incurred for non-urgent use of an urgent care provider
- Any out of pocket costs for non-emergency ambulance services
- Any out of pocket costs for outpatient prescription drugs.

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.

10,40,50,60,70,100,95,100

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
Student Health Insurance
Preferred Provider Organization (PPO)
Medical and Outpatient Prescription Drug Plan

Certificate of Coverage

Prepared exclusively for:

Policyholder: Illinois Institute of Technology
Policyholder number: 724532
Student policy effective date: 08/10/19
Student policy renewal date: 08/10/19
Plan effective date: 08/10/19
Plan issue date: 07/05/19

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). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

- State Notice of Non-Discrimination:
  The laws of the State of Illinois prohibit insurers from unfairly discriminating against any person based upon their status as a victim of family violence, sex, sexual preference or marital status and forbids excluding coverage for dependent child maternity.
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 for in-network and out-of-network coverage.

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.

 Entire Contract
This certificate of coverage, including the student policy, application and any amendments and riders, constitute your entire Aetna student policy. A change to the student policy is not valid unless approved by an executive officer of Aetna.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED. When you choose to use the services of an out-of-network provider for an eligible health service in non-emergency situations, benefit payments to out-of-network provider are not based upon the amount billed. Your benefit payment will be based on the recognized charge.

YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT SHOWN IN THE SCHEDULE OF BENEFITS AFTER THE PLAN HAS PAID ITS PORTION. After the plan has paid its portion of the bill as provided in 215 ILCS 5/356z.3a, out-of-network provider may bill you for any amount up to the billed charge.

Other than coinsurance and policy year deductible, in-network providers agree to accept discount payments for services without additional billing to you. You may obtain information about the participating status of professional providers and out-of-pocket expenses by calling the toll-free number on your ID card.
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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 and any covered dependents
- 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 in-network and out-of-network covered benefits for medical and pharmacy insurance coverage.

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. Family members can lose coverage for many reasons. 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 under your plan section.
- They are not carved out in the What your plan doesn’t cover –eligible health service exceptions and exclusions section. We refer to this entire section as the “Exceptions” 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 exception request review organization” or EERRO 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

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 into your Aetna secure website at 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.

How to contact us for help

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

- Logging onto your Aetna secure website at www.aetnastudenthealth.com
- Registering for Aetna, our secure Internet access to reliable health information, tools and resources.

Aetna 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.

You can also contact us by:

- Calling our Member Services at the toll-free number 1-877-480-4161
- Writing us at Aetna Life Insurance Company, 151 Farmington Ave, Hartford, CT 06156
Your ID card
We issued to you a digital ID card which you can view or print by going to the secure website at 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 and your covered dependents 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 www.aetnastudenthealth.com/mobile.
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
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible?

All classes of students are eligible.

If we find out that you do not meet this eligibility requirement, we are only required to refund any premium contribution minus any claims that we have paid.

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 and your dependents:
- During the enrollment period
- At other special times during the year (see the Special times you and your dependents can join the plan section below)

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

Who can be on your plan (who can be your dependent)

You can enroll the following family members on your plan. They are referred to in this certificate of coverage as your “covered dependents” or “dependents”.
- Your spouse that resides with you
- Your civil union partner that resides with you. The Religious Freedom Protection Act and Civil Union Act, 750 ILCS 75, allows both same-sex and different-sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples.
- Your domestic partner
- Your dependent children – your own or those of your spouse, civil union partner or domestic partner
  - The children must be under 26 years of age

A dependent does not include:
- An eligible student listed above in the Who is eligible section
You may continue coverage for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

**Adding new dependents**

You can add the following new dependents at any time during the year:

- **A spouse** - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 31 days of the date of your marriage.

- **A civil union partner** - If you enter a civil union, you can put your civil union partner on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your civil union.
  - Ask the policyholder when benefits for your civil union partner will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 31 days of the date of your civil union.

- **A domestic partner** - If you enter a domestic partnership, you can enroll your domestic partner on your health plan.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by the policyholder.
  - Ask the policyholder when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

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

- **An adopted child or a child legally placed with you for adoption** - A child that you, or that you and your spouse, civil union partner or domestic partner adopts or is placed with you for adoption is covered on your plan for the first 31 days after the adoption or the placement is complete.
  - To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption or placement for adoption.
  - You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
  - If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
  - If your coverage ends during this 31 day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31 day period has not ended.
• A stepchild - You may put a child of your spouse, civil union partner or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage, civil union or your Declaration of Domestic Partnership with your stepchild’s parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage, civil union or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
  - To keep your stepchild covered, we must receive your completed enrollment information within 31 days after the date of your marriage, civil union or your Declaration of Domestic Partnership.
  - You must still enroll the stepchild within 31 days after the date of your marriage, civil union or your Declaration of Domestic Partnership even when coverage does not require payment of an additional premium contribution for the stepchild.
  - If you miss this deadline, your stepchild will not have health benefits after the first 31 days.
  - If your coverage ends during this 31 day period, then your stepchild’s coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

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

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
• Change of covered dependent status
• You or your covered dependents enroll in any other health plan

Special times you and your dependents 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 have added a dependent because of marriage, birth, adoption, placement for adoption, or foster care. See the Adding new dependents section for more information.
• You or your dependents 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 a court orders that you cover a current spouse, civil union partner or domestic partner or a minor child on your health 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.

Dependent coverage
Your dependent’s coverage will take effect on the date we receive a completed enrollment application and you pay any required premium contribution. See the Adding new dependents section for details.

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 under your plan and Exceptions 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.

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. Also, for any precertification benefit penalty that is applied, see the schedule of benefits Precertification covered benefit penalty 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:

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<th>Non-emergency admissions:</th>
<th>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.</th>
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<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>
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<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>
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<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>Notification call for an emergency medical condition:</th>
<th>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.</th>
</tr>
</thead>
</table>

Written notification of precertification decisions

We will provide a written notification to you and your physician of the precertification decision, 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:
- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits Precertification covered benefit penalty section.
- 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>
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<tbody>
<tr>
<td>ART services</td>
<td>Applied behavior analysis</td>
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<tr>
<td>Obesity (bariatric) surgery</td>
<td>Certain prescription drugs and devices*</td>
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<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 disorders</td>
<td>Emergency transportation by airplane</td>
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<tr>
<td>Stays in a skilled nursing facility</td>
<td>Home health care</td>
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<td></td>
<td>Hospice services</td>
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<td></td>
<td>Intensive outpatient program (IOP) – mental disorder diagnoses</td>
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<td></td>
<td>Kidney dialysis</td>
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<td></td>
<td>Knee surgery</td>
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<td></td>
<td>Medical injectable drugs, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, botox, hepatitis C medications)*</td>
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<tr>
<td></td>
<td>Outpatient back surgery not performed in a physician's office</td>
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<td></td>
<td>Partial hospitalization treatment – mental disorder diagnoses</td>
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<td>Private duty nursing services</td>
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<td>Psychological testing/neuropsychological testing</td>
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<td>Sleep studies</td>
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<td>Transcranial magnetic stimulation (TMS)</td>
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<td></td>
<td>Wrist surgery</td>
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</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 onto the Aetna website at www.aetnastudenthealth.com.
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 on to your Aetna secure website at www.aetnastudenthealth.com.

If you do not precertify a prescription drug or device, a penalty will apply. See the schedule of benefits. Contact your prescriber or pharmacist if a prescription drug or device requires precertification.

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.

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 on to your Aetna secure website at www.aetnastudenthealth.com. Your physician can find additional details about the step therapy prescription drugs in our clinical policy bulletins.

Sometimes you or your prescriber may seek a medical exception request review to get health care services for drugs not covered or for brand-name, specialty or biosimilar prescription drugs or for which health care services are denied through precertification or step therapy. You or your prescriber can contact us and will need to provide us with the required clinical documentation. Any waiver granted as a result of a medical exception request review shall be based upon an individual, case by case determination, and will not apply or extend to other covered persons.

Important note:
Precertification and step therapy requirements do not apply to FDA-approved prescription drugs used for the treatment of substance use disorders, other than those established by applicable criteria.
How can I request a medical exception request review?

Sometimes you or your prescriber may ask for a medical exception request review to get health care services for prescription drugs that are not covered under this plan or for which health care services are denied through precertification or step therapy. You or your prescriber can contact us. You will need to provide us with the required clinical documentation. We will make a coverage determination within 72 hours after we receive your request and any information. We will tell you and your prescriber of our decision. Any exception granted is based upon an individual, case by case decision, and will not apply to other covered persons. If approved by us, you will receive the non-preferred benefit level and the exception will apply for the entire time of the prescription.

You, someone who represents you, or your prescriber may seek a quicker medical exception request review to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-preferred drug. You, someone who represents you or your prescriber may submit a request for a quicker review for an urgent situation by:

- Contacting our Precertification Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716
- Submitting the request in writing to CVS/pharmacy® Health ATTN: Aetna PA 1300 E Campbell Road Richardson, TX 75081

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your prescriber of our decision. If approved by us, the exception will apply for the entire time you have an urgent situation.

If you are denied a medical exception request review based on the above processes, you may have the right to a third party review by an independent external exception request review organization. If our claim decision is one that allows you to ask for an external exception request review, we will say that in the notice of adverse benefit determination we send you. That notice also will describe the external exception request review process. We will tell you, someone who represents you or your prescriber of the coverage determination of the external exception request review no later than 72 hours after we receive your request. If the medical exception request review is approved, coverage will be provided for the entire time of the prescription. For quicker medical exception request review in urgent situations, we will tell you, someone who represents you or your prescriber of the coverage determination no later than 24 hours after we receive your request. If the quicker medical exception request review is approved, coverage will be provided for the entire time you have an urgent situation.
Eligible health services under your plan

The information in this section is the first step to understanding your plan’s eligible health services.

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 exception (exclusion).
- Dental check-ups for children are generally covered but they are a covered benefit only up to a set number of visits a year. This is a limitation.

You can find out about these exceptions in the Exceptions section and about the 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.

