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
           International Students
Policyholder number: 890430
Student policy effective date: 08/01/2020
Plan effective date: 08/01/2020
Plan issue date: 06/16/2020
Actuarial value and metallic level: 81.85% - 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 separate maximums for **in-network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule of benefits you will find detailed explanations about your:
  - **Policy year deductibles**
  - **Copayments**
  - **Maximums**
  - **Coinsurance**
  - **Maximum out-of-pocket limits**

**Important note:**

All **covered benefits** are subject to the **policy year deductible**, **copayment** and **coinsurance** unless otherwise noted in the schedule of benefits below.

**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>$400</td>
<td>$120</td>
<td>$20</td>
<td>$80</td>
<td>$20</td>
</tr>
</tbody>
</table>

Plan features

<table>
<thead>
<tr>
<th>Plan features</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
</table>
| Policy year deductibles
| You have to meet your policy year deductible before this plan pays for benefits. |
| Student       | $400 per policy year | $800 per policy year    |
| Spouse        | $400 per policy year | $800 per policy year    |
| Each Child    | $400 per policy year | $800 per policy year    |

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>$7,500 per policy year</td>
<td>None</td>
</tr>
<tr>
<td>Spouse</td>
<td>$7,500 per policy year</td>
<td>None</td>
</tr>
<tr>
<td>Each child</td>
<td>$7,500 per policy year</td>
<td>None</td>
</tr>
<tr>
<td>Family</td>
<td>$15,000 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><strong>1. Preventive care and wellness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine physical exams</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:</td>
<td>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.</td>
<td></td>
</tr>
<tr>
<td>Maximum age and visit limits per policy year</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>
<tr>
<td>Covered persons age 22 &amp; over:</td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td></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 apply 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.
<table>
<thead>
<tr>
<th>Child health supervision services</th>
<th>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.</th>
<th>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.</th>
</tr>
</thead>
</table>
| 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. |

*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 screening and counseling services</th>
<th>Well woman preventive visits</th>
<th>Routine gynecological exams (including Pap smears)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity and/or healthy diet counseling office visits</td>
<td>Performed at a physician’s, obstetrician (OB), gynecologist (GYN) or OB/GYN office</td>
<td>100% (of the negotiated charge) per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration Women’s Preventive Services Administration.</td>
<td>1 visit</td>
</tr>
<tr>
<td>Preventive screening and counseling services</td>
<td>Preventive screening and counseling services</td>
<td></td>
</tr>
<tr>
<td>Misuse of alcohol and/or drugs counseling office visits</td>
<td></td>
<td>100% (of the negotiated charge) per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td></td>
<td>5 visits*</td>
</tr>
<tr>
<td>Preventive screening and counseling services</td>
<td></td>
<td>*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.</td>
</tr>
<tr>
<td>Use of tobacco products counseling office visits</td>
<td></td>
<td>100% (of the negotiated charge) per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td></td>
<td>8 visits*</td>
</tr>
<tr>
<td>Preventive screening and counseling services</td>
<td></td>
<td>*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.</td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
<table>
<thead>
<tr>
<th>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></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Depression screening counseling office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>1 visit*</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>
<td></td>
</tr>
<tr>
<td>Sexually transmitted infection counseling office visits</td>
<td></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 60 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></td>
<td></td>
</tr>
<tr>
<td>Age and frequency limitations</td>
<td>Not subject to any age or frequency 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>
</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.*
**Routine cancer screenings**  
Performed at a physician’s office, specialist’s office or facility.

<table>
<thead>
<tr>
<th>Routine cancer screenings</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 copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

**Maximimums**  
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](http://www.aetnastudenthealth.com) or calling the toll-free number on your ID card. in the How to contact us for help section.

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

**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](http://www.aetna.com) or calling the toll-free number on your ID card in the How to contact us for help section.

*Important note:  
Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the Outpatient diagnostic testing 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.*
### Prenatal care
Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)

<table>
<thead>
<tr>
<th>Preventive care services only</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 copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

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

### Comprehensive lactation support and counseling services

<table>
<thead>
<tr>
<th>Lactation counseling services - facility or office visits</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 copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

Lactation counseling services maximum visits per policy year either in a group or individual setting

| 6 visits* | |

*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>Breast pump supplies and accessories</th>
<th>100% (of the negotiated charge) per item</th>
<th>70% (of the recognized charge) per item</th>
</tr>
</thead>
<tbody>
<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.

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.*
### Family planning services—contraceptives

<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 counseling services office visit</td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</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>
<tr>
<td>Important note:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any visits that exceed the contraceptive counseling services maximum are covered under Physician services office visits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptives (prescription drugs and devices)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit</td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td>Voluntary sterilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient provider services</td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td>Outpatient provider services</td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or 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>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Physicians and other health professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician and specialist services (non-surgical and non-preventive)</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)</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) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>80% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>80% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</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>Description</th>
<th>Percentage Covered</th>
<th>Percentage Covered</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% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

### In-hospital non-surgical physician services

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage Covered</th>
<th>Percentage Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-hospital non-surgical physician services</td>
<td>80% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage Covered</th>
<th>Percentage Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office hours visits (non-surgical and non-preventive care) includes telemedicine consultations</td>
<td>$20 copayment per visit then the plan pays 80% (of the balance of the negotiated charge)</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Second opinion - cancer</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>
</tbody>
</table>

### Second surgical opinion

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage Covered</th>
<th>Percentage Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second surgical opinion</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

### Alternatives to physician office visits

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage Covered</th>
<th>Percentage Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk-in clinic visits (non-emergency visit)</td>
<td>$20 copayment per visit then the plan pays 80% (of the balance of the negotiated charge)</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

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

*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>

### 3. Hospital and other facility care

#### Hospital care (facility charges)

<table>
<thead>
<tr>
<th>Inpatient hospital (room and board) and other miscellaneous services and supplies</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>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>
</tbody>
</table>

#### Preadmission testing

<table>
<thead>
<tr>
<th>Preadmission testing</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>
</table>

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

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

<table>
<thead>
<tr>
<th>Anesthesia and related facility charges for a dental procedure</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>
</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.
### 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. | 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 | 80% (of the negotiated charge) | 50% (of the recognized charge) |

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

### 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>Inpatient facility (room and board) and miscellaneous inpatient care services and supplies</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></td>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Room and board include intensive care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible health services</td>
<td>In-network coverage*</td>
<td>Out-of-network coverage*</td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------</td>
<td>-------------------------</td>
<td></td>
</tr>
<tr>
<td>4. Emergency services and urgent care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital emergency room</td>
<td>$100 copayment per visit then the plan pays 80% (of the balance of the negotiated charge)</td>
<td>Paid the same as in-network coverage</td>
<td></td>
</tr>
<tr>
<td>Non-emergency care in a hospital emergency room</td>
<td>Not covered</td>
<td>Not covered</td>
<td></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>Urgent medical care provided by an urgent care provider</th>
<th>80% (of the negotiated charge) per visit</th>
<th>50% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<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.
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Pediatric dental care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to covered persons through the end of the month in which the person turns age 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type A services</td>
<td>100% (of the negotiated charge) per visit</td>
<td>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or deductible applies</td>
<td></td>
</tr>
<tr>
<td>Type B services</td>
<td>70% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Type C services</td>
<td>50% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Orthodontic services</td>
<td>50% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Dental emergency treatment</td>
<td>Covered according to the type of benefit and the place where the service is received. 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.

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

### Diagnostic and Preventive Care (Type A Services)

#### Dental Service or Supply

<table>
<thead>
<tr>
<th>Visits and Images</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Office visit during regular office hours for oral exam, limited to 2 visits every 12 months</td>
</tr>
<tr>
<td>• Problem-focused examination, limited to 2 visits every 12 months</td>
</tr>
<tr>
<td>• Oral evaluation-child under age 3, limited to 2 visits every 12 months</td>
</tr>
<tr>
<td>• Comprehensive oral evaluation, limited to 2 visits every 12 months</td>
</tr>
<tr>
<td>• Detailed and extensive oral evaluation-problem focused</td>
</tr>
<tr>
<td>• Comprehensive periodontal evaluation, limited to 2 visits every 12 months</td>
</tr>
<tr>
<td>• Complete image series, including bitewings, limited to 1 set every 3 years</td>
</tr>
<tr>
<td>• Periapical 1st images</td>
</tr>
<tr>
<td>• Intra-oral, occlusal radiographic image</td>
</tr>
<tr>
<td>• Bitewing image-one image, limited to 2 sets per 12 months*</td>
</tr>
<tr>
<td>• Bitewing image-two images, limited to 2 sets per 12 months*</td>
</tr>
<tr>
<td>• Bitewing image-three images, limited to 2 sets per 12 months*</td>
</tr>
<tr>
<td>• Bitewing image-four images, limited to 2 sets per 12 months*</td>
</tr>
<tr>
<td>• Vertical bitewing images, limited to 2 sets per year</td>
</tr>
<tr>
<td>• Panoramic images, limited to 1 set every 3 years</td>
</tr>
<tr>
<td>• Cephalometric image</td>
</tr>
<tr>
<td>• 2D oral/facial photographic images</td>
</tr>
<tr>
<td>• Interpretation of diagnostic image</td>
</tr>
<tr>
<td>• Diagnostic models</td>
</tr>
<tr>
<td>• Prophylaxis (cleaning)-Adult, limited to 2 treatments per year</td>
</tr>
<tr>
<td>• Prophylaxis (cleaning)-Child, limited to 2 treatments per year</td>
</tr>
<tr>
<td>• Topical fluoride varnish, limited to 2 courses every 12 months</td>
</tr>
<tr>
<td>• Topical application of fluoride, limited to 2 courses every 12 months</td>
</tr>
<tr>
<td>• Sealants, per tooth, limited to one application every 3 years for permanent molars</td>
</tr>
<tr>
<td>• Preventive resin restoration in a moderate to high caries risk patient, permanent tooth, limited to one application every 3 years for permanent molars</td>
</tr>
<tr>
<td>• Sealant repair, per tooth, limited to one application every 3 years for permanent molars</td>
</tr>
<tr>
<td>• Resin infiltration of lesion, limited to 1 per tooth every 3 years</td>
</tr>
<tr>
<td>• Emergency palliative treatment per visit</td>
</tr>
</tbody>
</table>

