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

Schedule of Benefits

Prepared exclusively for:

Policyholder: University of Missouri System - Columbia Domestic Students
Policyholder number: 890430
Student policy effective date: 08/15/2019
Plan effective date: 08/15/2019
Plan issue date: 06/20/2019
Actuarial value and metallic level: 81.90% - Gold

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

*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**

**How to contact us for help**

We are here to answer your questions.

- Log onto your Aetna secure website at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).
- Call Member Services at the toll-free number on your ID card 1-877-375-7905.

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**

**In-network coverage**

**Out-of-network coverage**

**Policy year deductible**

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

<table>
<thead>
<tr>
<th></th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$400 per policy year</td>
<td>$800 per policy year</td>
</tr>
<tr>
<td>Spouse</td>
<td>$400 per policy year</td>
<td>$800 per policy year</td>
</tr>
<tr>
<td>Each Child</td>
<td>$400 per policy year</td>
<td>$800 per policy year</td>
</tr>
</tbody>
</table>

**Policy year deductible waiver**

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

- In-network care for Preventive care and wellness, Family planning services - female contraceptives, and Pediatric Dental Services.
- In-network care and out-of-network care for immunizations for children under five years of age, Prescribed Medicines Expense, and Pediatric Vision Services.

*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>Student</td>
<td>$6,350 per policy year</td>
<td>None</td>
</tr>
<tr>
<td>Spouse</td>
<td>$6,350 per policy year</td>
<td>None</td>
</tr>
<tr>
<td>Each child</td>
<td>$6,350 per policy year</td>
<td>None</td>
</tr>
<tr>
<td>Family</td>
<td>$12,700 per policy year</td>
<td>None</td>
</tr>
</tbody>
</table>

**Precertification covered benefit penalty**

This only applies to out-of-network coverage: The certificate of coverage contains a complete description of the precertification program. You will find details on precertification requirements in the Medical necessity and precertification requirements section.

Failure to precertify your eligible health services when required will result in the following benefit penalty:

- A $500 benefit penalty will be applied separately to each type of eligible health services

The additional percentage or dollar amount of the recognized charge which you may pay as a penalty for failure to obtain precertification is not a covered benefit and will not be applied to the out-of-network policy year deductible amount or the maximum out-of-pocket limit, if any.

*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>1. Preventive care and wellness</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>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>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>Preventive care immunizations</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>Covered 100% for children up to 5 years of age. Deductible and coinsurance applies thereafter.</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximums</td>
<td>Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For details, contact your physician or Member Services by logging 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.*
**Child health supervision services**

| Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |

**Well baby/child exams**

| Limited to: Covered persons through age 22 | Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |

**Maximum visits per policy year**

- Limited to 7 exams in the first 12 months
- Limited to 3 exams in the second 12 months
- Limited to 3 exams in the third 12 months
- Limited to 1 exam thereafter per policy year benefit maximum

**Early intervention for infants and toddlers (First Steps)**

| Early intervention services office visit for children from birth to age 3 | Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |

**Well woman preventive visits**

**Routine gynecological exams (including Pap smears)**

- 100% (of the negotiated charge) per visit
- No copayment or policy year deductible applies
- 70% (of the recognized charge) per visit

**Maximums**

Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration Women’s Preventive Services Guidelines.

**Maximum visits per policy year**

1 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.*
### Preventive screening and counseling services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity and/or healthy diet counseling office visits</strong></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>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td><strong>Maximum visits per policy year</strong></td>
<td>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)*</td>
</tr>
<tr>
<td>(This maximum applies only to covered persons age 22 and older)</td>
<td></td>
</tr>
<tr>
<td>*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.</td>
<td></td>
</tr>
<tr>
<td><strong>Misuse of alcohol and/or drugs counseling office visits</strong></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>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td><strong>Maximum visits per policy year</strong></td>
<td>5 visits*</td>
</tr>
<tr>
<td>*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.</td>
<td></td>
</tr>
<tr>
<td><strong>Use of tobacco products counseling office visits</strong></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>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td><strong>Maximum visits per policy year</strong></td>
<td>8 visits*</td>
</tr>
<tr>
<td>*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.</td>
<td></td>
</tr>
<tr>
<td><strong>Depression screening counseling office visits</strong></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>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td><strong>Maximum visits per policy year</strong></td>
<td>1 visit*</td>
</tr>
<tr>
<td>*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one 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>Service Description</th>
<th>Cost Sharing Details</th>
<th>Cost Sharing Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexually transmitted infection counseling office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>2 visits*</td>
<td></td>
</tr>
<tr>
<td>*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genetic risk counseling for breast and ovarian cancer office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Age limitations</td>
<td>Not subject to any age limitations</td>
<td></td>
</tr>
<tr>
<td>Lead poisoning screening</td>
<td>Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
<tr>
<td>Routine cancer screenings</td>
<td>100% (of the negotiated charge) per visit</td>
<td>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Performed at a physician’s office, specialist’s office or facility.</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>
| Maximums                                                                           | Subject to any age; family history; and frequency guidelines as set forth in the most current:  
|                                                                                   | • 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  
|                                                                                   | • The comprehensive guidelines supported by the Health Resources and Services Administration.  
|                                                                                   | For details, contact your physician or Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or 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.*
| Mammogram maximums | Age 35 and older; subject to any family history; and frequency guidelines as set forth in the most current:
|• 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
|• The comprehensive guidelines supported by the Health Resources and Services Administration; or
|• State law (where stricter).
|For details, contact your physician or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the toll-free number on your ID card.

| 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.

| Prenatal care | Preventive care services only | 100% (of the negotiated charge) per visit
| No copayment or policy year deductible applies | 70% (of the recognized charge) per visit |

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.
### Comprehensive lactation support and counseling services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>100% (of the negotiated charge) per visit</th>
<th>70% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactation counseling services - facility or office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td></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>Lactation counseling services maximum visits per policy year either in a group or individual setting</td>
<td>6 visits*</td>
<td></td>
</tr>
</tbody>
</table>

*Important note:*
Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section.