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 on to your Aetna secure website at www.aetnastudenthealth.com or by calling the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.
5. We may use reasonable medical management techniques to determine the frequency, method, treatment, or setting of preventive care and wellness benefits when not specified in the recommendations and guidelines of the:

- 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

**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 for everyone ages 15-65 and other ages at increased risk
  - Screening for gestational diabetes for women, including women 24-28 weeks pregnant and those at risk of developing gestational diabetes
  - Screening for Diabetes (Type 2) for adults with high blood pressure
  - High-risk Human Papillomavirus (HPV) DNA testing for women 30 and older
  - Bone density screenings for osteoporosis
  - Aspirin use to prevent cardiovascular disease for men and women of certain ages
  - Blood pressure screening
  - Cholesterol screening for adults of certain ages or at higher risk
  - Depression screening
  - Hepatitis B screening for people and adolescents ages 11-17 at high risk. This includes:
    - People from countries with 2% or more Hepatitis B prevalence
    - U.S. born people not vaccinated as infants and with at least 1 parent born in a region with 8% or more Hepatitis B prevalence
  - Hepatitis C screening for:
    - Adults at increased risk
    - 1 time for everyone born 1945-1965
  - Latent tuberculosis screening for adults at increased risk
- 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. Doses, recommended ages, and recommended population vary.

- **Adults:**
  - Herpes zoster
  - Mumps
  - Rubella
  - Shingles if you are 60 years of age or over.
- **Adults and children from birth to age 18:**
  - Diphtheria
  - Hepatitis A
  - Hepatitis B
  - Human papillomavirus (HPV)
  - Influenza (flu shot)
  - Measles
  - Meningococcal
  - Pertussis (whooping cough)
  - Pneumococcal
  - Tetanus
  - Varicella (Chickenpox)
- **Children from birth to age 18:**
  - Haemophilus influenza type b
  - Inactive poliovirus
  - Rotavirus.

Your plan does not cover immunizations that are not considered preventive care, except for those required due to travel.

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, including surveillance tests for ovarian cancer for woman at risk for ovarian cancer. 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 urinary incontinence.
- Clinical breast exams as follows:
  - For women over 20 years of age but less than 40, at least every 3 years
  - For women 40 years of age and older, annually
- Breast cancer chemoprevention counseling
- Cervical cancer screening for sexually active woman
- Chlamydia infection screening for younger women and other women at higher risk
- HIV screening and counseling for sexually active woman
- Osteoporosis screening for women over age 60 depending on risk factors.
Eligible health services for pregnant or women who may become pregnant include:
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Anemia screening on a routine basis
- Folic acid supplements for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening
- Urinary tract or other infection screening.

Well child preventive visits
Eligible health services include routine:
- Autism screening for children at 18 and 24 months
- For children ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years and 15-17 years, the following:
  - Behavioral assessments
  - Dyslipidemia screening for children at higher risk of lipid disorders
  - Height, weight and body mass index (BMI) measurements
  - Medical history throughout development
  - Tuberculin testing for children at higher risk of tuberculosis
- Cervical dysplasia screening for sexually active females
- Developmental screening for children under age 3
- Fluoride chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hematocrit or hemoglobin screening
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- Iron supplements for children ages 6-12 months at risk for anemia
- Lead screening for children at risk of exposure
- Oral health risk assessment for young children ages: 0-11 months, 1-4 years and 5-10 years
- Phenylketonuria (PKU) screening for newborns.
- Critical newborn congenital heart defect screening
- Dental caries prevention: infants and children up to age 5
- Newborn blood screening
- Sensory vision screening

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
• **Substance use disorders**
  - *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
    - Abdominal aortic aneurysm one-time screening for men of specified ages who have never smoked
    - Treatment visits
    - Class 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.

• **Skin cancer behavioral counseling**
  - If you have fair skin and are between the ages of 10 to 24 years old, *eligible health services* include counseling services to help you reduce the risk of developing skin cancer. The counseling services will teach you how to minimize exposure to ultraviolet radiation.

• **Falls prevention counseling**
  - If you are age 65 years or older, *eligible health services* include counseling and evaluation services to help you assess whether exercise or physical therapy and vitamin D supplements can aid you in lowering your risk for falls.

**Routine cancer screenings**

- *Eligible health services* include the following routine cancer screenings:
  - Low dose mammography screening, for women age 35 and older (including x-ray examination, digital mammography and breast tomosynthesis) for the presence of occult breast cancer as follows:
    - For women 35-39, a baseline mammogram
    - For women 40 years of age and older, an annual mammogram
    - For women under 40, with a family or prior personal history of breast cancer, positive genetic testing or other risk factors, at necessary age and intervals
    - Comprehensive ultrasound screening and MRI of the entire breast(s) when a mammogram demonstrates heterogeneous or dense breast tissue, as determined by your physician
    - Screening MRI, as determined by your physician
• Annual digital rectal exams
• Prostate specific antigen (PSA) tests as recommended by your physician. This includes:
  - Asymptomatic men age 50 and older
  - African-American men age 40 and over
  - Men age 40 and over with family history of prostate cancer
• Colorectal cancer screening for adults over 50
• 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 adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years

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
• Hepatitis B screening at their first visit
• Expanded tobacco intervention and counseling for pregnant tobacco users

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 under your plan Maternity care, Well newborn nursery care and the Exceptions sections 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 three years) or
  - A manual breast pump (cost is covered by your plan once per pregnancy)

If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year 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 physician OB, GYN, or OB/GYN 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 physician during an office visit.

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 basic infertility
- Outpatient prescription drugs
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 telemedicine

Important note:

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

Telemedicine 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

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.

Your surgeon may perform two or more surgical or bilateral procedures on your during one operation but in separate operative fields. When this happens, we will pay:

- 100% of the surgery for the primary procedures
- 50% of the surgery for the secondary procedure
- 25% of the surgery for each of the other procedures, if any

If the surgeon performs both the surgical procedure and the anesthesia service, we will reduce the benefit that the plan pays for anesthesia by 50%.

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.

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 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 during the periods before and after surgery. A surgical assistant is under the supervision of a physician.

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 include treatment by the consultant.

The consultation may happen by way of telemedicine.

Important note:
Your student policy covers telemedicine. All in-person consultant office visits that are covered benefits are also covered if you use telemedicine instead.

Telemedicine 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 medial 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 health care services provided at walk-in clinics for:
- Unscheduled, non-medical emergency illnesses and injuries
- The administration of 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. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- 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 oral surgery or a dental procedure

Eligible health services include:

- General anesthesia
- Charges made by an anesthetist
- Related hospital or surgery center charges

for your oral surgery or 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.

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.

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
- Psychological and dietary counseling
- Pain management and symptom control
- 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
- Bereavement counseling
- 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

Outpatient private duty nursing
Eligible health services include private duty nursing care provided by an R.N. or L.P.N. for non-hospitalized acute illness or injury if your condition requires skilled nursing care and visiting nursing care is not adequate

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.

The in-network coverage cost-sharing for emergency services and urgent care from out-of-network providers ends when Aetna and the attending physician determine that you are medically able to travel or to be transported to an in-network 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.

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.
5. Pediatric dental care

Eligible health services include dental services and supplies provided by an in-network or out-of-network dental provider.

The eligible health services are those listed in the Pediatric dental care section of the schedule of benefits. We have grouped them as Type A, B and C, and orthodontic services.

Dental emergencies

Eligible dental services include dental services provided for a dental emergency. The care provided must be a covered benefit.

If you have a dental emergency, you should consider calling your dental in-network provider who may be more familiar with your dental needs. However, you can get treatment from any dentist including one that is an out-of-network provider. If you need help in finding a dentist, call Member Services at the toll-free number on your ID card.

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.

For follow-up care to treat the dental emergency, you should consider using your in-network dental provider so that you can get the maximum level of benefits. Follow-up care will be paid at the cost-sharing level that applies to the type of provider that gives you the care.

What rules and limits apply to dental care?

Several rules apply to the dental benefits. Following these rules will help you use the plan to your advantage by avoiding expenses that are not covered by the plan.

When does your plan cover orthodontic treatment?

Orthodontic treatment is covered if you have 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
  - Cleftocranial 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))
When does your plan cover replacements?
Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's "replacement rule". The replacement rule is that certain replacements of, or additions to, existing crowns, inlays, onlays and veneers, dentures or bridges are covered only when you give us proof that:

- 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.

When does your plan cover missing teeth that are not replaced?
The 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.

**When does your plan cover other treatment?**
Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

If a charge is made for a non-eligible health service and an eligible health service would provide an acceptable result, then your plan will pay a benefit for the eligible health service.

When alternate services or supplies can be used, the plan’s coverage will be limited to the expense of the least expensive service or supply that is:

- Customarily used nationwide for treatment
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition

You should review the differences in the expense of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more expensive treatment method. You are responsible for any charges in excess of what the plan will cover.
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 under your plan-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 (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
Temporomandibular joint dysfunction treatment (TMJ) and craniomandibular joint dysfunction treatment (CMJ)

Eligible health services include the:
- 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.

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.

Dermatological treatment

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

Maternity care

Eligible health services include prenatal (non-preventive care), including prenatal HIV testing 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 1 post-delivery home visit by a health care provider

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
- Hospital or birthing center visits and consultations for the well newborn by a physician but for not more than 1 Visit per day.
Pregnancy complications
Eligible health services include services and supplies from your provider for pregnancy complications.

Pregnancy complications means problems caused by pregnancy that pose a significant threat to the health of the mother or baby, including:

- Hyperemesis gravidarum (pernicious vomiting of pregnancy); toxemia with convulsions; severe bleeding before delivery due to premature separation of the placenta from any cause; bleeding after delivery severe enough to need a transfusion or blood
- Amniotic fluid tests, analyses, or intra-uterine fetal transfusion made for Rh incompatibility
- An emergency medical cesarean section due to pregnancy complications
- Miscarriage if not elective or therapeutic

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

Eligible health services include:

- The surgical procedure
- Physician pre-operative and post-operative hospital and office visits
- Inpatient and outpatient services (including outpatient surgery)
- Skilled nursing facility care
- Administration of anesthetics
- Outpatient diagnostic testing, lab work and radiological services
- Blood transfusions and the cost of un-replaced blood and blood products as well as the collection, processing and storage of self-donated blood after the surgery has been scheduled
- Gender reassignment counseling by a behavioral health provider
- Injectable and non-injectable hormone replacement therapy

Important Note:
As a reminder, gender reassignment (sex change) 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. Just log into your Aetna secure website at www.aetnastudenthealth.com for detailed information about this covered benefit, including eligibility 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 provider with expertise in treating autism spectrum disorder or 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.