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

### Space Maintainers

<table>
<thead>
<tr>
<th>Space maintainers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Space maintainers - Fixed (unilateral)</td>
</tr>
<tr>
<td>• Space maintainers - Fixed (bilateral, maxillary)</td>
</tr>
<tr>
<td>• Space maintainers - Fixed (bilateral, mandibular)</td>
</tr>
<tr>
<td>• Space maintainers - Removable (unilateral)</td>
</tr>
<tr>
<td>• Space maintainers - Removable (bilateral, maxillary)</td>
</tr>
<tr>
<td>• Space maintainers - Removable (bilateral, mandibular)</td>
</tr>
<tr>
<td>• Re-cementation of space maintainer</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.*
- 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
- Bone replacement graft for ridge preservation - per site
- Frenectomy
- Excision of hyperplastic tissue
- Excision of pericorneal gingiva

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

**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

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

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

**Endodontics**

Root canal therapy including medically necessary images:
- Anterior tooth
- Premolar tooth
- Molar tooth

*See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefits.*
Retreatment of previous root canal therapy including medically necessary images:

- Anterior tooth
- Premolar tooth
- Molar tooth
- 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

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

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

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
- 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
- Removable unilateral partial denture one piece cast metal (including clasps and teeth), mandibular, 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 cast high noble metal fixed partial denture, limited to 1 every 5 years
- Abutment supported retainer for cast 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
- 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

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

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
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 every 5 years
- Retainer inlay-porcelain/ceramic, limited to 1 every 5 years
- Retainer onlay-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 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 inlay-cast noble 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

(Prices 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 – ¾ porcelain/ceramic, 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
- 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

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
Orthodontic services
(Medically necessary orthodontic services include the removal of appliances and construction of retainer.)

<table>
<thead>
<tr>
<th>Dental service or supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Limited orthodontic treatment of the primary dentition</td>
</tr>
<tr>
<td>• Limited orthodontic treatment of the transitional dentition</td>
</tr>
<tr>
<td>• Limited orthodontic treatment of the adolescent dentition</td>
</tr>
<tr>
<td>• Interceptive orthodontic treatment of the primary dentition</td>
</tr>
<tr>
<td>• Interceptive orthodontic treatment of the transitional dentition</td>
</tr>
<tr>
<td>• Comprehensive orthodontic treatment of the transitional dentition</td>
</tr>
<tr>
<td>• Comprehensive orthodontic treatment of the adolescent dentition</td>
</tr>
<tr>
<td>• Comprehensive treatment of adult dentition</td>
</tr>
<tr>
<td>• Pre-orthodontic treatment examination to monitor growth and development</td>
</tr>
<tr>
<td>• Periodic orthodontic treatment visit (as part of contract)</td>
</tr>
<tr>
<td>• Orthodontic retention (removal of appliances, construction, and placement of retainers)</td>
</tr>
<tr>
<td>• Repair of orthodontic appliance</td>
</tr>
<tr>
<td>• Rebonding of recementing and/or repair, as required of fixed retainers</td>
</tr>
<tr>
<td>• Repair of fixed retainers</td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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>Outpatient physician or specialist surgical services</td>
<td>100% (of the negotiated charge)</td>
<td>70% (of the recognized charge)</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>
<tr>
<td><strong>Accidental injury to sound natural teeth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental injury to sound natural 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>Dermatological treatment</strong></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>
</table>

**Maternity care**

<table>
<thead>
<tr>
<th>Maternity care (includes delivery and postpartum care services in a hospital or birthing center)</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>
</table>

**Well newborn nursery care**

<table>
<thead>
<tr>
<th>Well newborn nursery care in a hospital or birthing center</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>
</table>

*Note: If applicable, the per admission copayment and/or policy year deductible amounts for newborns will be waived for nursery charges for the duration of the newborn’s initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.*

<table>
<thead>
<tr>
<th><strong>Pregnancy complications</strong></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>
</table>

<table>
<thead>
<tr>
<th><strong>Gender reassignment (sex change) treatment</strong></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>
</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.*
# Autism spectrum disorder

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

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

<table>
<thead>
<tr>
<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>
</tr>
<tr>
<td>Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies)</td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
</tr>
<tr>
<td>Mental disorder room and board intensive care</td>
</tr>
<tr>
<td>$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission</td>
</tr>
<tr>
<td>50% (of the recognized charge) per admission</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>
<tr>
<td>$20 copayment per visit then the plan pays 80% (of the balance of the negotiated charge) per visit</td>
</tr>
<tr>
<td>80% (of the negotiated charge) per visit</td>
</tr>
<tr>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>50% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
**Substance abuse related disorders treatment-inpatient**

<table>
<thead>
<tr>
<th>Inpatient hospital substance abuse detoxification (room and board and other miscellaneous hospital services and supplies)</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 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>50% (of the recognized charge) per admission</td>
<td></td>
</tr>
<tr>
<td>Substance abuse room and board intensive care</td>
<td>50% (of the recognized charge) per admission</td>
<td></td>
</tr>
</tbody>
</table>

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

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

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.*
| Reconstructive surgery and supplies (include 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. |

*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>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**

<table>
<thead>
<tr>
<th>Inpatient and outpatient transplant facility services</th>
<th>Covered according to the type of benefit and the place where the service is received. 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>
<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>Inpatient and outpatient transplant physician and specialist services</td>
<td>Covered according to the type of benefit and the place where the service is received. 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>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>Description</th>
<th>Benefit Amount</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>
<tr>
<td>Eligible health services</td>
<td>In-network coverage*</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Treatment of infertility</td>
<td></td>
</tr>
<tr>
<td>Basic infertility services</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>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7. Specific therapies and tests</strong></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>Chemotherapy</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>
</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 (GCIT-designated facility/provider) *</th>
<th>Out-of-network coverage (GCIT non-designated facility/provider) *</th>
<th>Out-of-network coverage *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gene-based, cellular and other innovative therapies (GCIT)</td>
<td>Services and supplies</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>

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

<table>
<thead>
<tr>
<th>Short-term rehabilitation and habilitation therapy services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient physical, occupational, speech, and cognitive therapies</strong></td>
</tr>
<tr>
<td>Combined for short-term rehabilitation services and habilitation therapy services</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>
</tr>
<tr>
<td><strong>Maximum visits per policy year</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chiropractic care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic treatment</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.*
<table>
<thead>
<tr>
<th>Speech and hearing disorders</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>Diagnostic testing for learning disabilities</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>

*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>8. Other services and supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acupuncture in lieu of anesthesia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture in lieu of anesthesia</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>Ambulance service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency ground, air or water ambulance</td>
<td>80% (of the negotiated charge) per trip</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td><strong>Clinical trial therapies (experimental or investigational)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<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>
<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>Clinical trials (routine patient costs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<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>
<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>Cancer clinical trials (routine patient costs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<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>
<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><strong>Durable medical equipment (DME)</strong></th>
<th><strong>Enteral formulas and nutritional supplements</strong></th>
<th><strong>Osteoporosis (non-preventive care)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable medical equipment</td>
<td>Enteral formulas and nutritional supplements</td>
<td>Physician’s or specialist’s office visits</td>
</tr>
<tr>
<td>80% (of the negotiated charge) per item</td>
<td>80% (of the negotiated charge) per item</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>50% (of the recognized charge) per item</td>
<td>50% (of the recognized charge) per item</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>

<table>
<thead>
<tr>
<th><strong>Prosthetic devices</strong></th>
<th><strong>Hearing aids and exams</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cochlear implants</td>
<td>Hearing aid exams</td>
</tr>
<tr>
<td>80% (of the negotiated charge) per item</td>
<td>80% (of the negotiated charge) per visit</td>
</tr>
<tr>
<td>50% (of the recognized charge) per item</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Cranial prosthetics</td>
<td>Hearing aid exam maximum</td>
</tr>
<tr>
<td><em>(Medical wigs)</em></td>
<td>One hearing exam every policy year</td>
</tr>
<tr>
<td>80% (of the negotiated charge) per item</td>
<td>80% (of the negotiated charge) per item</td>
</tr>
<tr>
<td>50% (of the recognized charge) per item</td>
<td>50% (of the recognized charge) per item</td>
</tr>
<tr>
<td>All other Prosthetic devices</td>
<td>Hearing aids maximum per ear</td>
</tr>
<tr>
<td>80% (of the negotiated charge) per item</td>
<td>One hearing aid per ear every policy year</td>
</tr>
<tr>
<td>50% (of the recognized charge) per item</td>
<td>50% (of the recognized 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

| Pediatric routine vision exams (including refraction) | 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. |

| Performed by a legally qualified ophthalmologist or optometrist | 100% (of the negotiated charge) per visit | 70% (of the recognized charge) per visit |
| | No policy year deductible applies | No policy year deductible applies |
| Maximum visits per policy year | 1 visit |

**Pediatric comprehensive low vision evaluations**

| Performed by a legally qualified ophthalmologist or optometrist | 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. |
| | Maximum | One comprehensive low vision evaluation every policy year |

**Pediatric vision care services and supplies**

| Office visit for fitting of contact lenses | 100% (of the negotiated charge) per visit | 70% (of the recognized charge) per visit |
| | No policy year deductible applies | No policy year deductible applies |
| Maximum visits per policy year | 1 visit |
### Pediatric vision care services and supplies

<table>
<thead>
<tr>
<th></th>
<th>100% (of the negotiated charge) per item</th>
<th>70% (of the recognized charge) per item</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximum number of eyeglass frames per policy year</th>
<th>One set of eyeglass frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum number of prescription lenses per policy year</td>
<td>One pair of prescription lenses</td>
</tr>
</tbody>
</table>
| Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery) | Daily disposables: up to 3-month supply  
Extended wear disposable: up to 6-month supply  
Non-disposable lenses: one set |
| Optical devices | 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. |
| Maximum number of optical devices per policy year | One optical device |

*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 maximum out-of-pocket limits as explained earlier in this schedule of benefits.

**Policy year deductible waiver**

**Policy year deductible waiver**
The policy year deductible is waived for all non-preferred preferred brand-name value preferred generic generic 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, and out-of-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 and out-of-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 and out-of-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.