### Breast feeding durable medical equipment

<table>
<thead>
<tr>
<th>Service Description</th>
<th>100% (of the negotiated charge) per item</th>
<th>70% (of the recognized charge) per item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast pump supplies and accessories</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% (of the negotiated charge) per item</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

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

### Family planning services – contraceptives

<table>
<thead>
<tr>
<th>Service Description</th>
<th>100% (of the negotiated charge) per visit</th>
<th>70% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive counseling services office visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></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>Contraceptive counseling services maximum visits per policy year either in a group or individual setting</td>
<td>2 visits*</td>
<td></td>
</tr>
</tbody>
</table>

Contraceptives (prescription drugs and devices)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>100% (of the negotiated charge) per item</th>
<th>70% (of the recognized charge) per item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit</td>
<td>100% (of the negotiated charge) per item</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</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.*
| Voluntary sterilization | Inpatient provider services | 100% (of the negotiated charge)  
No copayment or policy year deductible applies | 70% (of the recognized charge)  
No copayment or policy year deductible applies |
|------------------------|----------------------------|---------------------------------|---------------------------------|
|                        | Outpatient provider services | 100% (of the negotiated charge) per visit  
No copayment or policy year deductible applies | 70% (of the recognized charge) per 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>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)(includes telemedicine consultations)</td>
<td>$20 copayment per visit then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter</td>
<td>50% (of the recognized charge) per visit</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. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</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. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
<tr>
<td>Allergy sera and extracts administered via injection 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. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</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)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>80% (of the negotiated charge)</td>
<td>50% (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.
### Physician and specialist – outpatient surgical services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Plan Pays (of the negotiated charge) per visit</th>
<th>Member Pays (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<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%</td>
<td>50%</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>80%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### In-hospital non-surgical physician services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Plan Pays (of the negotiated charge) per visit</th>
<th>Member Pays (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-hospital non-surgical physician services</td>
<td>80%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Consultant services (non-surgical and non-preventive)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Plan Pays (of the negotiated charge) per visit</th>
<th>Member Pays (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation office visits</td>
<td>$20 copayment per visit then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Second opinion - cancer

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Plan Pays (of the negotiated charge) per visit</th>
<th>Member Pays (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Second surgical opinion

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Plan Pays (of the negotiated charge) per visit</th>
<th>Member Pays (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second surgical opinion</td>
<td>80%</td>
<td>50%</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.*
## Alternatives to physician office visits

### Walk-in clinic visits (non-emergency visit)

| Walk-in clinic (non-emergency visit) | $20 copayment per visit then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter | 50% (of the recognized charge) per visit |

**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>$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission</td>
<td>50% (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 <em>Physician and specialist-inpatient surgical services</em> 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. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
<tr>
<td>Anesthesia and related facility charges for a dental procedure</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
</tbody>
</table>

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Anesthesia and hospital charges for dental care

Anesthesia and hospital charges for dental care

Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.

Alternatives to hospital stays

Outpatient surgery (facility charges)

Facility charges for surgery performed in the outpatient department of a hospital or surgery center

For physician charges, refer to the Physician and specialist - outpatient surgical services benefit

80% (of the negotiated charge)  50% (of the recognized charge)

Home health care

Outpatient

80% (of the negotiated charge) per visit  50% (of the recognized charge) per visit

Maximum visits per policy year

Unlimited

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

Hospice care

Inpatient facility (room and board and other miscellaneous services and supplies)

80% (of the negotiated charge) per admission  50% (of the recognized charge) per admission

Outpatient

80% (of the negotiated charge) per visit  50% (of the recognized charge) per visit

Outpatient private duty nursing

Outpatient private duty nursing

80% (of the negotiated charge) per visit  50% (of the recognized charge) per 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>Skilled nursing facility</th>
<th>$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission</th>
<th>50% (of the recognized charge) per admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient facility (room and board) and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>miscellaneous inpatient care services and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject to semi-private room rate unless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.*
## Eligible health services

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

### 4. Emergency services and urgent care

#### Emergency services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital emergency room</td>
<td>$100 copayment per visit then the plan pays 80% (of the balance of the negotiated charge) per visit</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td>Non-emergency care in a hospital emergency room</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

#### 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.
- A separate hospital emergency room copayment will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment will be waived, and your inpatient copayment will apply.
- Covered benefits that are applied to the hospital emergency room copayment cannot be applied to any other copayment under the plan. Likewise, a copayment that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment.
- Separate copayment amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment amounts may be different from the hospital emergency room copayment. They are based on the specific service given to you.
- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment amounts that are different from the hospital emergency room copayment amounts.

#### Urgent care

<table>
<thead>
<tr>
<th>Service</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>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Non-urgent use of urgent care provider</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*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

<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><strong>Limited to covered persons through the end of the month in which the person turns age 19</strong></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. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</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.

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*See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefits.*
### 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
- Problem-focused examination, limited to 2 visits every 12 months
- Oral evaluation-child under age 3, limited to 2 visits every 12 months
- Comprehensive oral evaluation, limited to 2 visits every 12 months
- Detailed and extensive oral evaluation-problem focused
- Comprehensive periodontal evaluation, limited to 2 visits every 12 months
- Complete image series, including bitewings, limited to 1 set every 3 years
- Periapical 1st image
- Intra-oral, occlusal radiographic image
- Bitewing image—one image, limited to 2 sets per 12 months*
- Bitewing image-two images, limited to 2 sets per 12 months*
- Bitewing image-three images, limited to 2 sets per 12 months*
- Bitewing image-four images, limited to 2 sets per 12 months*
- Vertical bitewing images, limited to 2 sets per year
- Panoramic images, limited to 1 set every 3 years
- Cephalometric image
- 2D oral/facial photographic images
- Interpretation of diagnostic image
- Diagnostic models
- Prophylaxis (cleaning)-Adult, limited to 2 treatments per year
- Prophylaxis (cleaning)-Child, limited to 2 treatments per year
- Topical fluoride varnish, limited to 2 courses every 12 months
- Topical application of fluoride, limited to 2 courses every 12 months
- Sealants, per tooth, limited to one application every 3 years for permanent molars
- Preventive resin restoration in a moderate to high caries risk patient, permanent tooth, limited to one application every 3 years for permanent molars
- Sealant repair, per tooth, limited to one application every 3 years for permanent molars
- Resin infiltration of lesion, limited to 1 per tooth every 3 years
- Emergency palliative treatment per visit

*Note: Any number of bitewings submitted for the same date of service is considered a set

#### Space maintainers

- Space maintainers - Fixed (unilateral)
- Space maintainers - Fixed (bilateral, maxillary)
- Space maintainers – Fixed (bilateral, mandibular)
- Space maintainers - Removable (unilateral)
- Space maintainers - Removable (bilateral, maxillary)