Mental health treatment
Eligible health services include the treatment of mental 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, and 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.

A general medical hospital is not usually equipped to treat mental disorders. Once it has stabilized your condition, it will either:
- Admit you to its separate psychiatric section or unit or
- Transfer you to a psychiatric hospital or residential treatment facility

Treatment of a mental disorder in a general medical hospital is only covered if you are transferred to its separate psychiatric section or unit.

If the general medical hospital cannot transfer you to a psychiatric hospital or residential treatment facility or to its own separate psychiatric section or unit, then we will cover any eligible health services provided by the general medical hospital for the treatment of a mental disorder.

- **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
  - 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 to avoid placing you at risk for serious complications
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23 hour observation
    - Peer counseling support by a peer support specialist
      - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.
Substance use related disorders treatment

Eligible health services include the treatment of substance use disorder 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 and other services and supplies that are provided during your stay in a general medical hospital, psychiatric hospital or residential treatment facility.

A general medical hospital is not usually equipped to treat substance use disorder. Once a general medical hospital has stabilized your condition, it will either:

- Admit you to its separate substance use disorder section or unit
- Transfer you to a psychiatric hospital or residential treatment facility

Treatment of substance use disorder in a general medical hospital is only covered if you are:

- Admitted for the treatment of medical complications of substance use disorder
- Transferred to its separate substance use disorder section or unit

If the general medical hospital cannot transfer you to a psychiatric hospital or residential treatment facility or to its own separate psychiatric section or unit, then we will cover any eligible health services provided by the general medical hospital for the treatment of substance use disorder.

As used here, “medical complications” mean conditions such as electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- **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
  - Individual, group and family therapies for the treatment of substance use disorders
  - Other outpatient substance use disorder treatments such as:
    - Outpatient detoxification
    - Partial hospitalization treatment provided in a facility or program for treatment of substance use disorders provided under the direction of a physician
    - Intensive outpatient program provided in a facility or program for treatment of substance use disorders provided under the direction of a physician
    - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other substance use disorders, including administration of medications
    - Treatment of withdrawal symptoms
    - 24 hour observation
    - Peer counseling support by a peer support specialist
      - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.
Obesity (bariatric) surgery

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

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.
  - A physician office visit or in-home nurse visit within 48 hours after discharge.

- 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 the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy 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. You may also get transplant services at a non-IOE facility, but your cost share will be higher.
Important note:
- Many pre and post transplant medical services, even routine ones, are related to and may affect the success of your transplant. While 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.

Other transplants
Eligible health services include corneal (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants. Corneal and cartilage transplants are not available at IOE facilities.

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.

Comprehensive infertility services
Eligible health services include comprehensive infertility care. The first step to using your comprehensive infertility health care services is enrolling with our National Infertility Unit (NIU). To enroll you can reach our dedicated NIU at 1-800-575-5999.

Infertility services
You are eligible for infertility services if:
- You are covered under this plan as a student or as a covered dependent who is the student’s legal spouse, civil union partner or domestic partner, referred to as “your partner” or as a covered dependent age 18 or over.
- There exists a condition that:
  - Is demonstrated to cause the illness of infertility.
  - Has been recognized by your physician or infertility specialist and documented in your or your partner’s medical records.
- You or your partner has not had a voluntary sterilization with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- You or your partner do not have infertility that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- You have met the requirement for the number of months trying to conceive through egg and sperm contact.
Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators with expertise in all areas of infertility who can help:

- Enroll you in the infertility program
- Assist you with precertification of eligible health services
- Coordinate precertification for comprehensive infertility when these services are eligible health services
- Evaluate your medical records to determine whether comprehensive infertility services are reasonably likely to result in success
- Determine whether comprehensive infertility services are eligible health services

Your provider will request approval from us in advance for your infertility services. We will cover charges made by an infertility specialist for the following infertility services:

- Ovulation induction cycle(s) with menotropins
- Intrauterine insemination/artificial insemination

A “cycle” is an attempt at ovulation induction or intrauterine insemination. The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

**Advanced reproductive technology services**

Eligible health services include Assisted Reproductive Technology (ART) services. ART services are more advanced medical procedures or treatments performed to help a woman achieve pregnancy.

**ART services**

ART services include:

- In vitro fertilization (IVF)
- Zygote intrafallopian transfer (ZIFT)
- Gamete intrafallopian transfer (GIFT)
- Cryopreserved embryo transfers (Frozen Embryo Transfers (FET))
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery

You are eligible for ART services if:

- You are covered under this plan as a student or as a covered dependent who is the student’s legal spouse, civil union partner or domestic partner, referred to as “your partner” or as a covered dependent age 18 and above.

**Covered dependent** children are covered under this plan for ART services only in the case of fertility preservation due to planned treatment for medical conditions that will result in infertility.

- There exists a condition that:
  - Is demonstrated to cause the disease of infertility.
  - Has been recognized by your physician or infertility specialist and documented in your or your partner’s medical records.
- You or your partner has not had a voluntary sterilization with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- You or your partner does not have infertility that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
• You have exhausted the comprehensive infertility services benefits or have clinical need to move on to ART procedures. You have met the requirement for the number of months trying to conceive through egg and sperm contact.

• If you have been diagnosed with premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services through age 45 regardless of FSH level.

**Fertility preservation**
Fertility preservation involves the retrieval of mature eggs and/or sperm or the creation of embryos that are frozen for future use.

You are eligible for fertility preservation only when you:

- Are believed to be fertile
- Have planned services that will result in infertility such as:
  - Chemotherapy
  - Pelvic radiotherapy
  - Other gonadotoxic therapies
  - Ovarian or testicular removal

Along with the eligibility requirements above, you are eligible for fertility preservation benefits if, for example:

- You, your partner or dependent child are planning treatment that is demonstrated to result in infertility. Planned treatments include:
  - Bilateral orchietomy (removal of both testicles).
  - Bilateral oophorectomy (removal of both ovaries).
  - Hysterectomy (removal of the uterus).
  - Chemotherapy or radiation therapy that is established in medical literature to result in infertility.
- The eggs that will be retrieved for use are reasonably likely to result in a successful pregnancy by meeting the criteria below:

<table>
<thead>
<tr>
<th>You are</th>
<th>You need to have an unmedicated day 3 FSH test done within the past:</th>
<th>The results of your unmedicated day 3 FSH test:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A female under 35 years of age</td>
<td>12 months</td>
<td>Must be less than 19 mIU/mL in your most recent lab test to use your own eggs.</td>
</tr>
<tr>
<td>A female 35 years of age or older</td>
<td>12 months</td>
<td>If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40.</td>
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</tbody>
</table>

**Eligible health services** for fertility preservation will be paid on the same basis as other ART services benefits for persons who are infertile.
Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators with expertise in all areas of infertility who can help:

- Enroll in the infertility program.
- Assist you with precertification of eligible health services.
- Coordinate precertification for ART services and fertility preservation services when these services are eligible health services. Your provider should obtain precertification for fertility preservation services through the NIU either directly or through a reproductive endocrinologist.
- Evaluate your medical records to determine whether ART services and fertility preservation services are reasonably likely to result in success.
- Determine whether ART services and fertility preservation services are eligible health services.
- Case manage for the provision of ART services and fertility preservation services for an eligible covered person.

Your provider will request approval from us in advance for your ART services and fertility preservation services. We will cover charges made by an ART specialist for the following ART services:

- Any combination of the following ART services:
  - In vitro fertilization (IVF)*
  - Uterine embryo lavage
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Low tubal ovum transfer (LTOT)
  - Cryopreserved embryo transfers (Frozen Embryo Transfer (FET).)
  - Prescription drug therapy used during an oocyte retrieval cycle
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. The embryo transfer itself is not covered. (See the What your plan doesn’t cover – some eligible health service exceptions and exclusions section.)
- Charges associated with obtaining sperm from your partner when they are covered under this plan for ART services.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.

A “cycle” is an attempt at a particular type of infertility treatment (e.g., GIFT, ZIFT, cryopreserved embryo transfers). The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

*Note: In some plans with limits on the number of cycles of IVF covered, “one” cycle of IVF may be considered as one elective single embryo transfer (ESET) cycle followed consecutively by a frozen single embryo transfer cycle. This cycle definition applies only to persons who meet the criteria for ESET, as determined by our NIU and for whom the initial ESET cycle did not result in a documented fetal heartbeat. Eligible health services for ESET will be paid on the same basis as any other ART services benefit.
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.

Outpatient therapies

Breast cancer pain medication and therapy
Pain therapy is medically based and includes reasonably defined goals to stabilize or reduce pain with breast cancer. Your provider will periodically evaluate the effectiveness of the pain therapy against these goals.

Pain medication related to the treatment of breast cancer is covered under the outpatient prescription drug section.

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

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 onto your Aetna secure website at www.aetnastudenthealth.com.

Eligible health services also include the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including but not limited to the use of intravenous immunoglobulin therapy.

Immune gamma globulin therapy will be covered for persons diagnosed with a primary immunodeficiency when medically appropriate and ordered by a physician. Initial authorization will be for no less than 3 months with reauthorization every 6 months after. If you have been in treatment for 2 years, reauthorization will be every 12 months, unless more frequently indicated by your physician.
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 onto your Aetna secure website at www.aetnastudenthealth.com to determine if coverage is under the outpatient prescription drug benefit of this certificate of coverage.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care maximums.

**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 or by logging onto your Aetna secure website at 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 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
  - Treat parts of the body affected by multiple sclerosis to maintain your level of function
- 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.

Spinal manipulation services
Eligible health services include spinal manipulation services to correct a muscular or skeletal problem.

Your provider 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

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

Acupuncture in lieu of anesthesia
Eligible health services include acupuncture treatment (manual or electroacupuncture) provided by your physician, if the service is performed as a form of anesthesia in connection with a covered surgical procedure.

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 travelling from one hospital to another and
  - The first hospital cannot provide the emergency services you need
  - The two conditions above are met

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 may benefit from the treatment based on published, peer-reviewed scientific evidence

An "approved clinical trial" is a clinical trial that meets all of these criteria:
- The 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.
- 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.
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 use.
- 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.