**Important note:**
Review the *How to access out-of-network pharmacies* section of the certificate of coverage for more information on how these pharmacies are subject to higher out-of-pocket costs.

*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 biosimilar and generic prescription drugs</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30 supply filled at a retail pharmacy</td>
<td>$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy</td>
<td>$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Non-preferred biosimilar and generic prescription drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each fill up to a 30 supply filled at a retail pharmacy</td>
<td>$65 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy</td>
<td>$130 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Preferred biosimilar and brand-name prescription drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each fill up to a 30 supply filled at a retail pharmacy</td>
<td>$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy</td>
<td>$80 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</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>Non-preferred biosimilar and brand-name prescription drugs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$65 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy</td>
<td>$130 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty drugs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Orally administered anti-cancer prescription drugs (including specialty drugs)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>100% (of the negotiated charge) per prescription or refill</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventive care drugs and supplements</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care drugs and supplements filled at a retail pharmacy</td>
<td>100% (of the negotiated charge) per prescription or refill</td>
</tr>
<tr>
<td>For each 30 day supply</td>
<td>No copayment or policy year deductible applies</td>
</tr>
</tbody>
</table>

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

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
### Risk reducing breast cancer prescription drugs

<table>
<thead>
<tr>
<th>Risk reducing breast cancer prescription drugs 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>For each 30day supply</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

**Maximums:**

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

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.

### Tobacco cessation prescription and over-the-counter drugs

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

**Maximums**

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

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

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

### Dispense as written (DAW)

If a prescriber prescribes a covered brand-name prescription drug where a generic prescription drug equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost sharing for the brand-name prescription drug. If a prescriber does not specify DAW and you request a covered brand-name prescription drug where a generic prescription drug equivalent is available, you will be responsible for the cost difference between the brand-name prescription drug and the generic prescription drug, plus the cost sharing that applies to the brand-name prescription drug.

The cost difference related to a prescription drug that is not specified as “DAW” is not applied towards your maximum out-of-pocket limit.

*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
- Maximums
- 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> that are subject to the <strong>policy year deductible</strong> include covered benefits provided under the medical plan and outpatient <strong>prescription drug</strong> benefits provided under the prescription drug benefit.</td>
</tr>
</tbody>
</table>

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

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

**Individual**

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

**Copayments**

**In-network coverage**

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

**Out-of-network coverage**

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

*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**

Coinsurance is both the percentage of eligible health services that the plan pays and what you pay. The specific percentage that we have to pay for eligible health services is listed earlier in the schedule of benefits.

**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 and 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.

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
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 towards the limits for the rest of the policy year for all covered family members. 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 is the maximum amount you are responsible to pay for eligible health services during the policy year. This plan has an individual and family maximum out-of-pocket limit.

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.

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

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

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

Certificate of Coverage

Prepared exclusively for:

Policyholder: University of Missouri System - Columbia
International Students
Policyholder number: 890430
Student policy effective date: 08/01/20
Plan effective date: 08/01/20
Plan issue date: 06/16/20

Aetna Life Insurance Company
Hartford, Connecticut 06156
1-800-323-9930

Underwritten by Aetna Life Insurance Company

This certificate of coverage is your individual Certificate of Insurance (“Certificate”) while you are insured. It explains the rights and benefits that are determined by the student policy. The student policy is a contract between the Policyholder and the Company.

You have 10 days after you receive this student policy to read and review it. During that 10-day period, if you decide you do not want the student policy, you may return it to us at our Home Office or to the agent who sold it to you. As soon as it is returned, this student policy will be void from the beginning. Premium paid will be returned to you.
IMPORTANT NOTICES:

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

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

Thank you for choosing Aetna.

This is your certificate of coverage. It is one of three documents that together describe the benefits covered by your Aetna plan for in-network and out-of-network coverage.

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

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

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

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

Welcome to your Aetna plan for in-network and out-of-network.
Table of contents

Welcome

Let’s get started!
   Some notes on how we use words 7
   What your plan does – providing covered benefits 7
   How your plan works – starting and stopping coverage 7
   Eligible health services 7
   Paying for eligible health services - the general requirements 8
   Paying for eligible health services - sharing the expense 8
   Disagreements 8
   How your plan works while you are covered for in-network coverage 8
   How your plan works while you are covered for out-of-network coverage 9
   How to contact us for help 9
   Your ID card 9

Who the plan covers
   Who is eligible 10
   Medicare eligibility 10
   When you can join the plan 10
   When you can join the continuation of coverage plan 11
   Who can be on your plan (who can be your dependents) 11
   Adding new dependents 12
   Special times you and your dependents can join the plan 13
   Effective date of coverage 14

Medical necessity, and precertification requirements
   Medically necessary; medical necessity 15
   Precertification 15
   Step therapy 18
   How can I request a medical exception 19

Eligible health services under your plan
   1. Preventive care and wellness 20
   2. Physicians and other health professionals 27
   3. Hospital and other facility care 29
   4. Emergency services and urgent care 32
   5. Pediatric dental care 34
   6. Specific conditions 37
   7. Specific therapies and tests 46
   8. Other services 51
   9. Outpatient prescription drugs 57

What your plan doesn’t cover - eligible health service exceptions and exclusions 64
   General exceptions and exclusions (Exceptions) 64
   Exceptions and exclusions that apply to outpatient prescription drugs (Exceptions) 78
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>General provisions – other things you should know</td>
<td>101</td>
</tr>
<tr>
<td>Entire student policy</td>
<td>101</td>
</tr>
<tr>
<td>Administrative provisions</td>
<td>101</td>
</tr>
<tr>
<td>Coverage and services</td>
<td>101</td>
</tr>
<tr>
<td>Honest mistakes and intentional deception</td>
<td>103</td>
</tr>
<tr>
<td>Some other money issues</td>
<td>103</td>
</tr>
<tr>
<td>Your health information</td>
<td>104</td>
</tr>
<tr>
<td>Effect of benefits under other plans</td>
<td>104</td>
</tr>
<tr>
<td>Glossary</td>
<td>105</td>
</tr>
<tr>
<td>Discount programs</td>
<td>123</td>
</tr>
<tr>
<td>Schedule of benefits</td>
<td>Issued with your certificate of coverage</td>
</tr>
</tbody>
</table>
Let’s get started!

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

Some notes on how we use words in the certificate of coverage and schedule of benefits
- When we say “you” and “your”, we mean the covered student and any covered dependents
- When we say “us”, “we”, and “our”, we mean Aetna
- Some words appear in bold type and we define them in the Glossary section

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

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

This plan provides in-network and out-of-network covered benefits for medical and pharmacy insurance coverage.

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

Your coverage typically ends when you are no longer a student. Family members can lose coverage for many reasons. To learn more see the When coverage ends section.

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

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

So what are eligible health services? They are health care services that meet these three requirements:
- They are listed in the Eligible health services under your plan section.
- They are not carved out in the What your plan doesn’t cover – eligible health service exceptions and exclusions section. We refer to this entire section as the “Exceptions” section.
- They are not beyond any limits in the schedule of benefits.
Paying for eligible health services— the general requirements
There are several general requirements for the plan to pay any part of the expense for an eligible health service. They are:

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

You will find details on medical necessity and precertification requirements in the Medical necessity, precertification requirements section.

Paying for eligible health services— sharing the expense
Generally your plan and you will share the expense of your eligible health services when you meet the general requirements for paying.

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

Disagreements
We know that people sometimes see things differently.

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

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

How your plan works while you are covered for in-network coverage
Your in-network coverage helps you:

- Get and pay for a lot of – but not all – health care services
- Pay less cost share when you use an in-network provider

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

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

You don’t have to access care through school health services. You may go directly to in-network providers for eligible health services.

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

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

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

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

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

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

Your out-of-network coverage:

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

You will find details on:

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

How to contact us for help

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

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

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

You can also contact us by:

- Calling our Member Services at the toll-free number on your ID card or in the How to contact us for help section
- Writing us at Aetna Life Insurance Company, 151 Farmington Ave, Hartford, CT 06156

Your ID card

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

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

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

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

You will find information in this section about:
- Who is eligible?
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible?

You are eligible if you are a:
- Undergraduate students taking 6 or more credit hours
- Graduate students in a degree-seeking program
- Student in a special program such as internship or other practical training programs
- J-1 or F-1 International Student
- International Student in a special program such as Optional Practical Training or Academic Training

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)

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

For continuation of coverage plans, you must have been:
- A covered student under the student policy during this policy year or in the previous policy year and
- Covered under the student policy for at least 1 semester

Medicare eligibility

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

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

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

When you can join the plan

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

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

For continuation of coverage plans, you must:

- Enroll within 31 days of the date of lose of coverage under the student policy
- Elect a continuation period of up to 3 months
- Give us the all of the premium contribution for that period

The policyholder will notify you of the premium contribution amount that is due for your Continuation of coverage plan election. Premium refunds are not allowed.

The continuation of coverage plan of benefits is the same as the current active student policy. See the Continuation of coverage plan section for more information.

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

You can enroll the following family members on your plan. They are referred to in this certificate of coverage as your “covered dependents” or “dependents”.

- Your spouse that resides with you
- Your dependent children – your own or those of your spouse
  - The children must be under 26 years of age, and they include:
    - Your biological children
    - Your stepchildren
    - Your legally adopted children
    - A child legally placed with you for adoption
    - Any children you are responsible for under a qualified medical support order or court-order (without regard to whether or not the child resides with you)

You may continue coverage for a disabled child past the age limit shown above. See the Continuation of coverage for other reasons in the Special coverage options after your plan coverage ends section for more information.

For continuation of coverage plans, your dependent must have been:

- A covered dependent under the student policy during this policy year or in the previous policy year and
- Covered under the student policy for at least 4 months in a row

Newborns, adopted children, stepchildren, and children placed for adoption with you, are not eligible for continuation of coverage plans. Their coverage will end after the initial 31 day period of coverage under the continuation of coverage plan. If your coverage ends during this 31 day period, your dependent child’s coverage will end on the same day as your coverage. This applies even if the 31 day period has not expired.