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
• Space maintainers - Removable (bilateral, mandibular)
• 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)
• Treatment of complications (post-surgical) unusual circumstances, by report

**Images, pathology and prescription drugs**
• Extra-oral first 2D projection radiographic image
• Extra-oral posterior dental radiographic image
• Therapeutic drug injection, by report
• Infiltration of sustained release therapeutic drug – single or multiple sites – when D7220, D7230, D7240, D7241 or D7251 are rendered for extraction of wisdom teeth # 01, 16, 17, 32; performed by an oral surgeon

**Oral surgery**
• Extraction, coronal remnants-primary tooth
• Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
• Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth
• Coronectomy
• Removal of residual tooth roots
• Removal of impacted tooth (soft tissue)
• Removal of impacted tooth (partially bony)
• Removal of impacted tooth (completely bony)
• Removal of impacted tooth (completely bony with unusual surgical complications)
• Closure of oral fistula of maxillary sinus
• Tooth reimplantation
• Tooth transplantation
• Surgical access of an unerupted tooth
• Placement of device to facilitate eruption of impacted tooth
• Incision and drainage of abscess
• Alveoplasty, in conjunction with extractions-four or more teeth per quadrant
• Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces – per quadrant
• Alveoplasty, not in conjunction with extraction – per quadrant
• Alveoplasty, not in conjunction with extractions – 1 to 3 teeth or tooth spaces – per quadrant
• Removal of exostosis
• Removal of torus palatinus
• Removal of torus mandibularis
• Suture of soft tissue injury wound less than 5 CM

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
- Bone replacement graft for ridge preservation - per site
- Frenectomy
- Excision of hyperplastic tissue
- Excision of pericornal gingiva

**Periodontics**
- Periodontal scaling and root planing, per quadrant – 4 or more teeth, limited to 4 separate quadrants every 2 years
- Periodontal scaling and root planing – 1 to 3 teeth per quadrant; limited to once per quadrant every 2 years
- Periodontal maintenance procedures following active therapy, limited to 4 in 12 months combined with prophylaxis after completion of active periodontal therapy
- Collection and application of autologous blood concentrate product, limited to 1 every 3 years
- Occlusal adjustment - limited
- Occlusal adjustment - complete

**Endodontics**
- Pulp capping-direct
- Pulp capping-indirect
- Pulpotomy (therapeutic)
- Partial pulpotomy of apexogenesis
- Pulpal therapy – anterior primary tooth
- Pulpal therapy – posterior primary tooth
- Pulpal regeneration – initial visit
- Retrograde filling

**Restorative dentistry**
(Does not include inlays, crowns (other than prefabricated stainless steel or resin) and bridges. Multiple restorations in 1 surface are considered as a single restoration)
- Amalgam restorations– 1 surface
- Amalgam restorations – 2 surfaces
- Amalgam restorations – 3 surfaces
- Amalgam restorations – 4 or more surfaces
- Resin-based composite restorations – 1 surface anterior
- Resin-based composite restorations – 2 surfaces anterior
- Resin-based composite restorations – 3 surfaces anterior
- Resin based composite restorations – 4 or more surfaces or involving incisal angle (anterior)
- Resin-based composite crown, anterior
- Resin-based composite – 1 surface posterior
- Resin-based composite – 2 surfaces posterior
- Resin-based composite – 3 surfaces posterior
- Resin-based composite – 4 or more surfaces posterior

**Pins:**
- Pin retention – per tooth, in addition to amalgam or resin restoration

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
**Crowns (when tooth cannot be restored with a filling material):**
- Prefabricated stainless steel – primary teeth
- Prefabricated stainless steel – permanent teeth
- Prefabricated resin crown (excluding temporary crowns)
- Protective resin
- Interim therapeutic restoration – primary teeth
- Prefabricated porcelain/ceramic crown - primary teeth

**Re-cementation:**
- Inlay
- Fabricated-prefabricated post and core
- Crown
- Implant/abutment supported crown
- Implant/abutment supported fixed partial denture
- Fixed partial denture retainers

**Prosthodontics**

**Dentures and partials:**
- Adjustment to complete denture – upper (adjustments made within 6 months after installation, by the same dental provider who installed it, are inclusive to the denture)
- Adjustment to complete denture – lower (adjustments made within 6 months after installation, by the same dental provider who installed it, are inclusive to the denture)
- Adjustment to partial denture – upper (adjustments made within 6 months after installation, by the same dental provider who installed it, are inclusive to the denture)
- Adjustments to partial denture – lower (adjustments made within 6 months after installation, by the same dental provider who installed it, are inclusive to the denture)

**Repairs:**
- Repair broken complete denture base, mandibular
- Repair broken complete denture base, maxillary
- Replace missing or broken tooth-complete denture
- Repair resin partial denture base, mandibular
- Repair resin partial denture base, maxillary
- Repair cast partial framework, mandibular
- Repair cast partial framework, maxillary
- Repair or replace broken retentive/clasping materials – per tooth
- Replace broken tooth-per tooth (partial denture)
- Add tooth to existing partial denture
- Add clasp to existing partial denture - per tooth
- Replace all teeth and acrylic on cast metal framework - upper partial denture
- Replace all teeth and acrylic on cast metal framework - lower partial denture
- Special tissue conditioning, per denture - upper
- Special tissue conditioning, per denture - lower
- Add metal substructure to acrylic full denture (per arch)
- Rebase, complete upper denture
- Rebase, complete lower denture

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
- Rebase upper partial denture
- Rebase lower partial denture
- Reline complete upper denture (chairside)
- Reline complete lower denture (chairside)
- Reline upper partial denture (chairside)
- Reline lower partial denture (chairside)
- Reline complete upper denture (laboratory)
- Reline complete lower denture (laboratory)
- Reline upper partial denture (laboratory)
- Reline lower partial denture (laboratory)
- Fixed partial denture repair necessitated by material failure

**General anesthesia and intravenous sedation**
- Evaluation for moderate sedation, deep sedation or general anesthesia
- Deep sedation/general anesthesia – first 15 minutes
- General anesthesia/deep sedation-each subsequent 15-minute increment
- Intravenous moderate (conscious) sedation/analgesia – first 15 minutes
- Intravenous conscious sedation-each subsequent 15-minute increment