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. We list examples of those in the Exceptions section.

Enteral formulas and nutritional supplements

Eligible health services include enteral formulas and nutritional supplements used to treat malabsorption of food caused by:
- Crohn’s Disease
- Ulcerative colitis
- Gastroesophageal reflux
- Gastrointestinal motility;
- Chronic intestinal pseudoobstruction
- Phenylketonuria
- Eosinophilic gastrointestinal disorders
- Inherited diseases of amino acids and organic acids

Covered benefits also include food products modified to be low in protein for inherited diseases of amino acids 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 illness. Low protein modified food products do not include foods that are naturally low in protein.

Your physician must give you a written order for these supplies.
Orthotic devices
Eligible health services include mechanical supportive devices ordered by your physician for the treatment of weak or muscle deficient feet.

Osteoporosis (non-preventive care)
Eligible health services include the diagnosis, treatment and management of osteoporosis by a physician. The services include Food and Drug Administration approved technologies, including bone mass measurement.

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

Prosthetic device means a:
- 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

Customized orthotic device means a prosthetic device based on your physical illness.

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

Hearing aids
Eligible health services include hearing instruments and related hearing aid services, if you are under age 18, as described below:

Hearing instrument means:
- Any wearable, non-disposable, nonexperimental instrument or device designed to aid or make up for impaired human hearing
- Parts, attachments or accessories for the instrument or device, including an ear mold

Hearing aid services include:
- Audiometric exams
- Selection, fitting and adjustments of ear molds
- Hearing instrument repairs

Hearing aids and exams
Eligible health services include hearing care that includes hearing exams prescribed hearing aids and hearing aid services, if you are over age 18, as described below. And just a reminder, you'll find coverage limitations in the schedule of benefits.

Hearing aid means:
- Any wearable, non-disposable instrument or device designed to aid impaired human hearing
- Parts, attachments, or accessories
Eligible health services also include bone anchored hearing aids and cochlear implants.

**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.

**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.

**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.
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 request review

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.

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 onto your Aetna secure website at 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 of our in-network pharmacies.

If you fail to obtain your prescriptions at the designated in-network pharmacy, your prescriptions will not be covered as eligible health services under the plan.

Pharmacies include in-network retail and specialty pharmacies.

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 listed in the Eligible health services under your plan section
- They are not carved out in the What your plan doesn’t cover - eligible health service exceptions and 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.

Your outpatient prescription drug benefit includes drugs listed in the preferred drug guide. Prescription drugs listed on the formulary exclusions list are excluded unless a medical exception request review is approved by us prior to the prescription drug being picked up at the pharmacy. If it is medically necessary for you to use a prescription drug on the formulary exclusions list, you or your prescriber must request a medical exception request review. See the How can I request a medical exception section.

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, specialty or out-of-network pharmacy.
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. The in-network pharmacy will submit your claim. You will pay any cost sharing directly to the in-network pharmacy.

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.

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. Each prescription is limited to a maximum 30 day supply. 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 onto your Aetna secure website at www.aetnastudenthealth.com.

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

Prescription drug refill synchronization

You have the right to request synchronization of your prescription drug refills once per year when those prescription drugs:

- Are covered under your plan
- Are maintenance medications and have refills available when the request is made
- Are not Schedule II, III, or IV controlled substances
- Have met any applicable utilization management criteria at the time of the request
- Are of a type that can be safely split into short-fill periods
- Do not have special handling or sourcing needs that require a single, designated pharmacy to fill or refill

We will apply a prorated daily cost-share rate when needed to synchronize prescription drugs that meet all of the above criteria and are dispensed by a network pharmacy. Any dispensing fees will not be prorated and will be based on the number of prescriptions filled or refilled at the time of synchronization.

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 onto your Aetna secure website at 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.

We may cover the dispensing of up to a 12 month supply worth of contraception at one time.

**Important Note:**
You may qualify for a medical exception request review if your **provider** determines that the contraceptives covered standardly as preventive are not medically appropriate. Your **prescriber** may request a medical exception request review 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

See your medical plan and the *Diabetic services and supplies (including equipment and training)* section for coverage of blood glucose meters and external insulin pumps.

**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.

**Infertility drugs**
**Eligible health services** include oral and injectable **prescription drugs** used primarily for the purpose of treating the underlying cause of **infertility**.

**Off-label use**
U.S. Food and Drug Administration (FDA) approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your condition(s). Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your condition(s) in one of the following standard compendia:
  - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information)
  - Thomson Micromedex DrugDex System (DrugDex)
  - Clinical Pharmacology (Gold Standard, Inc.) or
  - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium
Use for your condition(s) has been proven as safe and effective by at least one well-designed controlled clinical trial, (i.e., a Phase III or single center controlled trial, also known as Phase II). Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
- The dosage of a drug for your condition(s) is equal to the dosage for the same condition(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above or
- The dosage has been proven to be safe and effective for your condition(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

Health care services related to off-label use of these drugs may be subject to precertification, step therapy or other requirements or limitations.

**Opioid antagonist drugs**

**Eligible health services** include opioid antagonist drugs, including the medication product, administrative devices and any pharmacy administrative fees relating to the dispensing of opioid antagonists. Included are refills for expired or utilized opioid antagonists.

An “opioid antagonist” is a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.

**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 onto your Aetna secure website at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) or calling Member Services at the toll-free number on your ID card.

**Prescription inhalants**

**Eligible health services** include inhalant prescription drugs for diagnoses of asthma or other life-threatening bronchial ailments.

**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.
Topical eye medication prescription drugs

Eligible health services include topical eye prescription drugs. They are paid according to the tier of drug as indicated in the schedule of benefits.

Refills of a prescription for topical eye medication will not be denied when:
- The prescription drug is used to treat a chronic condition of the eye
- You requested the refill before the last day of the prescribed dosage period and after at least 75% of the predicted days of use

The prescriber indicates on the original prescription that refills are permitted and early refills do not exceed the total number of refills prescribed

How you get an emergency prescription filled

You may not have access to an in-network pharmacy in an emergency or urgent care situation, or you may be traveling outside of the plan’s service area. 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.

How your outpatient prescription drug maximum out-of-pocket limit works
You will pay your outpatient prescription drug policy year deductible, copayments and coinsurance up to the outpatient prescription drug maximum out-of-pocket limit for your plan.

Your schedule of benefits shows the outpatient prescription drug maximum out-of-pocket limits that apply to your plan. Once you reach your outpatient prescription drug maximum out-of-pocket limit, your plan will pay for outpatient prescription drug covered benefits for the remainder of that policy year.

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 on to your Aetna secure website at 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 or log on to your Aetna secure website at www.aetnastudenthealth.com.

If you want to request an exception to a medical necessity or step therapy requirement, see the How can I request a medical exception request review? section or call the toll-free number on your member ID card for more information.

Important note:
Precertification and step therapy requirements do not apply to FDA-approved prescription drugs used for the treatment of substance use disorders, other than those established by applicable criteria.
Medical exceptions request review
Sometimes you or your prescriber may ask for a medical exception request review to request coverage for a prescription drug that is not covered or for which coverage is being discontinued (for reasons other than safety or drug manufacturer withdrawal) or from a step therapy requirement or dosage limitation. You, someone who represents you or your prescriber can contact us. You will need to provide us with the required clinical documentation. We will process your request through our standard medical exception request review within 72 hours after receipt. Any exception granted is based upon an individual, case by case decision, and will not apply to other members. If the medical exception request is approved by us, you will receive the preferred drug non-preferred benefit level and coverage for the prescription drug according to the terms of your plan.

You, someone who represents you or your prescriber may seek a quicker medical exception request review to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-preferred drug. You, someone who represents you or your prescriber may submit a request for a quicker review for an urgent situation by:

- Contacting our Precertification Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716
- Submitting the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road Richardson, TX 75081

We will make a coverage determination for your urgent request within 24 hours after we receive your request and will tell you, someone who represents you and your prescriber of our decision. If approved by us, the exception will apply for the entire time you have an urgent situation. In the case of denial, we will provide you with:

- The reason for the denial
- An alternate covered medication (if applicable)
- Information for submitting an appeal of the denial

If you are denied a medical exception request review based on the above processes, you may have the right to a third party review by an independent external exception request review organization. If our claim decision is one that allows you to ask for an external exception request review, we will say that in the notice of adverse benefit determination we send you. That notice also will describe the external exception request review process. We will tell you, someone who represents you or your prescriber of the coverage determination of the external exception request review no later than 72 hours after we receive your request. If the medical exception request review is approved, coverage will be provided for the entire time of the prescription. For quicker medical exception request reviews in urgent situations, we will tell you, someone who represents you or your prescriber of the coverage determination no later than 24 hours after we receive your request. If the quicker medical exception request review is approved, coverage will be provided for the entire time you have an urgent situation.

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.
What your plan doesn’t cover – eligible health service exceptions and 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 under your plan section. In that section we also told you that some health care services and supplies have exceptions and some are not covered at all which are called “exclusions”.

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

General exceptions and exclusions
The following are not eligible health services under your plan except as described in:

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

Acupuncture therapy
- Maintenance treatment
- Acupuncture when provided for the following conditions:
  - Acute low back pain
  - Addiction
  - AIDS
  - Amblyopia
  - Allergic rhinitis
  - Asthma
  - Autism spectrum disorders
  - Bell’s Palsy
  - Burning mouth syndrome
  - Cancer-related dyspnea
  - Carpal tunnel syndrome
  - Chemotherapy-induced leukopenia
  - Chemotherapy-induced neuropathic pain
  - Chronic pain syndrome (e.g., RSD, facial pain)
  - Chronic obstructive pulmonary disease
  - Diabetic peripheral neuropathy
  - Dry eyes
  - Erectile dysfunction
  - Facial spasm
  - Fetal breech presentation
  - Fibromyalgia
  - Fibrotic contractures
  - Glaucoma
  - Hypertension
  - Induction of labor
  - Infertility (e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
  - Insomnia
  - Irritable bowel syndrome
  - Menstrual cramps/dysmenorrhea
  - Mumps
  - Myofascial pain
- Myopia
- Neck pain/cervical spondylosis
- Obesity
- Painful neuropathies
- Parkinson’s disease
- Peripheral arterial disease (e.g., intermittent claudication)
- Phantom leg pain
- Polycystic ovary syndrome
- Post-herpetic neuralgia
- Psoriasis
- Psychiatric disorders (e.g., depression)
- Raynaud’s disease pain
- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

**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** to the **policyholder**.

**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
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered

**Breasts**
- Services and supplies given by a **provider** for breast reduction or gynecomastia
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, whether or not for psychological or emotional reasons, except where described in the Eligible health services under your plan - Reconstructive surgery and supplies section. Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.