Dependents enrolled in the student policy because of a court order can be covered under a continuation of coverage plan.
Adding new dependents
You can add the following new dependents at any time during the year:

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

- **A newborn child** - Your newborn child born to or adopted by you, is covered on your health plan for the first 31 days from the moment of birth.
  - To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31 day period.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
  - When you tell us of the newborn’s birth, we will send you the forms and instructions to enroll your newborn. We will also give you an additional ten (10) days from the date we provide these forms to enroll your newborn child. Your newborn will be covered for treatment of injury or illness, including medically diagnosed congenital defects and birth abnormalities.
  - If your coverage ends during this 31 day period, then your newborn’s coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

- **An adopted child or a child legally placed with you for adoption** - A child that you, or that you and your spouse adopts or is placed with you for adoption is covered on your plan for the first 31 days from the date of birth or the date of placement in your home, if a petition for adoption is filed within 30 days of the date of birth, or within 30 days from the date of placement in your home. The child will continue to be considered adopted unless she or he is removed from your home prior to issuance of a legal decree of adoption. Placement means “in the physical custody of the adoptive parent.” Coverage includes the necessary care and treatment of medical conditions existing prior to the date of placement.
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days from the date of placement for adoption or the final decree of adoption, whichever is earliest.
  - You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
  - If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
  - If your coverage ends during this 31 day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31 day period has not ended.

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

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

**If you have coverage for a student only, the newborn, adopted child, or the child for whom the subscriber has legal guardianship, will not have automatic coverage from birth. In order for the child to be covered from birth, the covered student must enroll the child within thirty-one (31) days of birth, adoption, filing for legal guardianship, or placement for adoption.**

**We will not refuse to enroll your child because she or he:**
- Was born out of wedlock
- Is not claimed as a dependent on your federal income tax return
- Does not live with you

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

**Special times you and your dependents can join the plan**
You can enroll in these situations:
- When you did not enroll in this plan before because:
  - You were covered by another health plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
  - You have added a dependent because of marriage, birth, adoption, placement for adoption, or foster care. See the *Adding new dependents* section for more information.
- You or your dependents become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your premium contribution for coverage under this plan.
- When a court orders that you cover a current spouse or a minor child on your health plan.
- When you are a victim of domestic abuse or spousal abandonment and you don’t want to be enrolled in the perpetrator’s health plan.

We must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.
Effective date of coverage

Enrollment

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

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

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

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

Continuation of coverage plan
Your and your dependent’s effective date of coverage under a continuation of coverage plan is the later to occur of:

- The date your and your dependent’s coverage under the student policy ends, or
- The date we receive your premium contribution.

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

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

This late enrollment provision does not apply to coverage under a continuation of coverage plan except for a dependent that must be enrolled due to a court order.
Medical necessity, precertification requirements

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

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

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

This section addresses the medical necessity, and precertification requirements.

Medically necessary; medical necessity

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

The medical necessity requirements are stated in the Glossary section, where we define "medically necessary, medical necessity". That is where we also explain what our medical directors or their physician designees consider when determining if an eligible health service is medically necessary. Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

Precertification

You need precertification from us for some eligible health services.

Precertification for medical services and supplies

In-network care

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

Out-of-network care

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

Sometimes you or your provider may want us to review a service that doesn’t require Precertification before you get care. This is called a predetermination, and it is different from Precertification. Predetermination means that you or your provider requests the pre-service clinical review of a service that does not require Precertification.
Precertification call
Precertification should be secured within the timeframes specified below. To obtain precertification, call Member Services at the toll-free number on your ID card or in the How to contact us for help section. This call must be made for:

<table>
<thead>
<tr>
<th>Non-emergency admissions:</th>
<th>You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.</th>
</tr>
</thead>
<tbody>
<tr>
<td>An emergency medical condition (including delivery of a newborn child):</td>
<td>You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>For An emergency admission (including delivery of a newborn child):</td>
<td>You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>An urgent admission:</td>
<td>You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.</td>
</tr>
<tr>
<td>Outpatient non-emergency services requiring precertification:</td>
<td>You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.</td>
</tr>
</tbody>
</table>

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

| Notification call for an emergency medical condition: | You, your physician or the facility must call us within 24 hours or as soon as reasonably possible after receiving emergency outpatient care, treatment or procedure. |

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

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

When you have an outpatient service or supply that requires precertification, we will notify you, your physician and the facility about your precertified outpatient service or supply. If your physician recommends that your outpatient service or supply benefits be extended, the additional outpatient benefits will need to be precertified. You, your physician, or the facility will need to call us at the number on your ID card as soon as reasonably possible, but no later than the final day of the authorized outpatient service or supply. We will review and process the request for the extended outpatient benefits. You and your physician will receive a notification of an approval or denial.
If precertification determines that the stay or outpatient services and supplies are not covered benefits, the notification will explain why and how you can appeal our decision. You or your provider may request a review of the precertification decision. See the When you disagree - claim decisions and grievance procedures section.

If we have precertified eligible health services under this plan, we will not change our decision, except if you have intentionally misrepresented your health condition or if your coverage ends before the eligible health services are provided.

If we refuse to precertify a request, we will notify your physician by telephone or electronically within 24 hours of our decision. We will then send you and your provider written or electronic notification within one working day of our initial notification. You can appeal this decision. See When you disagree- claims decisions and grievance procedures section.

What if you don’t obtain the required precertification?
If you don’t obtain the required precertification:
- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits Precertification covered benefit penalty section.
- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your out-of-network policy year deductibles or maximum out-of-pocket limits.

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

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

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

Access to Obstetrical and Gynecological (Ob/Gyn) Care
You do not need to obtain precertification to access or make an appointment to receive obstetrical or gynecological care from a health professional in our network who specializes in obstetrics or gynecology. The health professional, however, may recommend certain elective medical procedures that may require precertification. Preventive care services do not require precertification.

Precertification for prescription drugs and devices
Certain prescription drugs and devices are covered under the medical plan when they are given to you by your physician or health care facility and not obtained at a pharmacy. The following precertification information applies to these prescription drugs and devices.

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

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

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

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

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

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

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

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

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

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

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

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

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

You can find out about these exceptions in the Exceptions section and about the limitations in the schedule of benefits.

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

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

1. Preventive care and wellness

This section describes the eligible health services and supplies available under your plan when you are well.

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

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

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

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

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your physician or contact Member Services by logging on to your Aetna secure website at www.aetnastudenthealth.com or by calling the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.
5. We may use reasonable medical management techniques to determine the frequency, method, treatment, or setting of preventive care and wellness benefits when not specified in the recommendations and guidelines of the:
- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- United States Preventive Services Task Force
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

Routine physical exams
Eligible health services include office visits to your physician or other health professional for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:
- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents (including Child Health Supervision services).
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections (the plan covers HIV infection, including AIDS and ARC, the same as any other serious medical condition)
  - Screening for gestational diabetes for women
  - High-risk Human Papillomavirus (HPV) DNA testing for women 30 and older
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial hospital checkup. Newborn hearing screening includes the initial screening, necessary rescreening, audiological assessment and follow-up and initial amplifications.

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.
Child health supervision services
Even though they are not incurred in connection with an injury or disease, eligible health services include the following charges for Child Health Supervision Services for a dependent child birth through 12 years of age.

“Child health supervision services” means a periodic review of a child's physical and emotional status by a physician or under a physician’s supervision. A review shall include a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards. Included are:

- A review and written record of the child’s complete medical history
- Physical examination
- Developmental and behavioral assessment
- Anticipatory guidance and education
- Immunizations including diphtheria, haemophilus influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunization as recommended by the American Academy of Pediatrics
- Laboratory tests

All of the above will be in keeping with prevailing medical standards.

Eligible health services will only include charges of one physician for Child health supervision services performed at birth and at approximately each of the following ages:

<table>
<thead>
<tr>
<th>Age</th>
<th>2 months</th>
<th>4 months</th>
<th>6 months</th>
<th>9 months</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 months</td>
<td>18 months</td>
<td>2 years</td>
<td>3 years</td>
<td>4 years</td>
<td>5 years</td>
</tr>
<tr>
<td>6 years</td>
<td>8 years</td>
<td>10 years</td>
<td>12 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Limitations:
Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan
- Services which are for diagnosis or treatment of a suspected or identified injury or disease
- Services not performed by a physician or under his or her direct supervision
- Medicines, drugs, appliances, equipment, or supplies
- Dental exams

Early intervention for infants and toddlers (First Steps)
Eligible health services include:

- Physical therapy
- Occupational therapy
- Speech/language therapy
- Assistive technology
Coverage is only for a dependent child who:

- Qualifies for early intervention services under Part C of the Individuals with Disabilities Education Act
- Demonstrates developmental delays and other qualifying medical problems
- Receives services as part of an active individualized plan to enhance functional ability

This benefit is subject to an age limit as shown in the schedule of benefits.

**Well woman preventive visits**

**Eligible health services** include your routine:

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

**Preventive screening and counseling services**

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

Here is more detail about those benefits:

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

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

- **Use of tobacco products**
  **Eligible health services** include the following screening and counseling services to help you to stop the use of tobacco products:
  - Preventive counseling visits
  - Treatment visits
  - Class visits
Tobacco product means a substance containing tobacco or nicotine such as:
- Cigarettes
- Cigars
- Smoking tobacco
- Snuff
- Smokeless tobacco
- Candy-like products that contain tobacco

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

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

**Lead poisoning screening**
Eligible health services include testing pregnant women for lead poisoning and for all testing for lead poisoning.

**Routine cancer screenings**
Eligible health services include the following routine cancer screenings:
- Mammograms (age 35 and older or as recommended by a physician due to a family history of breast cancer)
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Pelvic examination
- Pap smear
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies (includes:
  - Bowel preparation medications
  - Anesthesia
  - Removal of polyps performed during a screening procedure
  - Pathology exam on any removed polyps)
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:
- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration
- State law (where stricter)
**Prenatal care**

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

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height
- Preeclampsia screening
- Anemia screening
- Chlamydia infection screening
- Hepatitis B screening
- Rh incompatibility screening

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

**Important note:**

You should review the benefit under *Eligible health services under your plan Maternity care, Well newborn nursery care* and the *Exceptions* sections of this certificate of coverage for more information on coverage for pregnancy expenses under this plan.