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

**Dental service or supply**

**Periodontics**
- Gingivectomy or gingivoplasty, per quadrant, limited to 1 per quadrant every 3 years
- Gingivectomy or gingivoplasty, 1 to 3 teeth per quadrant, limited to 1 per quadrant every 3 years
- Gingivectomy or gingivoplasty, to allow access for restorative procedure, per tooth, limited to 1 per quadrant every 3 years
- Gingival flap procedure – per quadrant, limited to 1 per quadrant every 3 years
- Gingival flap procedure –1 to 3 teeth, per quadrant, limited to 1 per quadrant every 3 years
- Clinical crown lengthening
- Osseous surgery, four or more contiguous teeth, limited to 1 per quadrant every 3 years
- Osseous surgery, including flap and closure, 1 to 3 teeth, contiguous teeth per quadrant, limited to 1 per site every 3 years
- Bone replacement graft – first site in quadrant, limited to 1 every 3 years
- Pedical soft tissue graft procedure
- Autogenous subepithelial connective tissue graft procedures
- Non-autogenous connective soft tissue allograft
- Free soft tissue graft procedure 1st tooth, implant or edentulous tooth position in graft
- Free soft tissue graft procedure each additional contiguous tooth, implant or edentulous tooth position in same graft site
- Autogenous connective tissue graft procedure--each additional contiguous tooth, implant or edentulous tooth position in same graft site
- Non-autogenous connective tissue graft procedure--each additional contiguous tooth, implant or edentulous tooth position in same graft site
- Full mouth debridement; limited to 1 treatment per lifetime

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

**Root canal therapy including medically necessary images:**

- Anterior tooth
- Premolar tooth
- Molar tooth

**Retreatment of previous root canal therapy including medically necessary images:**

- Anterior tooth (excluding final restorations)
- Premolar tooth (excluding final restorations)
- Molar tooth (excluding final restorations)
- Apexification/recalcification-initial visit
- Apexification/recalcification-interim medication replacement
- Apexification/recalcification-final visit
- Pulpal regeneration-initial visit
- Interim medications replacement
- Completion of treatment
- Apicoectomy-anterior
- Apicoectomy-premolar
- Apicoectomy-molar
- Apicoectomy-each additional tooth
- Root amputation
- Hemisection (including any root removal)

### 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.) Limited to 1 per tooth every 5 years.

- Inlay-metallic-1 surface, limited to 1 tooth every 5 years
- Inlay-metallic-2 surfaces, limited to 1 tooth every 5 years
- Inlay-metallic-3 or more surfaces, limited to 1 tooth every 5 years
- Onlay-metallic-2 surfaces, limited to 1 tooth every 5 years
- Onlay-metallic-3 surfaces, limited to 1 tooth every 5 years
- Onlay-metallic-4 or more surfaces, limited to 1 tooth every 5 years
- Inlay-porcelain/ceramic-1 surface, limited to 1 tooth every 5 years
- Inlay-porcelain/ceramic-2 surfaces, limited to 1 tooth every 5 years
- Inlay-porcelain/ceramic-3 or more surfaces, limited to 1 tooth every 5 years
- Onlay-porcelain/ceramic-2 surfaces, limited to 1 tooth every 5 years
- Onlay-porcelain/ceramic-3 surfaces, limited to 1 tooth every 5 years
- Onlay-porcelain/ceramic-in addition to inlay, limited to 1 tooth every 5 years
- Inlay-composite/resin-1 surface, limited to 1 tooth every 5 years
- Inlay-composite/resin-2 surfaces, limited to 1 tooth every 5 years
- Inlay-composite/resin-3 surfaces, limited to 1 tooth every 5 years
- Onlay-composite/resin-2 surfaces, limited to 1 tooth every 5 years
- Onlay-composite/resin-3 surfaces, limited to 1 tooth every 5 years
- Onlay-composite/resin- 4 or more surfaces, limited to 1 tooth every 5 years

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### Crowns (limited to 1 tooth every 5 years):
- Resin, limited to 1 tooth every 5 years
- Resin with high noble metal, limited to 1 tooth every 5 years
- Resin with base metal, limited to 1 tooth every 5 years
- Resin with noble metal, limited to 1 tooth every 5 years
- Porcelain/ceramic, limited to 1 tooth every 5 years
- Porcelain with high noble metal, limited to 1 tooth every 5 years
- Porcelain with base metal, limited to 1 tooth every 5 years
- Porcelain with noble metal, limited to 1 tooth every 5 years
- ¾ cast high noble metal, limited to 1 tooth every 5 years
- ¾ cast predominantly base metal, limited to 1 tooth every 5 years
- ¾ cast noble metal, limited to 1 tooth every 5 years
- ¾ porcelain/ceramic, limited to 1 tooth every 5 years
- Full cast high noble metal, limited to 1 tooth every 5 years
- Full cast base metal, limited to 1 tooth every 5 years
- Full cast noble metal, limited to 1 tooth every 5 years
- Titanium, limited to 1 tooth every 5 years
- Core build-up
- Post and core
- Each additional post
- Prefabricated post and core
- Each additional prefabricated post
- Labial veneer (resin) - chairside
- Labial veneer (resin laminate) – laboratory, limited to 1 tooth every 5 years
- Labial veneer (porcelain) – laboratory, limited to 1 tooth every 5 years

### Repairs:
- Crown repair
- Inlay repair
- Onlay repair
- Veneer repair

### Prosthodontics

#### Dentures and partial dentures:
(Replacement of existing dentures or partial dentures/bridges, limited to 1 every 5 years)
- Complete upper denture, limited to 1 every 5 years
- Complete lower denture, limited to 1 every 5 years
- Immediate upper denture, limited to 1 every 5 years
- Immediate lower denture, limited to 1 every 5 years
- Maxillary partial denture (upper), resin base (including retentive/clasping materials, rests, and teeth), limited to 1 every 5 years
- Mandibular partial denture (lower), resin base (including retentive/clasping materials, rests, and teeth), limited to 1 every 5 years
- Partial upper, cast metal base with resin saddles (including any conventional clasps, rests, and teeth), 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.*
- **Partial lower**, cast metal base with resin saddles (including any conventional clasps, rests, and teeth), limited to 1 every 5 years
- Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth), limited to 1 every 5 years
- Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth), limited to 1 every 5 years
- Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) includes limited follow-up care only; does not include future rebasing, limited to 1 every 5 years
- Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth), limited to 1 every 5 years
- Interim partial denture, upper
- Interim partial denture, lower
- Removable unilateral partial denture one-piece cast metal (including clasps and teeth), maxillary, limited to 1 every 5 years