This exclusion does not apply to:
- Surgery after an accidental injury when performed as soon as medically feasible
- Coverage that may be provided under the Eligible health services under your plan - Gender reassignment (sex change) treatment section.
- This exclusion does not apply to:
  - The removal of breast implants due to an illness or injury

Custodial care
Examples 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/jejunalostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care except in connection with hospice care, adult (or child) day care, or convalescent care
- Institutional care. 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

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.

Early intensive behavioral interventions
Examples of these services are:
- Certain early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions
Educational services
Examples of these services are:
- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment program
  - Job training
  - Job hardening programs
- Services provided by a governmental school district

Elective treatment or elective surgery
- **Elective treatment** or elective surgery except as specifically covered under the student policy and provided while the student policy is in effect

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 under your plan – 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

Family planning services - other
- Reversal of voluntary sterilization procedures, including related follow-up care
- Family planning services received while confined as an inpatient in a hospital or other facility
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

Foot care
- Except as covered in the Eligible health services under your plan 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

Gender reassignment (sex change) treatment
- **Cosmetic** services and supplies such as:
  - Rhinoplasty
  - Face-lifting
  - Lip enhancement
  - Facial bone reduction
- Lepharoplasty
- Breast augmentation
- Liposuction of the waist (body contouring)
- Reduction thyroid chondroplasty (tracheal shave)
- Hair removal (including electrolysis of face and neck)
- Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which are used in feminization
- Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic

**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

**Hearing aids**
If you are under age 18, the following services or supplies:
- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 36 month period
- Replacement parts for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any hearing aid prescribed by someone other than a hearing care professional
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries and auxiliary equipment.
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

**Hearing aids and exams** except as described in the Eligible health services under your plan - (Hearing aids) section
The following services or supplies:
- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 24 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 given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries, amplifiers, and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech
**Home health care**, except as described in the *Eligible health services under your plan - (Home health care)* section
- 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**, except as described in the *Eligible health services under your plan - (Hospice care)* section
- Funeral arrangements
- Pastoral counseling
- **Respite care**
- Bereavement counseling
- Financial or legal counseling which includes estate planning and the drafting of a will
- Homemaker or caretaker services that are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

**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 under your plan –Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment* section.

**Judgment 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 or first party medical benefits payable under any other mandatory no-fault law
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

Mental health treatment

- Mental health services for the following categories (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association:
  - Stays in a facility for treatment of dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders except as described in the Eligible health services under your plan – Preventive care and wellness section
  - Pathological gambling, kleptomania, pyromania
  - School and/or education service including special educational, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation

Motor vehicle accidents

- Services and supplies given by a provider for injuries sustained from a motor vehicle accident but only when benefits are provided under any motor vehicle no-fault law. This applies whether or not a claim is made for such benefits.

Non-medically necessary services and supplies

- Services and supplies which are not medically necessary for the diagnosis, care, or treatment of an illness or injury or the restoration of physiological functions. This includes behavioral health services that are not primarily aimed at the treatment of illness, injury, restoration of physiological functions or that do not have a physiological or organic basis. This applies even if they are prescribed, recommended, or approved by your physician, dental provider, or vision care provider. This exception does not apply to Preventive care and wellness benefits.

Non-U.S. citizen

- Services and supplies received by a covered person (who is not a United States citizen) within the covered person’s home country but only if the home country has a socialized medicine program
Organ removal
- Services and supplies given by a provider to remove an organ from your body for the purpose of donating or selling the organ except as described in the Eligible health services under your plan section. This does not apply if you are donating the organ to a spouse, domestic partner, civil union partner, child, brother, sister, or parent.

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

Prosthetic devices
Except as described in the Eligible health services under your plan – Prosthetic devices and customized orthotic devices section
- 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
- Cochlear implants

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 under your plan section

School health services
- Services and supplies normally provided by the policyholder’s:
  - School health services
  - Infirmary
  - Hospital
  - Pharmacy or

by health professionals who
- Are employed by
- Are affiliated with
- Have an agreement or arrangement with, or
- Are otherwise designated by

the policyholder.
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

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 under your plan – Preventive care and wellness section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs section
  - Nicotine patches
  - Gum

Transplant services
- 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 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

Treatment of infertility
- All charges associated with:
  - Cryopreservation (freezing) of eggs, embryos or sperm. However, subsequent non-experimental or investigational procedures that use the cryopreserved substance are covered.
- Reversal of voluntary sterilizations, including follow-up care. However, if a voluntary sterilization is successfully reversed, infertility benefits are available if your diagnosis meets the definition of infertility
- Travel costs within 100 miles of your home or travel cost not required by Aetna
- Infertility treatment for covered dependents under age 18
- Non-medical costs of an egg or sperm donor
- Selected termination of an embryo, unless the life of the mother would be in danger if all embryos were carried to full term
- Experimental or investigational infertility treatment as determined by the American Society for Reproductive Medicine
- Services provided to a surrogate. If you choose to use a surrogate, this does not apply to the cost for procedures to obtain the eggs, sperm or embryo from a covered individual
- ART services are not provided for out-of-network care
Vision care
Pediatric vision care services and supplies, except as described in the Eligible health services under your plan – Pediatric vision care section

Adult vision care
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Adult vision care services and supplies
Your plan does not cover adult vision care services and supplies, except as described in the Eligible health services under your plan – Other services section.
- Special supplies such as non-prescription sunglasses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a hospital or other facility for health care
- Eye exams for contact lenses or their fitting
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Wilderness Treatment Programs
- Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

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.
Exceptions and exclusions that apply to outpatient prescription drugs

Contraceptive methods, procedures, services, and supplies for contraceptive purposes
- Contraceptive methods, procedures, services, and supplies for contraceptive purposes as elected by the policyholder due to an exemption or accommodation in accordance with applicable federal or state law and regulation
- Services provided as a result of complications resulting from voluntary sterilization procedure and related follow-up care

Drugs or medications
- Administered or entirely consumed at the time and place it is prescribed or dispensed
- 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 in the Eligible health services under your plan – Outpatient prescription drugs section
- That is therapeutically equivalent or therapeutically alternative to a covered prescription drug including biosimilar (unless a medical exception request review is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception request review is approved)
- Not approved by the FDA or not proven safe and 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 Aetna’s Pharmacy and Therapeutics Committee
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the share or appearance of a sex organ
- 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

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

You may select an in-network provider from the directory through your Aetna secure website at 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

However, 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.

<table>
<thead>
<tr>
<th>Request for approval</th>
<th>If you are a new enrollee and your provider is an out-of-network provider</th>
<th>When your provider stops participation with Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You need to complete a Transition Coverage Request form and send it to us. You can get this form by contacting Member Services at the toll-free number on your ID card.</td>
<td>You or your provider should call us for approval to continue any care.</td>
</tr>
<tr>
<td>Length of transitional period</td>
<td>Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.</td>
<td>Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. This date is based on the date the provider terminated their participation with us.</td>
</tr>
</tbody>
</table>

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

We will authorize coverage for the transitional period only if the provider agrees to our usual terms and conditions for contracting providers.
**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.

**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**.
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 policyholder.</td>
<td>• You must send us notice and proof within 20 days or as soon as reasonably possible.</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></td>
<td>• A completed claim form and any additional information required by us.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• • A description of services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• • Bill of charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• • Any medical documentation you received from your provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• You must send us notice and proof within 90 days or as soon as reasonably possible.</td>
</tr>
<tr>
<td>Proof of loss (claim)</td>
<td>• A completed claim form and any additional information required by us.</td>
<td>• You must send us notice and proof within 90 days or as soon as reasonably possible.</td>
</tr>
<tr>
<td>Benefit payment</td>
<td>• Written proof must be provided for all benefits.</td>
<td>• Benefits will be paid within 30 days after the necessary proof to support the claim is received. If benefits are not paid within 30 days after proof of loss is received, you are entitled to 9% interest. Interest will be calculated from the 30th day until the date the benefits are paid. However, interest less than $1 may not be paid.</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>• Benefits will be paid within 30 days after the necessary proof to support the claim is received. If benefits are not paid within 30 days after proof of loss is received, you are entitled to 9% interest. Interest will be calculated from the 30th day until the date the benefits are paid. However, interest less than $1 may not be paid.</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 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 exception request review organization if the situation is eligible for external exception request 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.

For treatment of substance use disorders: If we determine that benefits are no longer medically necessary, we will provide you written notice within 24 hours of the adverse determination and advise you of your right to request an external review.
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 by (us)</td>
<td>72 hours</td>
<td>15 days</td>
<td>30 days</td>
<td>24 hours for urgent request* or 72 hours if clinical information is required and received more than 24 hours after request*</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>15 calendar days for non-urgent request</td>
</tr>
<tr>
<td>Extensions</td>
<td>None</td>
<td>15 days</td>
<td>15 days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Additional information request (us)</td>
<td>72 hours</td>
<td>15 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>45 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.

**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. When a complaint is received from the Division of Insurance, we will respond within 21 days of receiving the complaint.
You may contact the Department of Insurance at any time. Complaints to the Department of Insurance may be submitted in the following ways:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 W. Washington Street
Springfield, IL 62767
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number
Consumer_complaints@ins.state.il.us Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

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.

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.

The deadline for filing an appeal will not be postponed or delayed by a provider appeal unless the provider is acting as your authorized representative.

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

You may also contact Aetna at the following address:
Aetna Life Insurance Company
Appeals Resolution Team
PO Box 14464
Lexington, KY 40512

You may also contact us by calling Member Services at the toll-free number on the back of your ID card.