**Comprehensive lactation support and counseling services**

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

**Breast feeding durable medical equipment**

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

**Breast pump**

*Eligible health services* include:

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

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

**Breast pump supplies and accessories**

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

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

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

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

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

Important note:
See the following sections for more information:
- Family planning services - other
- Maternity care
- Well newborn nursery care
- Treatment of basic infertility
- Outpatient prescription drugs
2. Physicians and other health professionals

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

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

Allergy testing and treatment

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

Physician and specialist – inpatient surgical services

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

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

we will pay for the one that costs the most.

Your surgeon may perform two or more surgical or bilateral procedures on you during one operation but in separate operative fields. When this happens, we will pay:
- 100% of the surgery for the primary procedures
- 50% of the surgery for the secondary procedure
- 25% of the surgery for each of the other procedures, if any

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

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

Anesthetist

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

Surgical assistant

Covered benefits for your surgery include the services of a surgical assistant. A “surgical assistant” is a health professional trained to assist in surgery and during the periods before and after surgery. A surgical assistant is under the supervision of a physician.
Physician and specialist – outpatient surgical services
Eligible health services include the services of:
- The surgeon who performs your surgery in the outpatient department of a hospital or surgery center
- Your surgeon who you visit before and after the surgery

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

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

Consultant services (non-surgical and non-preventive)
Eligible health services include the services of a consultant to confirm a diagnosis made by your physician or to determine a diagnosis. Your physician or specialist must make the request for the consultant services.

Covered benefits include treatment by the consultant.

The consultation may happen by way of telemedicine.

Important note:
Your student policy covers telemedicine but only when you get your consult through a provider that has contracted with Aetna to offer these services. All in-person consultant office visits that are covered benefits are also covered if you use telemedicine instead.

Telemedicine may have different cost sharing than other outpatient services. See the schedule of benefits for more information.

Second opinion – cancer
Eligible health services include a second opinion by a specialist in the field of medicine related to your newly-diagnosed cancer condition. We will precertify your request to see an out-of-network provider for a second medical opinion if expertise or equally effective treatment for your cancer diagnosis cannot be provided by or through a network provider. You are responsible for obtaining the precertification. You or your physician must notify Aetna in advance.

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

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

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

Walk-in clinic (non-emergency visit)
Eligible health services include, but are not limited to, health care services provided at walk-in clinics for:
- Scheduled and unscheduled visits for illnesses and injuries that are not emergency medical conditions
- Preventive care immunizations administered within the scope of the clinic’s license
3. Hospital and other facility care

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

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

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

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

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

for your oral surgery or dental procedure.

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

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

Eligible health services include the administration of general anesthesia and hospital charges provided in a hospital, surgery center, or physician’s office for dental care provided to the following covered persons:

- A child under 5 years of age
- A person who is severely disabled
- A person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental services are provided

Alternatives to hospital stays

Outpatient surgery (facility charges)

Eligible health services include facility services provided and supplies used in connection with outpatient surgery performed in a surgery center or a hospital’s outpatient department.

<table>
<thead>
<tr>
<th>Important note:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some surgeries can be done safely in a physician’s office. For those surgeries, your plan will pay only for physician services and not a separate facility fee.</td>
</tr>
</tbody>
</table>

Home health care

Eligible health services include home health care services provided by a home health care agency in the home, but only when all of the following criteria are met:

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

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

Home health care services do not include custodial care.

Hospice care

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

The types of hospice care services that are eligible for coverage include:

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

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

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

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

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

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

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

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

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

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

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

For follow-up care, you are covered when:

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

In case of a medical emergency

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

Non-emergency condition

If you go to an emergency room for what is not an emergency medical condition, the plan will not cover your expenses. See the schedule of benefits and the Emergency services and urgent care and Precertification covered benefit penalty sections for specific plan details.
In case of an urgent condition

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

Non-urgent care
If you go to an urgent care facility for what is not an urgent condition, the plan will not cover your expenses. See the Emergency services and urgent care and Precertification covered benefit penalty sections in the schedule of benefits for specific plan details.

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

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

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

Dental emergencies

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

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

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

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

What rules and limits apply to dental care?

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

When does your plan cover orthodontic treatment?

Orthodontic treatment is covered if you have a severe, dysfunctional, disabling condition, such as:

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

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

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

- Crowns
- Inlays
- Onlays
- Veneers
- complete dentures removable partial dentures fixed partial dentures (bridges) other prosthetic services

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

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

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

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

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

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

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

In determining the amount of benefits payable, we will take into account alternate procedures, services, or courses of dental treatment for the dental condition in question in order to accomplish the anticipated result. See the When does your plan cover other treatment? section below.
What is a course of dental treatment?
A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more dentists to treat a dental condition that was diagnosed by the attending dentist during an oral examination. A course of treatment starts on the date your dentist first renders a service to correct or treat the diagnosed dental condition.

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

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

When alternate services or supplies can be used, the plan's coverage will be limited to the expense of the least expensive service or supply that is:
- Customarily used nationwide for treatment
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition

You should review the differences in the expense of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more expensive treatment method. You are responsible for any charges in excess of what the plan will cover.
6. Specific conditions

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

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

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

Diabetic services and supplies (including equipment and training)
Eligible health services include medically necessary and appropriate services prescribed by your physician such as:

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

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

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

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

- Voluntary sterilization for males
Temporomandibular joint dysfunction treatment (TMJ) and craniomandibular joint dysfunction treatment (CMJ)

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

for TMJ and CMJ) by a provider.

Impacted wisdom teeth

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

Accidental injury to sound natural teeth

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

Dermatological treatment

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

Maternity care

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

After your child is born, **eligible health services** include:
- 48 hours of inpatient care in a hospital or birthing center after a vaginal delivery
- 96 hours of inpatient care in a hospital or birthing center after a cesarean delivery
- A shorter stay if the attending physician, with the consent of the mother, discharges the mother or newborn earlier
- The mother could be discharged earlier

Well newborn nursery care

**Eligible health services** include routine care of your well newborn child in a hospital or birthing center such as:
- Well newborn nursery care during the mother’s stay but for not more than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery
- Hospital or birthing center visits and consultations for the well newborn by a physician but for not more than 1 visit per day
- 2 post-delivery visits, at least one of which shall be a home visit by an R.N. or physician. 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:
  - 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.

**Pregnancy complications**

*Eligible health services* include services and supplies from your provider for pregnancy complications.

Pregnancy complications means problems caused by pregnancy that pose a significant threat to the health of the mother or baby, including, but not limited to:

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

**Gender reassignment (sex change) treatment**

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

*Eligible health services* include:

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

**Important Note:**

As a reminder, gender reassignment (sex change) treatment requires precertification by Aetna. Your in-network provider is responsible for obtaining precertification. You are responsible for obtaining precertification when you use an out-of-network provider. Just log into your Aetna secure website at www.aetnastudenthealth.com for detailed information about this covered benefit, including eligibility requirements. You can also call Member Services at the toll-free number on your ID card or in the How to contact us for help section.
**Autism spectrum disorder**

Autism Spectrum Disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association as a neurobiological disorder, an *illness* of the nervous system that includes:

- Autistic disorder
- Asperger's syndrome
- Pervasive developmental disorder (not otherwise specified)
- Rett's syndrome
- Childhood disintegrative disorder

**Eligible health services** include the services and supplies provided by a *physician*, autism service provider or *behavioral health provider* for the diagnosis, testing and treatment of autism spectrum disorders, including:

- Psychiatric and psychological services
- Habilitative and rehabilitative care, including applied behavior analysis, speech, occupational and physical therapy
- Medications
- Equipment related to care

We will only cover this treatment if a *physician*, autism service provider, line therapist, or *behavioral health provider* prescribes or orders it as part of a treatment plan.

We will cover certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is the design, implementation and evaluation of environmental changes, using behavior incentives and penalties to create socially meaningful progress in human behavior. This includes the use of:

- Direct observation
- Measurement and
- Functional analysis of the relationships between environment and behavior

**Important note:**

As a reminder, applied behavior analysis requires *precertification* by Aetna. Your *in-network provider* is responsible for obtaining *precertification*. You are responsible for obtaining *precertification* when you use an *out-of-network provider*.
Mental health treatment

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

- **Inpatient room and board** at the semi-private room rate, and other services and supplies related to your condition that are provided during your stay in a general medical hospital, psychiatric hospital, or residential treatment facility.

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

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

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

- **Outpatient treatment** received while not confined as an inpatient in a general medical hospital, psychiatric hospital, or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (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.
Substance abuse related disorders treatment

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

- **Inpatient room and board** at the semi-private room rate and other services and supplies that are provided during your stay in a general medical hospital, psychiatric hospital, alcoholism treatment facility or residential treatment facility.

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

Treatment of substance abuse in a general medical hospital is only covered if you are:
- Admitted for the treatment of medical complications of substance abuse
- Transferred to its separate substance abuse section or unit

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

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

- Outpatient treatment received while not confined as an inpatient in a general medical hospital, psychiatric hospital, 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.
Important note:
Your student policy covers telemedicine for mental disorders and substance abuse. All in-person physician or behavioral health provider office visits that are covered benefits are also covered if you use telemedicine instead.

Telemedicine may have different cost sharing than other outpatient services. See the schedule of benefits for more information.

Oral and maxillofacial treatment (mouth, jaws and teeth)
Eligible health services include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a physician, a dental provider and hospital:

- Non-surgical treatment of infections or illness.
- Surgery needed to:
  - Treat a fracture, dislocation, or wound.
  - Cut out teeth partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Hospital services and supplies received for a stay required because of your condition.
- Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair, and are firmly attached to your jaw bone at the time of your injury.
  - Other body tissues of the mouth fractured or cut due to injury.
- Crowns, dentures, bridges, or in-mouth appliances only for:
  - The first denture or fixed bridgework to replace lost teeth.
  - The first crown needed to repair each damaged tooth.
  - An in-mouth appliance used in the first course of orthodontic treatment after an injury.
- Accidental injuries and other trauma. Trauma which occurs as a result of biting or chewing is not considered accidental injury, even if it is unplanned or unexpected. Oral surgery and related dental services to return sound natural teeth to their pre-trauma functional state. These services must take place no later than 24 months after the injury or enrollment in the plan, whichever is later.
  - Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.
  - If a child needs oral surgery as the result of accidental injury or trauma, surgery may be postponed until a certain level of growth has been achieved.
- Removal of tumors and cysts requiring pathological examination.
- Fluoride treatment, removal of teeth and hyperbaric oxygen therapy in connection with covered radiation therapy.
- Oral surgery and related dental services to correct a gross anatomical defect present at birth that result in significant functional impairment of a body part, if the services or supplies will improve function.
  - Related dental services are limited to:
    o The first placement of a permanent crown or cap to repair a broken tooth
    o The first placement of dentures or bridgework to replace lost teeth
    o Orthodontic therapy to preposition teeth
Reconstructive surgery and supplies

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

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

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.