**Implant services:**
- Surgical placement of implant: endosteal, limited to 1 every 5 years
- Surgical placement of interim implant body, limited to 1 every 5 years
- Surgical placement of eposteal implant, limited to 1 every 5 years
- Transosteal implant, including hardware, limited to 1 every 5 years
- Connecting bar – implant or abutment supported, limited to 1 every 5 years
- Prefabricated abutment, limited to 1 every 5 years
- Custom fabricated abutment, limited to 1 every 5 years
- Abutment supported porcelain/ceramic crown, limited to 1 every 5 years
- Abutment supported porcelain fused to high noble metal, limited to 1 every 5 years
- Abutment supported porcelain fused to predominantly base metal crown, limited to 1 every 5 years
- Abutment supported porcelain fused to noble metal crown, limited to 1 every 5 years
- Abutment supported cast high noble metal crown, limited to 1 every 5 years
- Abutment supported cast predominantly base metal crown, limited to 1 every 5 years
- Abutment supported cast noble metal crown, limited to 1 every 5 years
- Implant supported porcelain/ceramic crown, limited to 1 every 5 years
- Implant supported porcelain fused to high noble metal (titanium), limited to 1 every 5 years
- Implant supported metal crown (titanium), limited to 1 every 5 years
- Abutment supported retainer for porcelain/ceramic fixed partial denture, limited to 1 every 5 years
- Abutment supported retainer for porcelain fused to high noble metal fixed partial denture, limited to 1 every 5 years
- Abutment supported retainer for porcelain fused to predominantly base metal fixed partial denture, limited to 1 every 5 years
- Abutment supported retainer for porcelain fused to noble metal fixed partial denture, limited to 1 every 5 years
- Abutment supported retainer for cast high noble metal fixed partial denture, limited to 1 every 5 years
- Abutment supported retainer for predominantly base metal fixed partial denture, 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.
- Abutment supported retainer for cast noble metal fixed partial denture, limited to 1 every 5 years
- Implant supported retainer for ceramic fixed partial denture, limited to 1 every 5 years
- Implant supported retainer for porcelain fused to high noble metal fixed partial denture, limited to 1 every 5 years
- Implant supported retainer for cast metal fixed partial denture, limited to 1 every 5 years
- Implant maintenance procedures, limited to 1 every 5 years
- Repair implant prosthesis, limited to 1 every 5 years
- Replacement of semi-precious or precision attachment, limited to 1 every 5 years
- Abutment supported crown titanium, limited to 1 every 5 years
- Repair implant abutment, limited to 1 every 5 years
- Remove broken implant retaining screw, limited to 1 every 5 years
- Implant removal, by report, limited to 1 every 5 years
- Debridement of a peri-implant defect or defects surrounding a simple implant, limited to 1 every 5 years
- Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant, limited to 1 every 5 years
- Bone graft for repair of peri-implant defect, limited to 1 every 5 years
- Bone graft at time of implant placement, limited to 1 every 5 years
- Implant/abutment supported removable denture – upper, limited to 1 every 5 years
- Implant/abutment supported removable denture – lower, limited to 1 every 5 years
- Implant/abutment supported removable denture for partially edentulous arch – upper, limited to 1 every 5 years
- Implant/abutment supported removable denture for partially edentulous arch – lower, limited to 1 every 5 years
- Implant/abutment supported fixed denture for completely edentulous arch – upper, limited to 1 every 5 years
- Implant/abutment supported fixed denture for completely edentulous – lower, limited to 1 every 5 years
- Implant/abutment supported fixed denture for partially edentulous arch – upper, limited to 1 every 5 years
- Implant/abutment supported fixed denture for partially edentulous – lower, limited to 1 every 5 years
- Implant/abutment supported interim fixed denture for edentulous arch – maxillary
- Implant index, limited to 1 every 5 years

**Pontics-Fixed partial denture:**
- Cast high noble metal, limited to 1 every 5 years
- Cast base metal, limited to 1 every 5 years
- Cast noble metal, limited to 1 every 5 years
- Titanium, limited to 1 every 5 years
- Porcelain fused to high noble metal, limited to 1 every 5 years
- Porcelain fused to base metal, limited to 1 every 5 years
- Porcelain fused to 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/ceramic, limited to 1 every 5 years
- Resin with high noble metal, limited to 1 every 5 years
- Resin with predominantly base metal, limited to 1 every 5 years
- Resin with noble metal, limited to 1 every 5 years

**Inlays/Onlays-Fixed partial denture:**
- Retainer cast metal for resin bonded fixed prosthesis, limited to 1 every 5 years
- Retainer porcelain/ceramic for resin bonded fixed prosthesis, limited to 1 tooth every 5 years
- Retainer inlay-porcelain/ceramic, limited to 1 every 5 years
- Retainer inlay-cast high noble metal, 2 surfaces, limited to 1 every 5 years
- Retainer inlay-cast predominantly base metal, 2 surfaces, limited to 1 every 5 years
- Retainer inlay-cast noble metal 2 surfaces, limited to 1 tooth every 5 years
- Retainer inlay-cast high noble metal, 3 or more surfaces, limited to 1 every 5 years
- Retainer inlay-cast predominantly base metal, 3 or more surfaces, limited to 1 every 5 years
- Retainer onlay-cast high noble metal, 3 or more surfaces, limited to 1 every 5 years
- Retainer onlay-cast predominantly base metal, 3 or more surfaces, limited to 1 every 5 years
- Retainer onlay-cast noble metal, 3 or more surfaces, 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. Specialized techniques and characterizations are not eligible.)

**Crowns-Fixed partial dentures:**
- Retainer crown – porcelain/ceramic, limited to 1 every 5 years
- Retainer crown – porcelain fused to high noble metal, limited to 1 every 5 years
- Retainer crown – porcelain fused to predominantly base metal, limited to 1 every 5 years
- Retainer crown – porcelain fused to noble metal, limited to 1 every 5 years
- Retainer crown – ¾ cast high noble metal, limited to 1 every 5 years
- Retainer crown – ¾ cast predominantly base metal, limited to 1 every 5 years
- Retainer crown – ¾ cast noble metal, limited to 1 every 5 years
- Retainer crown – full cast high noble metal, limited to 1 every 5 years
- Retainer crown – full cast predominantly base metal, limited to 1 every 5 years
- Retainer crown – full cast noble metal, limited to 1 every 5 years