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 appeal one time under this plan.
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. 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>Administrative appeal determinations</td>
<td>Not applicable</td>
<td>30 calendar days</td>
<td>60 calendar days</td>
<td>As appropriate to type of claim</td>
</tr>
<tr>
<td>Health care services appeal determinations</td>
<td>24 hours</td>
<td>15 business days</td>
<td>15 business days</td>
<td>None</td>
</tr>
<tr>
<td>Extensions</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

Exhaustion of appeals process
In most situations we encourage you to complete the appeal process with us before you can take these other actions:
- Contact the Illinois Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Illinois Department of Insurance
- Appeal through an external exception request 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:
- 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 exception request review process.
- You filed an appeal under the internal appeal process and we did not provide a written decision within:
  - 30 days from the date you filed an appeal of a concurrent or preservice claim
  - 60 days from the date you filed an appeal of a post-service claim except to the extent your agreed to a delay.
- You filed a request for an expedited internal review and we did not provide a decision within 48 hours, except to the extent you requested or agreed to a delay.
- Your provider certifies in writing that the recommended health care service or treatment is experimental or investigational would be significantly less effective if delayed.
- We did not follow all of the claim determination and appeal requirements of the Illinois or the Federal Department of Health and Human Services. But, you will not be able to proceed directly to external exception request review if:
  - The rule violation was minor and not likely to influence a decision or harm you.
  - The violation was for a good cause or beyond our control.
  - The violation was part of an ongoing, good faith exchange between you and us.
External exception request review

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

You have a right to external exception request review only if:
- Your claim is denied, reduced or terminated because we determined that it was experimental or investigation or it did not meet our requirements for:
  - medical necessity
  - appropriateness
  - health care setting
  - level of care
  - effectiveness
- Coverage was rescinded. This does not include a cancellation of coverage due to failure to pay any required premium.
- You have received an adverse determination.

You have a right to external exception request 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

If our claim decision is one for which you can seek external exception request 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 exception request review process. It will include a copy of the Request for External Exception Request Review form at the final adverse determination level. It will also include the Authorized Representative form and the Health Care Provider Certification form for expedited and experimental requests.

You must submit the Request for External Exception Request Review Form:
- To the Illinois Department of Insurance
- Within 4 months of the date you received the final determination from us
- And you must include a copy of the notice from us and all other important information that supports your request

You or your authorized representative may submit additional information with the Request for External Exception Request Review form.

The deadline for filing an external exception request review will not be postponed or delayed by a provider’s external exception request review unless the provider is acting as your authorized representative.

The address and toll-free number for the Office of Consumer Health Information at the Illinois Department of Insurance is:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Exception Request Review Unit
320 W. Washington Street
Springfield, IL 62767
(877) 850-4740 Toll-free phone
(217) 557-8495 Fax number
Doi.externalreview@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf
You will pay for any cost associated with obtaining documentation (i.e. medical records fees, copying fees, etc.) for additional information you send and want reviewed by the EERRO. We will pay for information we send to the EERRO plus the cost of the review.

The Illinois Department of Insurance will:
- Contact the EERRO that will conduct the review of your claim

The EERRO 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 EERRO makes, unless we can show conflict of interest, bias or fraud.

**How long will it take to get an EERRO decision?**
Within 5 days, but no more than 45 days after receiving all necessary information, the EERRO will notify you of their decision.

But sometimes you can get a faster external exception request review decision. Your **provider** must request an external expedited request review from the Illinois Department of Insurance. Your request for an external expedited request review must be initiated within 24 hours after you receive our notice of our adverse determination. Upon receipt from the Department of Insurance, we will respond to the eligibility request for an external expedited request review within 24 hours. If your request for an external expedited request review meets the requirements for an external expedited request review, the EERRO will make their decision within 72 hours. For **substance use disorder** decisions, if the EERRO upholds an adverse determination, we will provide **covered benefits** through the day following the determination by the EERRO.

There are two scenarios when you may be able to get a faster external exception request review:

**For initial adverse determinations**
Your **provider** tells us 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

**For final adverse determinations**
Your **provider** tells us 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 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

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

**Fees and expenses**
Except for the fees associated with the external exception request review, 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>
<tr>
<td>Dependent under your spouse’s plan and your parent’s plan</td>
<td>The plan that has covered the person longer*</td>
<td>The other plan covering you as a dependent*</td>
</tr>
<tr>
<td>COB rules for dependent children</td>
<td></td>
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<tr>
<td>----------------------------------</td>
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<tr>
<td><strong>Child of:</strong></td>
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<td></td>
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<tr>
<td>• Parents who are married or</td>
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<td></td>
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<tr>
<td>living together</td>
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<tr>
<td>The “birthday rule” applies. The</td>
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<tr>
<td>plan of the parent whose</td>
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<tr>
<td>birthday* (month and day only)</td>
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<tr>
<td>falls earlier in the <strong>calendar</strong></td>
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<tr>
<td>year.</td>
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<tr>
<td>*Same birthdays--the plan that</td>
<td></td>
<td></td>
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<tr>
<td>has covered a parent longer is</td>
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<td><strong>primary</strong>.</td>
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<tr>
<td>The plan of the parent born</td>
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<td>later in the year (month and day</td>
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<tr>
<td>only).*</td>
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<td></td>
</tr>
<tr>
<td>*Same birthdays--the plan that</td>
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<tr>
<td>has covered a parent longer is</td>
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<tr>
<td><strong>primary</strong>.</td>
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<tr>
<td><strong>Child of:</strong></td>
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<tr>
<td>• Parents separated or</td>
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<tr>
<td>divorced or not living together</td>
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<td>• With court-order</td>
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<td>The plan of the parent whom the</td>
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<td>court said is responsible for</td>
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<td>health coverage.</td>
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<td>But if that parent has no</td>
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<td>coverage then their spouse’s</td>
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<td>plan is primary.</td>
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<tr>
<td>The plan of the other parent.</td>
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<td>But if that parent has no</td>
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<td>coverage, then their spouse’s</td>
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<td>plan is primary.</td>
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<td><strong>Child of:</strong></td>
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<tr>
<td>• Parents separated or</td>
<td></td>
<td></td>
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<tr>
<td>divorced or not living together</td>
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<tr>
<td>– court-order states both parents</td>
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<tr>
<td>are responsible for coverage or</td>
<td></td>
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<tr>
<td>have joint custody</td>
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<tr>
<td>Primary and secondary coverage is</td>
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<tr>
<td>based on the birthday rule.</td>
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<tr>
<td><strong>Child of:</strong></td>
<td></td>
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<tr>
<td>• Parents separated or</td>
<td></td>
<td></td>
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<tr>
<td>divorced or not living together</td>
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<tr>
<td>and there is no court-order</td>
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<tr>
<td>The order of benefit payments is:</td>
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<tr>
<td>• The plan of the custodial parent</td>
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<tr>
<td>pays first</td>
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<td>• The plan of the spouse of the</td>
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<tr>
<td>custodial parent (if any) pays</td>
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<td>second</td>
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<tr>
<td>• The plan of the noncustodial</td>
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<tr>
<td>parents pays next</td>
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</tr>
<tr>
<td>• The plan of the spouse of the</td>
<td></td>
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</tr>
<tr>
<td>noncustodial parent (if any) pays</td>
<td></td>
<td></td>
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<tr>
<td>last</td>
<td></td>
<td></td>
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<tr>
<td><strong>Child of:</strong> Individual</td>
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<tr>
<td>who is not a parent (i.e.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>stepparent or grandparent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treat the person the same as a</td>
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</tr>
<tr>
<td>parent when making the order of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>benefits determination:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>See <strong>Child of</strong> content above.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Longer or shorter length of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>coverage**</td>
<td></td>
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</tr>
<tr>
<td>If none of the above rules</td>
<td></td>
<td></td>
</tr>
<tr>
<td>determine the order of payment,</td>
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<tr>
<td>the plan that has covered the</td>
<td></td>
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<tr>
<td>person longer is primary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other rules do not apply</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If none of the above rules apply,</td>
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</tr>
<tr>
<td>the plans share expenses equally.</td>
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<td></td>
</tr>
</tbody>
</table>

*Same birthdays--the plan that has covered a parent longer is primary*
### How are benefits paid?

<table>
<thead>
<tr>
<th></th>
<th>Description</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>
</tr>
<tr>
<td>Secondary plan</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>Benefit reserve</td>
<td>The benefit reserve:</td>
</tr>
<tr>
<td></td>
<td>- Is made up of the amount that the secondary plan saved due to COB</td>
</tr>
<tr>
<td></td>
<td>- Is used to cover any unpaid allowable expenses</td>
</tr>
<tr>
<td></td>
<td>- Balance is erased at the end of each policy year</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

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.
How are benefits paid?

<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, Medicare becomes primary payer on the first of the month in which the transplant takes place.</td>
<td>Medicare</td>
</tr>
</tbody>
</table>

*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.

How are benefits paid?

<table>
<thead>
<tr>
<th>We are primary</th>
<th>We pay your claims as if there is no Medicare coverage.</th>
</tr>
</thead>
<tbody>
<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>

Charges that satisfy your Part B deductible will be applied in the order received. We will apply the largest charge first when two or more charges are received at the same time.

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 on to your Aetna secure member website at [www.aetnastudenthealth.com](http://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 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

If your coverage ends because you die, premiums will be refunded, on a pro-rata basis, upon receipt of notice of your death. Refund of premium will not be computed by the use of a short-rate table.

If your coverage ends because you withdraw from school for reasons other than entering the armed forces, we will not refund premium contributions. You are covered for the policy term for which you enrolled and paid the premium contribution.

If you withdraw from school because you have entered the armed forces, premiums will be refunded, on a pro-rata basis, when we receive your application within 90 days from the date of the withdrawal.

As an Illinois resident, if your coverage lapses due to military service and you were honorably discharged, you and your dependents, that may have been eligible for a federal government sponsored health insurance program, may be reinstated in this plan if you otherwise remain eligible for coverage. Reinstatement is subject to payment of the current required premium.

We must receive a request for reinstatement no later than 63 days following the later of:

- Deactivation
- Loss of coverage under the federal government-sponsored health insurance program.

We may request proof of loss of coverage and the timing of the loss of coverage of the government-sponsored coverage in order to determine eligibility for reinstatement. The effective date of the reinstatement will be the first of the month following receipt of the notice requesting reinstatement.