Treatment of infertility
Basic infertility services
Eligible health services include seeing a physician or infertility specialist:
- To diagnose and evaluate the underlying medical cause of infertility.
- To do surgery to treat the underlying medical cause of infertility. Examples are endometriosis surgery or, for men, varicocele surgery.
7. Specific therapies and tests

Outpatient diagnostic testing

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

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

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

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

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

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

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

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

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

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. We call these “GCIT services.”
Eligible health services for GCIT include:

- Cellular immunotherapies.
- Genetically modified viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.
- All human gene therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza® (Nusinersen).
  - siRNA.
  - mRNA.
  - microRNA therapies.

Facilities/providers for gene-based, cellular and other innovative therapies

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

Outpatient infusion therapy

Eligible health services include infusion therapy you receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a hospital
- A physician in their office
- A home care provider in your home

You can access the list of preferred infusion locations by contacting Member Services at the toll-free number on your ID card or in the How to contact us for help section or by logging onto your Aetna secure website at www.aetnastudenthealth.com.

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

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

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care maximums.
Outpatient radiation therapy
Eligible health services include the following radiology services provided by a health professional:

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

Specialty prescription drugs
Eligible health services include specialty prescription drugs when they are:

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

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

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

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

- Whole blood
- Blood components
- The administration of whole blood and blood components

Short-term cardiac and pulmonary rehabilitation services
Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

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

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

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

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

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

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

**Outpatient cognitive rehabilitation, physical, occupational, and speech therapy**

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

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

**Short-term habilitation therapy services**
Short-term habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn’t walking or talking at the expected age).
Eligible health services include short-term habilitation therapy services your physician prescribes. The services have to be performed by:

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

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

Outpatient physical, occupational, and speech habilitation therapy

Eligible health services include:

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

Chiropractic care

Eligible health services include initial diagnosis and treatment of the diagnosed disorder. Diagnosis and treatment must be within the scope of the chiropractor’s license.

Speech and hearing disorder

Eligible health services include the diagnosis and treatment for loss or impairment of speech and hearing, including speech, language and hearing disorders caused by genetic or birth defects, injury, illness, developmental disabilities or delays. It also includes those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both, and such treatment must fall within the scope of the license or certification.

The treatment for loss or impairment of speech and hearing is covered regardless of whether or not the person suffering from that loss or impairment had the capacity for speech, language or hearing before the loss or impairment occurred. Services may also include assessment and evaluation of the need for augmentative and alternative communication devices.

Coverage must be provided regardless of whether the eligible health services are provided in a hospital, clinic or private office, but does not extend to a school-based setting.

Diagnostic testing for learning disabilities

Eligible health services include diagnostic testing for:

- Attention deficit disorder
- Attention deficit hyperactive disorder

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

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

Ambulance service
Eligible health services include transport by professional ambulance services.

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

For non-emergency services:
- From hospital to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a hospital if an ambulance is the only safe way to transport you
- From your home, the scene of an accident or medical emergency to a hospital

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

Clinical trial therapies (experimental or investigational)
Eligible health services include experimental or investigational drugs, devices, treatments or procedures from a provider under an “approved clinical trial” only when you have cancer or terminal illnesses and all of the following conditions are met:
- Standard therapies have not been effective or are not appropriate
- We determine based on published, peer-reviewed scientific evidence that you may benefit from the treatment

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

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

Cancer Clinical trials (routine patient costs)

Eligible health services include “routine patient care costs” for drugs or devices incurred to you by a provider in connection with participation in a phase II, III or IV clinical trial. The purpose of the clinical trial is the prevention, early detection and treatment of cancer.

Routine care for phase II clinical trials must be:

- Sanctioned by the NIH or National Cancer Institute
- Conducted at an academic or National Cancer Institute Center and
- You are actually enrolled in the clinical trial and not merely following the protocol of a phase II clinical trial.

Routine care for phase III and IV clinical trials must satisfy the following:

- The study or investigation is approved or funded by one or more of the following:
  - The National Institutes of Health (NIH)
  - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
  - The Food and Drug Administration (FDA) in the form of an investigational new drug application
  - The Department of Veterans Affairs
  - The Department of Defense
  - An institutional review board in Missouri that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or
  - A qualified research entity that meets the criteria for NIH Center support grant eligibility.
- The treating facility and provider must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.
- The clinical trial providers obtained your informed consent to participate in the clinical trial and they did so by following legal and ethical standards.
**Durable medical equipment (DME)**

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

Coverage includes:

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

We:

- Assume no responsibility
- Make no express or implied warranties

concerning the outcome of any covered DME items.

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

Your plan only covers the same type of DME that Medicare covers. But there are some DME items Medicare covers that your plan does not. We list examples of those in the *Exceptions* section.

**Enteral formulas and nutritional supplements**

**Eligible health services** include enteral formulas and nutritional supplements used to treat malabsorption of food caused by:

- Crohn’s Disease
- Ulcerative colitis
- Gastroesophageal reflux
- Gastrointestinal motility;
- Chronic intestinal pseudo-obstruction
- Phenylketonuria
- Eosinophilic gastrointestinal disorders
- Inherited diseases of amino acids and organic acids

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

Your physician must give you a written order for these supplies.
Osteoporosis (non-preventive care)
Eligible health services include the diagnosis, treatment and management of osteoporosis by a physician. The services include Food and Drug Administration approved technologies, including bone mass measurement.

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

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

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

See Reconstructive surgery and supplies in the Specific conditions section for coverage of breast prosthesis following a mastectomy.

Hearing aids and exams
Eligible health services include hearing care that includes hearing exams, prescribed hearing aids and hearing aid services as described below. Coverage for initial amplification after newborn hearing screenings (including any necessary rescreening, audiological assessment and follow-up) is also included.

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

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

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

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

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

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

Vision care

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

Vision care services and supplies
Eligible health services include:
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, prescription lenses or prescription contact lenses that are identified as preferred by a vision provider
- Eyeglass frames, prescription lenses or prescription contact lenses that are identified as non-preferred by a vision provider
- Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses
- Aphakic prescription lenses prescribed after cataract surgery has been performed
- Low vision services including comprehensive low vision evaluations and prescribed optical devices, such as high-power spectacles, magnifiers, and telescopes
- Contact lenses for the following conditions:
  - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using conventional lenses
  - Pathological myopia
  - Anisometropia
- Aniseikonia
- Aniridia
- Corneal disorders
- Post-traumatic disorders
- Irregular astigmatism
- Aphakia
- High Ametropia exceeding -12D or +9D in spherical equivalent

When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

**Prescription** lenses include choice of:
- Glass or plastic lenses
- All lens powers (single vision, bifocal, trifocal, lenticular)
- Standard progressive Lens
- Fashion and gradient tinting
- Oversized and glass-grey #3 prescription sunglass lenses.

Additional lens options include:
- Ultraviolet Protective Coating
- Polycarbonate Lenses (if not child, monocular or prescription >+/-.600 diopters)
- Blended Segment Lenses
- Intermediate Vision Lenses
- Premium Progressives (Varilux, etc.)
- Photochromic Glass Lenses
- Plastic Photosensitive Lenses (Transitions)
- Polarized Lenses
- Standard Anti-Reflective (AR) Coating
- Premium AR Coating
- Ultra AR Coating
- Scratch Resistant Coating
- Hi-Index Lenses
9. Outpatient prescription drugs

What you need to know about your outpatient prescription drug benefits

Read this section carefully so that you know:

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

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

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.

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

How to access in-network pharmacies

How do you find an in-network pharmacy?

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

- Online: By logging onto your Aetna secure website at www.aetnastudenthealth.com.
- By phone: Call Member Services at the toll-free number on your ID card or the How to contact us for help section. During regular business hours, a Member Services representative can assist you. Our automated telephone assistant can give you this information 24 hours a day.

You may go to any of our in-network pharmacies.

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

Pharmacies include in-network retail, mail order and specialty pharmacies.
How to access out-of-network pharmacies

You can directly access an out-of-network pharmacy to get covered outpatient prescription drugs. If you use an out-of-network pharmacy to obtain outpatient prescription drugs, you are subject to a higher out-of-pocket expense and are responsible for:

- Your out-of-network copayment
- Your out-of-network coinsurance
- Any charges over our recognized charge
- Submitting your own claims

Eligible health services under your outpatient prescription drug benefit

What does your outpatient prescription drug benefit cover?

Eligible health services under your outpatient prescription drug benefit include:

Any pharmacy service that meets these three requirements:

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

Your plan benefits are covered when you follow the plan’s general rules:

- You need a prescription from your prescriber
- You need to show your ID card to the pharmacy when you get a prescription filled

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

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

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

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

What outpatient prescription drugs are covered

Your prescriber may give you a prescription in different ways, including:

- Writing out a prescription that you then take to a pharmacy
- Calling or e-mailing a pharmacy to order the medication
- Submitting your prescription electronically to a pharmacy

Once you receive a prescription from your prescriber, you may fill the prescription at an in-network retail, mail order or specialty or out-of-network pharmacy.
Prescription drug synchronization
If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, you’re in-network pharmacy can coordinate that for you. We will apply a prorated daily cost share rate to a partial fill of a maintenance drug, if needed, to synchronize your prescription drugs.

Types of pharmacies

Retail pharmacy
Generally, retail pharmacies may be used for up to a 30 day supply of prescription drugs. You should show your ID card to the in-network pharmacy every time you get a prescription filled. The in-network pharmacy will submit your claim. You will pay any cost sharing directly to the in-network pharmacy.

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

All prescriptions and refills over a 30 day supply must be filled at an in-network mail order pharmacy.