- Stress breakers
- Pediatric partial denture, limited to 1 every 5 years
- Removable appliance therapy
- Fixed or cemented appliance therapy
- Cleaning and inspection of removable complete denture, upper
- Cleaning and inspection of removable complete partial denture, lower
- Cleaning and inspection of removable complete partial denture, upper
- Cleaning and inspection of removable complete denture, lower

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
- Occlusal guard – hard appliance, full arch
- Occlusal guard – soft appliance, full arch
- Occlusal guard – hard appliance, partial arch
- Occlusal guard adjustment, not eligible within first 6 months after placement of appliance

**Orthodontic services**

*Medically necessary orthodontic services include the removal of appliances and construction of retainer.*

**Dental service or supply**

- Limited orthodontic treatment of the primary dentition
- Limited orthodontic treatment of the transitional dentition
- Limited orthodontic treatment of the adolescent dentition
- Interceptive orthodontic treatment of the primary dentition
- Interceptive orthodontic treatment of the transitional dentition
- Comprehensive orthodontic treatment of the transitional dentition
- Comprehensive orthodontic treatment of the adolescent dentition
- Comprehensive treatment of adult dentition
- Pre-orthodontic treatment examination to monitor growth and development
- Periodic orthodontic treatment visit (as part of contract)
- Orthodontic retention (removal of appliances, construction, and placement of retainers)
- Repair of orthodontic appliance
- Rebonding of re cementing and/or repair, as required of fixed retainers
- Repair of fixed retainers

*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>6. Specific conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Birthing center (facility charges)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient (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><strong>Diabetic services and supplies (including equipment and training)</strong></td>
<td></td>
<td></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. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
<tr>
<td><strong>Family planning services – other</strong></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>100% (of the negotiated charge)</td>
<td>70% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Outpatient physician or specialist surgical services</td>
<td>100% (of the negotiated charge)</td>
<td>70% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td><strong>Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TMJ and CMJ treatment</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
<tr>
<td><strong>Impacted wisdom teeth</strong></td>
<td></td>
<td></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>

*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>Accidental injury to sound natural teeth</strong></th>
<th>80% (of the negotiated charge)</th>
<th>80% (of the recognized charge)</th>
</tr>
</thead>
</table>

**Dermatological treatment**

| Dermatological treatment | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |

**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. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |

**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>50% (of the recognized charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

**Pregnancy complications**

| Inpatient (room and board and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |

*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.

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### 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. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |

### Autism spectrum disorder

| Autism spectrum disorder diagnosis and testing | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |
| Autism spectrum disorder treatment (includes physician and specialist office visits) | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |
| Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |
| Applied behavior analysis | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |

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<table>
<thead>
<tr>
<th>Mental health treatment</th>
<th>Mental health treatment – inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital mental disorders treatment (room and board and other miscellaneous hospital services and supplies)</td>
<td>$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission</td>
</tr>
<tr>
<td>Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies)</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
<td></td>
</tr>
<tr>
<td>Mental disorder room and board intensive care</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental health treatment – outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient mental disorder treatment office visits to a physician or behavioral health provider (includes telemedicine consultations)</td>
</tr>
<tr>
<td>Other outpatient mental disorders treatment (includes skilled behavioral health services in the home)</td>
</tr>
<tr>
<td>Partial hospitalization treatment</td>
</tr>
<tr>
<td>Intensive outpatient program</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.*
### Substance abuse related disorders treatment-inpatient

<table>
<thead>
<tr>
<th>Detoxification – inpatient</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital substance abuse detoxification (room and board and other miscellaneous hospital services and supplies)</td>
<td>$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Inpatient hospital substance abuse rehabilitation (room and board and other miscellaneous hospital services and supplies)</td>
<td>$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Inpatient residential treatment facility substance abuse (room and board and other miscellaneous residential treatment facility services and supplies)</td>
<td>$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
<td>$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Substance abuse room and board intensive care</td>
<td>$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
</tbody>
</table>

### Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation

| Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine consultations) | $20 copayment per visit then the plan pays 80% (of the balance of the negotiated charge) per visit | 50% (of the recognized charge) per visit |
| Other outpatient substance abuse services | 80% (of the negotiated charge) per visit | 50% (of the recognized charge) per visit |
| Partial hospitalization treatment | 80% (of the negotiated charge) per visit | 50% (of the recognized charge) per visit |
| Intensive Outpatient Program | 80% (of the negotiated charge) per visit | 50% (of the recognized charge) per visit |

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### Reconstructive surgery and supplies

| Reconstructive surgery and supplies (includes reconstructive breast surgery) | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |

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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>Non-IOE facility and out-of-network facility</td>
</tr>
</tbody>
</table>

### Transplant services

| Inpatient and outpatient transplant facility services | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |

| Inpatient and outpatient transplant physician and specialist services | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |

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<table>
<thead>
<tr>
<th>Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Benefit for donor searches for bone marrow/stem cell transplants for a covered Transplant procedure</td>
<td>$30,000 per transplant</td>
</tr>
<tr>
<td>Maximum Benefit for Dose intensive chemotherapy/autologous bone marrow transplants for stem cell transplants for breast cancer treatment incurred while covered under any Aetna or Aetna-affiliated plan:</td>
<td>$100,000 per transplant</td>
</tr>
<tr>
<td>Human Leukocyte Antigen Testing for A, B and DR Antigens:</td>
<td>Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of infertility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic infertility services</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. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
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### Eligible health services

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Specific therapies and tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient diagnostic testing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic complex imaging services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td>Diagnostic lab work and radiological services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic lab work and radiological services performed in the outpatient department of a hospital or other facility</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td><strong>Outpatient infusion therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility</td>
<td>Covered according to the type of benefit or the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit or the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
<tr>
<td><strong>Outpatient radiation therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient radiation therapy</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td><strong>Specialty prescription drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting</td>
<td>Covered according to the type of benefit or the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit or the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient respiratory therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory therapy</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td><strong>Transfusion or kidney dialysis of blood</strong></td>
<td></td>
<td></td>
</tr>
<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. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
<tr>
<td><strong>Short-term cardiac and pulmonary rehabilitation services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Pulmonary rehabilitation</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td><strong>Short-term rehabilitation and habilitation therapy services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient physical, occupational, speech, and cognitive therapies</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (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>
<tr>
<td>The copayment or coinsurance for any physical therapy and occupational therapy services will be no greater than a physician’s office visit copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic treatment*</td>
<td>80% per visit</td>
<td>50% per visit</td>
</tr>
</tbody>
</table>

*Important note:*
- Up to 26 visits per policy year for Chiropractic care are covered without precertification. Any treatment beyond 26 visits per policy year may require precertification.
- The cost-share for a single chiropractic service will not be more than 50% of the negotiated or recognized charge (as applicable) for that service.