When will coverage end for any dependents?
Coverage for your dependent will end if:

- For a dependent child, on the first premium due date following the child’s 26th birthday.
- Your dependent is no longer eligible for coverage.
- The date dependents are no longer an eligible class.
- You do not make the required premium contribution toward the cost of dependents’ coverage.
- Your coverage ends for any of the reasons listed above.
- For your spouse, the date the marriage ends in divorce or annulment.
In addition, coverage for your domestic partner or civil union partner will end on the earlier of:
- The date this plan no longer allows coverage for domestic partners or civil unions.
- The date the domestic partnership or civil union ends. For domestic partnerships, you should provide the policyholder a completed and signed Declaration of Termination of Domestic Partnership.

**What happens to your dependent coverage if you die?**
Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

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

We may immediately end your and your dependents 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.
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 or your dependents 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.

Your dependent is “totally disabled” if that person 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 or your dependents are no longer totally disabled
- When you become covered by another health benefits plan or
- 3 months of coverage

How can you extend coverage when getting inpatient care when coverage ends?
Your coverage may be extended if you or your dependents 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.

How can you extend coverage for your disabled child beyond the plan age limits?
You have the right to extend coverage for your disabled covered dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly (more than 50% of income) on you for support

The right to coverage will continue only as long as a physician certifies that your child still is disabled and your coverage under the student policy remains in effect.

We may ask you to send us proof of the disability within 31 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.
We may ask you to send proof that your child is disabled after coverage is extended. We won’t ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don’t, we can terminate coverage for your dependent child.

Your disabled child's coverage will end:
- On the date the child is no longer disabled and dependent upon you for support or
- As explained in the *When will coverage end for any dependents* section

**How can your dependents continue coverage after you die?**
Your dependents can continue coverage after your death if:
- You were covered at the time of your death
- The request is made within 31 days after your death
- Payment is made for the coverage

Your dependent’s coverage will end on the earliest date:
- The end of the 12th month period after your death
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- Any required contributions stop or
- The date your spouse remarries

To request extension of coverage, the dependent or their representative can just call Member Services at the toll-free number on your ID card.
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. Also, you are bound by our interpretation of this certificate of coverage when we administer your coverage, so long as we use reasonable authority.

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.

If your dependent status changes the amount of your dependent 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.

If a service cannot be provided to you
Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can’t, we may refund you or the policyholder any unearned premium.
**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**
At our expense, we have the right and opportunity to have a **physician** of our choice examine you. This will be done at all reasonable times while a claim is pending. We may also conduct an autopsy in the case of death, when law does not forbid it.

**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 exception request review organization
Some other money issues

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 or another insurance company.

To help us get paid back, you are doing four things now:
• 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.

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.
Glossary A-M

Accident or accidental
An injury to you that is not planned or anticipated.

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 properly licensed or certified to provide diagnostic and/or therapeutic services for mental disorders and substance use disorder under the laws of the jurisdiction where the individual practices.

Brand-name prescription drug
A U.S. Food and Drug Administration (FDA) approved prescription drug marketed with a specific brand 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 dependent
A person who is insured under the student policy as a dependent of a covered student.
Covered person
A covered student or a covered dependent of 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
- Group
- Organization
- Dental facility
- Other institution or person

Dentist(s)
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.
Directory
The list of in-network providers for your plan. The most up-to-date directory for your plan appears at www.aetnastudenthealth.com under the DocFind® label. When searching DocFind®, 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 and your dependent’s coverage begins under this certificate of coverage as noted in Aetna’s records.

Elective treatment:
Services and supplies provided to you when there is no evidence of pathology, dysfunction, or illness in any part of your body. Examples of elective treatment are:
- Breast reduction
- Sub mucous resection and/or other surgical correction for deviated nasal septum, other than for the treatment of a covered medical condition

Eligible health services
The health care services and supplies and outpatient prescription drugs listed in the Eligible health services under your plan section and not carved out or limited in the Exceptions 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
A recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, illness, or injury is of a severe nature. And that if you don’t get immediate medical care it could result in:
- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus
- In the case of a pregnant woman:
  - Serious jeopardy to the health of the fetus
  - One who is having contractions and there is inadequate time to effect a safe transfer to another hospital before delivery or
  - A transfer may pose a threat to the health or safety of the woman or unborn child
Emergency services
Treatment given in an ambulance and a hospital’s emergency room for an emergency medical condition. This includes evaluation of, and treatment to stabilize an emergency medical condition.

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
A prescription drug with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Health professional
A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, physicians, nurses, dental providers, vision care providers, 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 RN, LPN, or LVN. 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 6 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 use disorder
- Residential treatment facility for mental 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 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
The inability to:
- Conceive after 1 year of unprotected heterosexual sexual intercourse or 6 months of unprotected heterosexual sexual intercourse if the female partner is over age 35, or attempts to produce conception
- Conceive after diagnosed with a condition affecting fertility
- Sustain a successful pregnancy

Women without a male partner may be considered infertile if they are unable to conceive or produce conception after 1 year of donor insemination 6 cycles for women aged 35 or older.

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 disorder** or **substance use disorder** issue 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.

**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 or any **covered dependents** per **policy year** for **eligible health services**.

**Medically necessary/Medical necessity**

Health care services that we determine a **provider** exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness** or **injury**, or its symptoms, and that we determine are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s **illness** or **injury**
- Not primarily for the convenience of the patient, **physician**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s **illness** or **injury**

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
- Consistent with the standards set forth in policy issues involving clinical judgment
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 disorder
A mental disorder as defined in the most recent edition of the International Classification of Disease or Diagnostic or the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.

Morbid obesity/Morbidly obese
This means the body mass index is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea or
- Diabetes
Negotiated charge
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.

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 disorder or substance use 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 and specialty pharmacy. It also includes an out-of-network retail 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.

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 drugs and devices established by Aetna or an affiliate. It does not include all prescription 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 www.aetnastudenthealth.com/formulary.

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 use disorders and mental disorders.

Mental disorder includes related substance use 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 supplies not mentioned below</td>
<td>105% of the Medicare allowed rate</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
- **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.

R.N.
A registered nurse.
Residential treatment facility (mental 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 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 use disorder)

An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for substance use disorder 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 use disorder 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 use disorder 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 at retail prices.

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.

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.

Serious mental illness
Serious mental illness is defined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM is a book published by the American Psychiatric Association. Serious mental illness includes the following mental disorders:
- Schizophrenia
- Paranoids and other psychotic disorders
- Bipolar disorders (hypomanic, manic, depressive and mixed)
- Major depressive disorders (single episode or recurrent)
- Schizoaffective disorders (bipolar or depressive)
- Pervasive developmental disorders
- Obsessive-compulsive disorders
- Depression in childhood & adolescence
- Panic disorder
- Post-traumatic stress disorders (acute, chronic, or with delayed onset)
- Eating disorders, including but not limited to:
  - Anorexia nervosa
  - Bulimia nervosa
  - Pica
  - Rumination disorder
  - Avoidant/restrictive food intake disorder
  - Other specified feeding or eating disorder (OSFED)
  - Any other eating disorder contained in the most recent version of the DSM

Service area
The geographic area where in-network providers for this plan are located.

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 disorders or substance use disorder.
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 prescription drugs
These are prescription drugs that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

You can access the list of these specialty prescription drugs by calling Member Services at the toll-free number on your ID card or by logging on to your Aetna secure website at www.aetnastudenthealth.com.

This list can be reviewed and changed monthly by Aetna or an affiliate. On a yearly basis, Aetna evaluates this entire list to provide you with the most clinically appropriate and cost effective prescription drugs. Notice of a negative change to this list will be sent to affected covered persons within 60 days before the change. A negative change includes:

- Tier changes resulting in a higher out-of-pocket cost
- Addition of precertification, step therapy or quantity limit requirements
- Removal of a prescription drug from the preferred drug guide

Specialty pharmacy
This is a pharmacy designated by Aetna as an in-network pharmacy to fill prescriptions for specialty prescription drugs.

Stay
A full-time inpatient confinement for which a room and board charge is made.

Step therapy
A form of precertification under which certain prescription drugs will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by Aetna or an affiliate. An updated copy of the list of drugs subject to step therapy shall be available upon request by you or may be accessed on the Aetna website at www.aetnastudenthealth.com/formulary.

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 use disorder**
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the most current edition of the *International Classification of Disease* or the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a mental disorder that are a focus of attention or treatment. Or an addiction to nicotine products, food or caffeine intoxication, except as consistent with existing mental health parity requirements.

*Substance use disorder* also includes the following **mental disorders** as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:
- Substance use disorders
- Substance dependence disorders
- Substance induced disorders

**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

**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 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.

**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.

**Walk-in clinic**
A free-standing health care facility. Neither of the following should be considered a walk-in clinic:
- An emergency room
- The outpatient department of a hospital

10,20,30,40,50,60,70,80,95,100,102,110,120,130,140,150,160,170,180,190
Aetna Life Insurance Company

Student Health – Medical and Outpatient Prescription Drug PPO Insurance
Certificate of Coverage Amendment

Policyholder: Illinois Institute of Technology

Student policy number: 724532

Effective date: 08/10/2019

Your student policy has changed. The certificate of coverage is revised to reflect this. The changes are effective on the date shown above.

The changes are as follows:

1. The *How your plan works while you are covered for in-network coverage* section is replaced with the following:

**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*

**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 into your *Aetna* secure website at 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.
2. The following changes apply to the list of services requiring precertification, as shown in the Precertification – What types of services and supplies require precertification section:
   - “Home health care” is added to the outpatient services list
   - “Hospice services” is added to the outpatient services list
   - “Outpatient detoxification” is removed from the list
   - “Substance use disorders” is removed from the list

3. The following Important note is added to the Precertification for prescription drugs and devices section:

   Important note:
   Precertification and step therapy requirements do not apply to FDA-approved prescription drugs used for the treatment of substance use disorders, other than those established by applicable criteria.

4. The Preventive care immunizations benefit in the Eligible health services under your plan – Preventive care and wellness section is replaced by the following:

**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. Doses, recommended ages, and recommended population vary.

- **Adults:**
  - Herpes zoster
  - Mumps
  - Rubella
  - Shingles if you are 60 years of age or over.

- **Adults and children from birth to age 18:**
  - Diphtheria
  - Hepatitis A
  - Hepatitis B
  - Human papillomavirus (HPV)
  - Influenza (flu shot)
  - Measles
  - Meningococcal
  - Pertussis (whooping cough)
  - Pneumococcal
  - Tetanus
  - Varicella (Chickenpox)

- **Children from birth to age 18:**
  - Haemophilus influenza type b
  - Inactive poliovirus
  - Rotavirus.