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

Outpatient prescription drugs are covered when dispensed by an in-network mail order pharmacy. Each prescription is limited to a maximum 90 day supply. Prescriptions for less than a 31 day supply or more than a 90 day supply are not eligible for coverage when dispensed by an in-network mail order pharmacy.

Specialty pharmacy

Specialty prescription drugs often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. Each prescription is limited to a maximum 30 day supply. You can access the list of specialty prescription drugs by contacting Member Services at the toll-free number on your ID card or in the How to contact us for help section or by logging onto your Aetna secure website at www.aetnastudenthealth.com.

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

Other services

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

We cover over-the-counter (OTC) and generic prescription drugs and devices for each of the methods identified by the FDA at no cost share. If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug for that method at no cost share.
**Important Note:**
You may qualify for a medical exception if your **provider** determines that the contraceptives covered standardly as preventive are not medically appropriate. Your **prescriber** may request a medical exception and submit the exception to us.

**Diabetic supplies**
**Eligible health services** include but are not limited to the following diabetic supplies upon **prescription** by a **prescriber**:
- Injection devices including insulin syringes, needles and pens
- Test strips - blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs

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

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

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

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

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

**Off-label use**
U.S. Food and Drug Administration (FDA) approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your condition(s). Eligibility for coverage is subject to the following:
- The drug must be accepted as safe and effective to treat your condition(s) in one of the following standard compendia:
  - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information)
  - Thomson Micromedex DrugDex System (DrugDex)
  - Clinical Pharmacology (Gold Standard, Inc.) or
  - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium
- Use for your condition(s) has been proven as safe and effective by at least one well-designed controlled clinical trial, (i.e., a Phase III or single center controlled trial, also known as Phase II). Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
  - The dosage of a drug for your condition(s) is equal to the dosage for the same condition(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above or
  - The dosage has been proven to be safe and effective for your condition(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.
Health care services related to off-label use of these drugs may be subject to precertification, step therapy or other requirements or limitations.

**Orally administered anti-cancer drugs, including chemotherapy drugs**

**Eligible health services** include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication. Coverage for orally administered anti-cancer medication will be provided the same as intravenously administered or injected anti-cancer medication.

**Over-the-counter drugs**

**Eligible health services** include certain over-the-counter medications, as determined by the plan. Coverage of the selected over-the-counter medications requires a prescription. You can access the list by logging onto your Aetna secure website at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) or calling Member Services at the toll-free number on your ID card or in the How to contact us for help section.

**Preventive care drugs and supplements**

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

**Risk-reducing breast cancer prescription drugs**

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

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

**Tobacco cessation prescription and over-the-counter drugs**

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

**How you get an emergency prescription filled**

You may not have access to an in-network pharmacy in an emergency or urgent care situation, or you may be traveling outside of the plan’s service area. If you must fill a prescription in either situation, we will reimburse you as shown in the table below.

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

Note that early prescription eye drops will be covered, as long as your provider precertified the early refills.
Where your schedule of benefits fits in
You are responsible for paying your part of the cost sharing. The schedule of benefits shows any benefit limitations and any out-of-pocket costs you are responsible for. Keep in mind that you are responsible for costs not covered under this plan.

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

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

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

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

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

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

Aetna will not retroactively reduce or terminate a previously approved service or supply unless:
- Such authorization is based on a material misrepresentation or omission about the treated or cause of the health condition; or
- The plan terminated before services are provided; or
- Coverage terminated before the services were provided

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

You will find the step therapy prescription drugs on the preferred drug guide. For the most up-to-date information, call Member Services at the toll-free number on your ID card or in the How to contact us for help section or log on to your Aetna secure website at www.aetnastudenthealth.com.
Medical exceptions
Sometimes you or your prescriber may ask for a medical exception to get health care services for drugs not covered or for brand-name, specialty or biosimilar prescription drugs or for which health care services are denied through precertification or step therapy. You, someone who represents you or your prescriber can contact us. You will need to provide us with the required clinical documentation. We will make a coverage determination within 72 hours after we receive your request and any information and will tell you and your prescriber of our decision. Any exception granted is based upon an individual, case by case decision, and will not apply to other members. If approved by us, you will receive the preferred or non-preferred drug benefit level and the exception will apply for the entire time of the prescription.

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

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

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

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

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

Any outpatient prescription drug that has duration of action extending beyond one (1) month shall require the number of copayments per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) copayments.
What your plan doesn’t cover – eligible health service exceptions and exclusions

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

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

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

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

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

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

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

**Alternative health care**
- Services and supplies given by a provider for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and traditional Chinese medicine.
Ambulance services
- Non-emergency transport by fixed wing air ambulance
- Non-emergency ambulance transports except as covered under the Eligible health services under your plan section of this certificate of coverage

Armed forces
- Services and supplies received from a provider as a result of an injury sustained, or illness contracted, while in the service of the armed forces of any country. When you enter the armed forces of any country, we will refund any unearned pro-rata premium to the policyholder.

Artificial organs
- Any device that would perform the function of a body organ

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

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

Blood 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

Blood, blood plasma, synthetic blood, blood derivatives or substitutes except as specifically provided in the Eligible health services under your plan section.
Examples of these are:
- The provision of blood to the hospital, other than blood derived clotting factors
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered

Breasts
- Services and supplies given by a provider for breast reduction or gynecomastia

Clinical trial therapies (experimental or investigational)
- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the Eligible health services under your plan - Clinical trial therapies (experimental or investigational) section
Clinical trial therapies (routine patient costs)
- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna’s claim policies)
- In-network coverage limited to benefits for routine patient services provided within the network

Cartilage transplants
- Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

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

Cosmetic services and plastic surgery
- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body. Whether or not for psychological or emotional reasons. Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.

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

Court-ordered services and supplies
- This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding, unless they are a covered benefit under your plan

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/jejuno stomy/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

Dermatological treatment
- Cosmetic treatment and procedures
Dental care for adults
• Dental services for adults including services related to:
  − The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
  − Dental services related to the gums
  − Apicoectomy (dental root resection)
  − Orthodontics
  − Root canal treatment
  − Soft tissue impactions
  − Alveolectomy
  − Augmentation and vestibuloplasty treatment of periodontal disease
  − False teeth
  − Prosthetic restoration of dental implants
  − Dental implants

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

Durable medical equipment (DME)
Examples of these items are:
• Whirlpools
• Portable whirlpool pumps
• Sauna baths
• Massage devices
• Over bed tables
• Elevators
• Communication aids
• Vision aids
• Telephone alert systems
• Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician

Early intensive behavioral interventions
Examples of these services are:
• Certain early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions

Educational services
Examples of these services are:
• Any service or supply for education, training or retraining services or testing. This includes:
  − Special education
  − Remedial education
  − Wilderness treatment program
  − Job training
  − Job hardening programs
• Services provided by a governmental school district

Elective treatment or elective surgery
• Elective treatment or elective surgery except as specifically covered under the student policy and provided while the student policy is in effect
Enteral formulas and nutritional supplements

- Any food item, including infant formulas, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the Eligible health services under your plan – Enteral formulas and nutritional supplements section

Examinations

Any health or dental examinations needed:

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

Emergency services and urgent care

- Non-emergency services in a hospital emergency room facility
- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons’ main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Family planning services - other

- Voluntary termination of pregnancy
- Reversal of voluntary sterilization procedures, including related follow-up care
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

Felony

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

Foot care

- Unless required for the treatment of diabetes, except as specifically provided in the Eligible health services under your plan section Services and supplies for:
  - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet
Gender reassignment (sex change) treatment
- Cosmetic services and supplies such as:
  - Rhinoplasty
  - Face-lifting
  - Lip enhancement
  - Facial bone reduction
  - Blepharoplasty
  - Breast augmentation
  - Liposuction of the waist (body contouring)
  - Reduction thyroid chondroplasty (tracheal shave)
  - Hair removal (including electrolysis of face and neck)
  - Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which are used in feminization
  - Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic

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

Please refer to the Medical necessity and Precertification requirements section.

Hospice care
- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling which includes estate planning and the drafting of a will
- Homemaker or caretaker services that are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

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

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

Mandatory no-fault laws
- Treatment for an injury to the extent benefits are payable under any state no-fault automobile coverage or first party medical benefits payable under any other mandatory no-fault law
Maintenance care
- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services and Autism Spectrum Disorder. See the Eligible health services under your plan – Habilitation therapy services and the Eligible health services under your plan- Autism Spectrum Disorders section

Maternity and related newborn care
- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

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

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

Mental health treatment
- The following categories (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association) are not covered:
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders except as described in the Eligible health services under your plan – Preventive care and wellness section

Motor vehicle accidents
- Services and supplies given by a provider for injuries sustained from a motor vehicle accident but only when benefits are payable under other valid and collectible insurance. This applies whether or not a claim is made for such benefits.

Non-medically necessary services and supplies
- Services and supplies which are not medically necessary for the diagnosis, care, or treatment of an illness or injury or the restoration of physiological functions. This includes behavioral health services that are not primarily aimed at the treatment of illness, injury, restoration of physiological functions or that do not have a physiological or organic basis. This applies even if they are prescribed, recommended, or approved by your physician, dental provider, or vision care provider. This exception does not apply to Preventive care and wellness benefits.
Obesity (bariatric) surgery
- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the Eligible health services under your plan – Preventive care and wellness section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
  - Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Organ removal
- Services and supplies given by a provider to remove an organ from your body for the purpose of donating or selling the organ except as described in the Eligible health services under your plan section. This does not apply if you are donating the organ to a spouse, domestic partner, civil union partner, child, brother, sister, or parent.