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Speech and hearing disorders</strong></td>
<td><strong>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</strong></td>
</tr>
<tr>
<td><strong>Diagnostic testing for learning disabilities</strong></td>
<td><strong>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</strong></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>8. Other services and supplies</td>
<td>Acupuncture in lieu of anesthesia</td>
<td>Acupuncture in lieu of anesthesia</td>
</tr>
<tr>
<td></td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
<tr>
<td>Ambulance service</td>
<td>Emergency ground, air or water ambulance</td>
<td>80% (of the negotiated charge) per trip</td>
</tr>
<tr>
<td>Clinical trial therapies (experimental or investigational)</td>
<td>Clinical trial therapies</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
<tr>
<td>Clinical trials (routine patient costs)</td>
<td>Clinical trial (routine patient costs)</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
<tr>
<td>Cancer clinical trials (routine patient costs)</td>
<td>Cancer clinical trial (routine patient costs)</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</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>Durable medical equipment (DME)</th>
<th>80% (of the negotiated charge) per item</th>
<th>50% (of the recognized charge) per item</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% (of the negotiated charge) per item</td>
<td>50% (of the recognized charge) per item</td>
</tr>
<tr>
<td></td>
<td>Enteral formulas and nutritional supplements</td>
<td>80% (of the negotiated charge) per item</td>
</tr>
<tr>
<td></td>
<td>Enteral formulas and nutritional supplements</td>
<td>80% (of the negotiated charge) per item</td>
</tr>
<tr>
<td></td>
<td>Osteoporosis (non-preventive care)</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
<tr>
<td></td>
<td>Physician’s or specialist’s office visits</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
</tr>
<tr>
<td></td>
<td>Prosthetic devices</td>
<td>Cochlear implants</td>
</tr>
<tr>
<td></td>
<td>Cochlear implants</td>
<td>80% (of the negotiated charge) per item</td>
</tr>
<tr>
<td></td>
<td>Cranial prosthetics (Medical wigs)</td>
<td>80% (of the negotiated charge) per item</td>
</tr>
<tr>
<td></td>
<td>Cranial prosthetics (Medical wigs)</td>
<td>80% (of the negotiated charge) per item</td>
</tr>
<tr>
<td></td>
<td>All other Prosthetic devices</td>
<td>80% (of the negotiated charge) per item</td>
</tr>
<tr>
<td></td>
<td>Hearing aids and exams</td>
<td>Hearing aid exams</td>
</tr>
<tr>
<td></td>
<td>Hearing aid exams</td>
<td>80% (of the negotiated charge) per visit</td>
</tr>
<tr>
<td></td>
<td>Hearing aid exam maximum</td>
<td>One hearing exam every policy year</td>
</tr>
<tr>
<td></td>
<td>Hearing aids</td>
<td>80% (of the negotiated charge) per item</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.*
**Podiatric (foot care) treatment**

| Physician and Specialist non-routine foot care treatment | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. | Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred. |

**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>Pediatric routine vision exams (including refraction)</th>
<th>100% (of the negotiated charge) per visit</th>
<th>70% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed by a legally qualified ophthalmologist or optometrist</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
</tbody>
</table>

**Pediatric comprehensive low vision evaluations**

<table>
<thead>
<tr>
<th>Performed by a legally qualified ophthalmologist or optometrist</th>
<th>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</th>
<th>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum</td>
<td>One comprehensive low vision evaluation every policy year</td>
<td></td>
</tr>
</tbody>
</table>

**Pediatric vision care services and supplies**

<table>
<thead>
<tr>
<th>Office visit for fitting of contact lenses</th>
<th>100% (of the negotiated charge) per visit</th>
<th>70% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</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 vision care services and supplies</th>
<th>100% (of the negotiated charge) per item</th>
<th>70% (of the recognized charge) per item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyeglass frames, prescription lenses or prescription contact lenses</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>Extended wear disposable: up to 6-month supply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-disposable lenses: one set</td>
</tr>
<tr>
<td>Optical devices</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</td>
<td>Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.</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 waiver**

The policy year deductible is waived for all prescription drugs filled at an in-network and out-of-network retail pharmacy or mail order pharmacy.

**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 or mail order in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.

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

The policy year deductible and the prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail or mail order in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.

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

**Policy year deductible and copayment waiver for contraceptives**

The policy year deductible and the prescription drug copayment will not apply to 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 (including specialty drugs)</th>
<th>For each fill up to a 30-day supply filled at a retail pharmacy</th>
<th>$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</th>
<th>$15 copayment per supply then the plan pays 100% (of the balance of the recognized charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy</td>
<td>$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$30 copayment per supply then the plan pays 100% (of the balance of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Non-preferred generic prescription drugs (including specialty drugs)</td>
<td>For each fill up to a 30-day supply filled at a retail pharmacy</td>
<td>$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$50 copayment per supply then the plan pays 100% (of the balance of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy</td>
<td>$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$100 copayment per supply then the plan pays 100% (of the balance of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</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.*
## Preferred brand-name prescription drugs (including specialty drugs)

| For each fill up to a 30-day supply filled at a retail pharmacy | $35 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) | $35 copayment per supply then the plan pays 100% (of the balance of the recognized charge) | No policy year deductible applies | No policy year deductible applies |
| More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy | $70 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) | $70 copayment per supply then the plan pays 100% (of the balance of the recognized charge) | No policy year deductible applies | No policy year deductible applies |

## Non-preferred brand-name prescription drugs (including specialty drugs)

| For each fill up to a 30-day supply filled at a retail pharmacy | $50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) | $50 copayment per supply then the plan pays 100% (of the balance of the recognized charge) | No policy year deductible applies | No policy year deductible applies |
| More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy | $100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) | $100 copayment per supply then the plan pays 100% (of the balance of the recognized charge) | No policy year deductible applies | No policy year deductible applies |

## Orally administered anti-cancer prescription drugs

| For each fill up to a 30-day supply filled at a retail pharmacy | 100% (of the negotiated charge) per prescription or refill | 100% (of the recognized charge) per prescription or refill | No policy year deductible applies | No policy year deductible applies |

*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>Preventive care drugs and supplements</th>
<th>Preventive care drugs and supplements filled at a retail 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></td>
<td>For each 30-day supply</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximums</td>
<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>
<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. 1-877-375-7905</td>
<td></td>
</tr>
<tr>
<td>Risk reducing breast cancer prescription drugs</td>
<td>Risk reducing breast cancer prescription drugs filled at a retail pharmacy</td>
<td>100% (of the negotiated charge) per prescription or refill</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
</tr>
<tr>
<td></td>
<td>For each 30-day supply</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximums</td>
<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>
<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. 1-877-375-7905</td>
<td></td>
</tr>
<tr>
<td>Tobacco cessation prescription and over-the-counter drugs</td>
<td>Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy</td>
<td>100% (of the negotiated charge) per prescription or refill</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
</tr>
<tr>
<td></td>
<td>For each 30-day supply</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximums</td>
<td>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.</td>
<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>
<td>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. 1-877-375-7905</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.*
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.