Your plan does not cover immunizations that are not considered preventive care, except for those required due to travel.
5. The *Well woman preventive visits* benefit in the *Eligible health services under your plan – Preventive care and wellness* section is replaced by the following:

**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, including surveillance tests for ovarian cancer for woman at risk for ovarian cancer. 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 urinary incontinence.
- Clinical breast exams as follows:
  - For women over 20 years of age but less than 40, at least every 3 years
  - For women 40 years of age and older, annually
- Breast cancer chemoprevention counseling
- Cervical cancer screening for sexually active woman
- Chlamydia infection screening for younger women and other women at higher risk
- HIV screening and counseling for sexually active woman
- Osteoporosis screening for women over age 60 depending on risk factors.

**Eligible health services** for pregnant or women who may become pregnant include:

- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Anemia screening on a routine basis
- Folic acid supplements for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening
- Urinary tract or other infection screening.

6. References to “misuse of alcohol and/or drugs” appearing in the *Preventive screening and counseling services* section” benefit in the *Eligible health services under your plan – Preventive care and wellness* section are replaced with “substance use disorders”.

7. The *When does your plan cover missing teeth that are not replaced* provision in the *Eligible health services under your plan – Pediatric dental care* section is replaced by the following:

**When does your plan cover missing teeth that are not replaced?**

The 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.
8. The Well newborn nursery care provision in the Eligible health services under your plan – Specific conditions section is replaced by the following:

**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
- Hospital or birthing center visits and consultations for the well newborn by a physician but for not more than 1 visit per day.

9. The outpatient Mental health treatment benefit in the Eligible health services under your plan – Specific conditions section is replaced by the following:

**Mental health treatment**

- 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
  - 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 to avoid placing you at risk for serious complications
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23 hour observation
    - Peer counseling support by a peer support specialist
      - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.
10. The outpatient *Substance use disorders related treatment* benefit in the *Eligible health services under your plan – Specific conditions* section is replaced by the following:

**Substance use disorders related treatment**
- 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
  - Individual, group and family therapies for the treatment of *substance use disorders*
  - Other outpatient *substance use disorder* treatments such as:
    - Outpatient *detoxification*
    - *Partial hospitalization treatment* provided in a facility or program for treatment of *substance use disorders* provided under the direction of a *physician*
    - *Intensive outpatient program* provided in a facility or program for treatment of *substance use disorders* provided under the direction of a *physician*
    - Ambulatory *detoxification* which are outpatient services that monitor withdrawal from alcohol or other *substance use disorders*, including administration of medications
    - Treatment of withdrawal symptoms
    - 24 hour observation
    - Peer counseling support by a peer support specialist
      - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a *behavioral health provider*.

11. The *Transplant services* benefit in the *Eligible health services under your plan – Specific conditions* section is replaced by the following:

**Transplant services**

*Eligible health services* include transplant services provided by a *physician* and *hospital*.

This includes the following transplant types:
- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy 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. You may also get transplant services at a non-IOE facility, but your cost share will be higher.

**Important note:**
- Many pre and post transplant medical services, even routine ones, are related to and may affect the success of your transplant. While 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.

Other transplants
Eligible health services include corneal (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants. Corneal and cartilage transplants are not available at IOE facilities.

12. The chart appearing in the Fertility preservation benefit in the Eligible health services under your plan – Specific conditions section is replaced by the following:

<table>
<thead>
<tr>
<th>You are</th>
<th>You need to have an unmedicated day 3 FSH test done within the past:</th>
<th>The results of your unmedicated day 3 FSH test:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A female under 35 years of age</td>
<td>12 months</td>
<td>Must be less than 19 mIU/mL in your most recent lab test to use your own eggs.</td>
</tr>
<tr>
<td>A female 35 years of age or older</td>
<td>12 months</td>
<td>If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40.</td>
</tr>
</tbody>
</table>

13. The following Hearing aids benefit is added to the Eligible health services under your plan - Other services section:

Hearing aids
Eligible health services include hearing instruments and related hearing aid services, if you are under age 18, as described below:

Hearing instrument means:
- Any wearable, non-disposable, nonexperimental instrument or device designed to aid or make up for impaired human hearing
- Parts, attachments or accessories for the instrument or device, including an ear mold

Hearing aid services include:
- Audiometric exams
- Selection, fitting and adjustments of ear molds
- Hearing instrument repairs
14. The Hearing aids and exams benefit in the Eligible health services under your plan-Other services section is replaced by the following:

**Hearing aids and exams**

*Eligible health services* include hearing care that includes hearing exams prescribed hearing aids and hearing aid services, if you are over age 18, as described below. And just a reminder, you'll find coverage limitations in the schedule of benefits.

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

*Eligible health services also include bone anchored hearing aids and cochlear implants.*

15. The following Important note is added to the What precertification requirements apply? section of Outpatient prescription drugs section benefit section:

**Important note:**

Precertification and step therapy requirements do not apply to FDA-approved prescription drugs used for the treatment of substance use disorders, other than those established by applicable criteria.

16. The Court-order services and supplies exclusion in the What your plan doesn’t cover – eligible health service exceptions and exclusions section is replaced by the following:

**Court-ordered services and supplies**

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding. This exclusion does not apply to court-ordered U.S. FDA-approved prescription drugs for the treatment of substance use disorders and any associated counseling or wraparound services.

17. The Custodial care exclusion in the What your plan doesn’t cover – eligible health service exceptions and exclusions section is replaced by the following:

**Custodial care**

Examples 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/jejunosotmy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care except in connection with hospice care, adult (or child) day care, or convalescent care
- Institutional care. 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
18. The Hearing aids and exams exclusion in the What your plan doesn’t cover – eligible health service exceptions and exclusions section is replaced by the following:

**Hearing aids**
If you are under age 18, the following services or supplies:
- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 36 month period
- Replacement parts for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any hearing aid prescribed by someone other than a hearing care professional
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries and auxiliary equipment.
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

**Hearing aids and exams** except as described in the Eligible health services under your plan - (Hearing aids) section
The following services or supplies:
- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 24 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 given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries, amplifiers, and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

19. The Transplant services exclusion in the What your plan doesn’t cover – eligible health service exceptions and exclusions section is replaced by the following:

**Transplant services**
- 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
20. The first paragraph of the *Who provides the care section* is replaced by the following paragraphs:

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*.

21. The *In-network providers* provision in the *Who provides the care section* is replaced by the following:

**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 under your plan* section
- **Urgent care** – refer to the description of emergency services and urgent care in the *Eligible health services under your plan* section
- **Transplants** – see the description of transplant services in the *Eligible health services under your plan – Specific conditions* section

You may select an *in-network provider* from the directory through your *Aetna* secure website at [www.aetnastudenthealth.com](http://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.

22. The following paragraph is added to *Concurrent care claim reduction or termination* in the *When you disagree-claim decisions and appeal procedures- Types of claims and communicating our decisions* section:

For treatment of *substance use disorders*: If we determine that benefits are no longer *medically necessary*, we will provide you written notice within 24 hours of the adverse determination and advise you of your right to request an external review.
The Appeals of adverse benefit determinations provision in the When you disagree-claim decisions and appeal procedures section is replaced by the following:

**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.

The deadline for filing an appeal will not be postponed or delayed by a provider appeal unless the provider is acting as your authorized representative.

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

You may also contact Aetna at the following address:
Aetna Life Insurance Company
Appeals Resolution Team
PO Box 14464
Lexington, KY 40512

You may also contact us by calling Member Services at the toll-free number on the back of your ID card.

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 appeal one time under this plan.

**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. 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>Administrative appeal determinations</td>
<td>Not applicable</td>
<td>30 calendar days</td>
<td>60 calendar days</td>
<td>As appropriate to type of claim</td>
</tr>
<tr>
<td>Health care services appeal determinations</td>
<td>24 hours</td>
<td>15 business days</td>
<td>15 business days</td>
<td></td>
</tr>
<tr>
<td>Extensions</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

24. The *How long will it take to get an EERRO decision?* in the *External exception request review* section is replaced with the following:

**How long will it take to get an EERRO decision?**
Within 5 days, but no more than 45 days after receiving all necessary information, the EERRO will notify you of their decision.

But sometimes you can get a faster external exception request review decision. Your *provider* must request an external expedited request review from the Illinois Department of Insurance. Your request for an external expedited request review must be initiated within 24 hours after you receive our notice of our adverse determination. Upon receipt from the Department of Insurance, we will respond to the eligibility request for an external expedited request review within 24 hours. If your request for an external expedited request review meets the requirements for an external expedited request review, the EERRO will make their decision within 72 hours. For *substance use disorder* decisions, if the EERRO upholds an adverse determination, we will provide *covered benefits* through the day following the determination by the EERRO.

There are two scenarios when you may be able to get a faster external exception request review:

**For initial adverse determinations**
Your *provider* tells us 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

**For final adverse determinations**
Your *provider* tells us 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 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
25. The first paragraph of Your coverage can change in the General provisions – other things you should know section is replaced by the following:

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.

26. Definitions for the terms “Mental disorder”, “Negotiated charge,” “School health services,” and “Substance use disorder” in the Glossary section are replaced by the following:

Mental disorder
A mental disorder as defined in the most recent edition of the International Classification of Disease or Diagnostic or the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.

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.

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.

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.
Substance use disorder
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the most current edition of the *International Classification of Disease* or the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a mental disorder that are a focus of attention or treatment. Or an addiction to nicotine products, food or caffeine intoxication, except as consistent with existing mental health parity requirements.

Substance use disorder also includes the following mental disorders as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

- Substance use disorders
- Substance dependence disorders
- Substance induced disorders

This amendment makes no other changes to the student policy, certificate of coverage, or schedule of benefits.

Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

IL Cert Amendment
Amendment 1
Issue date 07/05/2019
Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call the number listed on your ID card at no cost.

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 complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  ○ Qualified sign language interpreters
  ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:
  ○ Qualified interpreters
  ○ Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)


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Language Assistance

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您ID卡上所列的號碼，無需付費。 (Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。(Japanese)

Pour jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat identifikasyon ou gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)