<table>
<thead>
<tr>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is the amount you owe for in-network and out-of-network <strong>eligible health services</strong> each <strong>policy year</strong> before the plan begins to pay for <strong>eligible health services</strong>. See the <strong>Policy year deductibles</strong> provision at the beginning of this schedule for any exceptions to this general rule. This <strong>policy year deductible</strong> applies separately to you and each of your covered dependents. After the amount you pay for <strong>eligible health services</strong> reaches the <strong>policy year deductible</strong>, this plan will begin to pay for <strong>eligible health services</strong> for the rest of the <strong>policy year</strong>.</td>
</tr>
</tbody>
</table>

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

| 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. |

<table>
<thead>
<tr>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coinsurance</strong> is both the percentage of <strong>eligible health services</strong> that the plan pays and what you pay. The specific percentage that we have to pay for <strong>eligible health services</strong> is listed earlier in the schedule of benefits.</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.*
### Maximum out-of-pocket limits provisions

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

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

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.

#### 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

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.

Important notices:
1. You will be responsible for only one **copayment** or **coinsurance** for a covered **prescription drug** if the required single dosage is unavailable and/or a combination of dosage amounts is needed to fill the **prescription**. Such **copayment** or **coinsurance** requirement shall not apply to prescriptions in excess of a one (1) month supply.
2. If you are presently taking a **prescription drug**, Aetna will notify you electronically, or in writing upon your request, at least 31 days prior to any deletions (other than generic substitutions) in Aetna's **prescription drug formulary** that affect you.

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

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

Policyholder: University of Missouri System - Columbia Domestic Students

Student policy number: 890430

Effective date: 08/15/2019

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.

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 active attendance paragraphs in the *Who the plan covers – Who is eligible* section are replaced with the following:

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective. You cannot meet this eligibility requirement if you take courses through:

- Home study
- Correspondence
- Television (TV)

3. 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

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.

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. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified *illness* or *injury*.
- Preventive care breast cancer (BRCA) gene blood testing by a *physician* and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.
6. 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 visits per day
- 2 post-delivery visits, at least one of which shall be a home visit by an R.N. or **physician**. The location and schedule of the post-delivery visits is determined by the attending **physician**. Post-delivery care visits by an R.N. or **physician** include, but are not limited to:
  - Assessing the health of the newborn and mother
  - Parent education
  - Training in breast or bottle feeding
  - Providing childhood immunization education and services
  - Performing any necessary and appropriate clinical tests and
  - The submission of a metabolic specimen satisfactory to the state laboratory

Post-delivery visits and determination of a shorter hospital stay will be conducted in accordance with the most current version of the “Guidelines for Perinatal Care” prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality, in the condition of the mother or the child, observed by the nurse shall be reported to the attending physician as medically appropriate.

Post-delivery home visits will not be subject to any home health care maximums.

Coverage also includes the services and supplies needed for circumcision by a **provider**.

7. 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 (includes **telemedicine** consultations)
  - Individual, group and family therapies for the treatment of mental health
  - Other outpatient mental health treatment such as:
    - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease 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.

8. The outpatient Substance abuse related disorders treatment benefit in the Eligible health services under your plan – Specific conditions section is replaced by the following:

**Substance abuse related disorders treatment**

- Outpatient treatment received while not confined as an inpatient in a general medical hospital, psychiatric hospital, alcoholism treatment facility 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 (includes telemedicine consultations)
  - Individual, group and family therapies for the treatment of substance abuse
  - Other outpatient substance abuse treatment such as:
    - Outpatient detoxification
    - Partial hospitalization treatment provided in a facility or program for treatment of substance abuse provided under the direction of a physician
    - Intensive outpatient program provided in a facility or program for treatment of substance abuse provided under the direction of a physician
    - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other substance abuse, including administration of medications
    - Treatment of withdrawal symptoms
    - 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.

An alcoholism treatment facility is a residential or nonresidential facility certified by the Department of Mental Health for the treatment of alcoholism.
Transplant services

Eligible health services include transplant services provided by a physician and hospital. Human leukocyte antigen testing (histocompatibility locus antigen testing) for A, B, and DR antigens testing are covered when requested for a bone marrow transplant. The testing must be performed in a facility which is accredited by one of the following:

- The American Association of Blood Banks or its successors,
- The College of American Pathologists,
- The American Society for Histocompatibility and Immunogenetics (ASHI)
- Any other national accrediting body with requirements that are considerably equal to or stricter than those of the College of American Pathologists and licensed under the Clinical Laboratory Improvement Act.

At the time of testing, the person being tested must complete and sign an informed consent form which also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

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.

Blood and body fluid exposure

- Services and supplies provided for the treatment of an illness that results from your clinical related injury as these are covered elsewhere in the student policy
11. The Cornea or cartilage transplants exclusion is added to the *What your plan doesn’t cover – eligible health service exceptions and exclusions* section.

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

12. 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/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care 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

13. 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
- Travel and lodging expenses
- Treatment of breast cancer by dose intensive chemotherapy, autologous bone marrow transplants or stem cell transplants.

14. The *Immunizations related to travel or work* exclusion in the *What your plan doesn’t cover – eligible health service exceptions and exclusions – Exceptions and exclusions that apply to outpatient prescription drugs* section is replaced by the following:

**Immunizations related to work**
15. 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*.

16. 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. 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.

17. 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.
18. Definitions for the terms “Negotiated charge” and “School health services” in the Glossary section are replaced by the following:

**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.

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)

MO Cert Amendment  
Amendment 1  
Issue Date 06/20/2019
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, CRCordinator@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)

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 امده 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)