Oral and maxillofacial treatment (mouth, jaws and teeth)
Dental implants

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

Outpatient infusion therapy
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan

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

Outpatient surgery
- A stay in a hospital (Hospital stays are covered in the Eligible health services under your plan – Hospital and other facility care section)
- A separate facility charge for surgery performed in a physician’s office
- Services of another physician for the administration of a local anesthetic
Pediatric dental care

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the Eligible health services under your plan section. Facings on molar crowns and pontics will always be considered cosmetic.
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material or
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary) mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and cranio mandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the Eligible health services under your plan – Specific conditions section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in the Eligible health services under your plan – Pediatric dental care section
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the Eligible health services under your plan — Pediatric dental care section
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party
Preventive care and wellness

- Services for diagnosis or treatment of a suspected or identified illness or injury
- Exams given during your stay for medical care
- Services not given by or under a physician's direction
- Psychiatric, psychological, personality or emotional testing or exams
- Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods or devices
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Female voluntary sterilization procedures that were not billed separately by the provider or were not the primary purpose of a confinement

Prosthetic devices

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft
- Communication aids

Riot

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

Routine exams

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

Services provided by a family member

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

Sexual dysfunction and enhancement

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

Sinus surgery

- Any services or supplies given by providers for sinus surgery except for acute purulent sinusitis
Sleep apnea
- Any services or supplies given by providers for the treatment of obstructive sleep apnea and sleep disorders

Specialty prescription drugs
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug benefit

Sports
- Any services or supplies given by providers as a result from play or practice of collegiate or intercollegiate sports, not including club sports and intramurals

Strength and performance
- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

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

Telemedicine
- Services given when you are not present at the same time as the provider
- Services including:
  - Telephone calls for behavioral health services
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Temporomandibular joint dysfunction treatment (TMJ) and craniomandibular joint dysfunction treatment (CMJ)
- Dental implants

Therapies and tests
- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

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

**Transplant services**
- Services and supplies furnished to a donor when the recipient is not a *covered person*
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing *illness*
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing *illness*
- Travel and lodging expenses

**Treatment in a federal, state, or governmental entity**
- Any care in a *hospital* or other facility owned or operated by any federal, state or other governmental entity, unless a proper claim is submitted by the hospital or other facility and such benefits have not already been paid directly to you prior to Aetna’s receipt of a proper claim from the hospital or facility

**Treatment of infertility**
- Injectable *infertility* medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father
  - Cryopreservation of eggs, embryos or sperm
  - Storage of eggs, embryos, or sperm
  - Thawing of cryopreserved eggs, embryos or sperm
  - The care of the donor in a donor egg cycle which includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which the person is not genetically related
  - Obtaining sperm for ART services from males who are not covered under this plan
- Home ovulation prediction kits or home pregnancy tests
- The purchase of donor embryos, donor oocytes, or donor sperm
- Reversal of voluntary sterilizations, including follow-up care
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)
Vision Care
Pediatric vision care services and supplies
• Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Adult vision care
• Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
• Eyeglass frames, prescription lenses and prescription contact lenses that are not identified as preferred by a vision in-network provider
• Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

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

Wilderness Treatment Programs
• See Educational services within this section

Work related illness or injuries
• Coverage available to you under worker’s compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
• A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers’ compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered “non-occupational” regardless of cause.
Exceptions and exclusions that apply to outpatient prescription drugs

Abortion drugs

Any services related to the dispensing, injection or application of a drug

Biological sera

Compounded prescriptions
- Compound prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones

Cosmetic drugs
- Medications or preparations used for cosmetic purposes

Devices, products and appliances, except those that are specially covered

Dietary supplements including medical foods

Drugs or medications
- Administered or entirely consumed at the time and place it is prescribed or dispensed
- Which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs section
- That is therapeutically equivalent or therapeutically alternative to a covered prescription drug (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved)
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan while an inpatient of a healthcare facility
- Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by Aetna's Pharmacy and Therapeutics Committee
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the share or appearance of a sex organ
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies

Duplicative drug therapy (e.g. two antihistamine drugs)

Genetic care
- Any treatment, device, drug, service or supply to alter the body’s genes, genetic make-up, or the expression of the body’s genes except for the correction of congenital birth defects

Immunizations related to work

Immunization agents
Implantable drugs and associated devices except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs section.

Infertility
- Injectable prescription drugs used primarily for the treatment of infertility

Injectables
- Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us.
- Needles and syringes, except for those used for self-administration of an injectable drug.
- Any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as specifically provided in the Eligible health services under your plan – Diabetic services and supplies (including equipment and training) section

Prescription drugs:
- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this rider.
- Dispensed by a mail order pharmacy that include prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the preferred drug guide.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not medically necessary, or otherwise improper, and drugs obtained for use by anyone other than the person identified on the ID card.

Refills
- Refills dispensed more than one year from the date the latest prescription order was written

Replacement of lost or stolen prescriptions

Test agents except diabetic test agents

Tobacco cessation
- Tobacco cessation products unless recommended by the United States Preventive Services Task Force (USPSTF)
Who provides the care

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

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

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

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

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

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

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

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

You may have to find a new **provider** when:
- You join the plan and the **provider** you have now is not in the network
- You are already covered under another Aetna plan and your **provider** stops being in our network if your provider stops being in our network, we will notify you in writing 30 working days before this happens.

However, in some cases such as disability, pregnancy or life-threatening illnesses, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called **continuity of care**.

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

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

We will authorize coverage for the transitional period only if the **provider** agrees to our usual terms and conditions for contracting **providers**.
What the plan pays and what you pay

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

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

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

The general rule
When you get eligible health services:

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

    And then

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

    And then

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

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

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

Important exceptions – when you pay all
You pay the entire expense for an eligible health service:

- When you get a health care service or supply that is not medically necessary. See the Medical necessity, precertification requirements section.

- When your plan requires precertification, your physician requested it, we refused it, and you get an eligible health service without precertification. See the Medical necessity, and precertification requirements section.

In all these cases, the provider may require you to pay the entire charge. Any amount you pay will not count towards your policy year deductible or towards your maximum out-of-pocket limit.
Special financial responsibility
You are responsible for the entire expense of:
- Cancelled or missed appointments

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit a claim</td>
<td>• You should notify and request a claim form from the <strong>policyholder</strong>. If you do not receive a</td>
<td>• Within 90 days of your request.</td>
</tr>
<tr>
<td></td>
<td>claim form from <strong>Aetna</strong> within 15 days you will be considered to have complied with the</td>
<td>• We won’t void or reduce your claim if you can’t send us notice and proof of loss within the</td>
</tr>
<tr>
<td></td>
<td>requirements for submitting a proof of loss</td>
<td>required time.</td>
</tr>
<tr>
<td></td>
<td>• The claim form will provide instructions on how to complete and where to send the form(s).</td>
<td>• If you are unable to complete a claim form, you may send us:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A description of services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bill of charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Any medical documentation you received from your provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If you are unable to complete a claim form, you may send us:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A description of services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bill of charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Any medical documentation you received from your provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If you are unable to complete a claim form, you may send us:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A description of services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bill of charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Any medical documentation you received from your provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• You must send us notice and proof as soon as reasonably possible.</td>
</tr>
<tr>
<td>Proof of loss (claim)</td>
<td>• A completed claim form and any additional information required by us.</td>
<td>• Benefits will be paid within 30 processing days after receipt of a filed claim, or as soon as</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the necessary proof to support the claim is received</td>
</tr>
<tr>
<td>Benefit payment</td>
<td>• Written proof must be provided for all benefits.</td>
<td>• Processing days are the number of days that the claim is in our possession. This does not</td>
</tr>
<tr>
<td></td>
<td>• If we challenge any portion of a claim, the unchallenged portion of the claim will be paid</td>
<td>include days while we are waiting for additional information from the <strong>provider</strong>.</td>
</tr>
<tr>
<td></td>
<td>promptly after the receipt of proof of loss.</td>
<td></td>
</tr>
</tbody>
</table>
Types of claims and communicating our claim decisions
You or your provider is required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the provider or to you as appropriate.

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim/Emergency care claim
An urgent claim is one for which the physician treating you decides that a delay in getting medical care, could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. However, the condition is not so severe as to require emergency services. Precertification is not required for emergency medical conditions.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby, but emergency services are not required.

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

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

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

Concurrent care claim reduction or termination
During a concurrent care claim review, we may extend the length of your coverage. This occurs when you ask us to approve more services than we already have approved. Examples are extending a hospital stay or adding a number of visits to a provider.

If we deny your request for a concurrent care claim extension, we will notify you of such a determination. You will have enough time to file a grievance of an adverse benefit determination. Your coverage for the service or supply will continue until you receive a final grievance decision from us or an external review organization, if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as copayments, coinsurance and deductibles that apply to the service or supply. If we uphold our decision at the final internal grievance, you will be responsible for all of the expenses for the service or supply received during the continuation period.

Note that if we have precertified eligible health services under this plan, we will not change our decision, except if you have intentionally misrepresented your health condition or if your coverage ends before the eligible health services are provided.

Timely Access to Review
A toll-free telephone number is listed on the back of your member ID card, if you or your provider need to contact Aetna’s review staff.
The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision. Where state regulations are stricter than federal regulations, we will abide by state regulations.

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

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Urgent care claim</th>
<th>Pre-service claim</th>
<th>Post-service claim</th>
<th>Concurrent care claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial determination (us)</td>
<td>72 hours for prospective urgent/emergent request</td>
<td>36 hours, which shall include one working day, of obtaining all necessary information</td>
<td>30 calendar days</td>
<td>24 hours for urgent request* Or an adverse decision</td>
</tr>
<tr>
<td></td>
<td>60 minutes for precertification of for immediate post-evaluation or post-stabilization services. The precertification will be deemed approved if a decision is not made within 30 minutes</td>
<td></td>
<td></td>
<td>1 working day for non-urgent request or approval</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15 calendar days for non-urgent request</td>
</tr>
<tr>
<td>Extensions</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Additional information request (us)</td>
<td>72 hours</td>
<td>15 calendar days</td>
<td>30 calendar days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Response to additional information request (you)</td>
<td>48 hours</td>
<td>45 days</td>
<td>45 days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Written or electronic confirmation to you and your provider</td>
<td>1 working day for an adverse decision</td>
<td>1 working day for an adverse decision</td>
<td>10 working days</td>
<td>1 working day</td>
</tr>
<tr>
<td></td>
<td>2 working days for approval</td>
<td>2 working days for approval</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*We have to receive the request at least 24 hours before the previously approved health care services end.

Timeframes and requirements listed are based on state and federal regulations. Where state regulations are stricter than federal regulations, we will abide by state regulations.
Adverse benefit determinations
We pay many claims at the full rate negotiated charge with an in-network provider and the recognized charge with an out-of-network provider, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an “adverse benefit determination” or “adverse decision”. It is also an “adverse benefit determination” if:

- We rescind your coverage entirely
- We deny your request for:
  - A concurrent claim extension
  - An admission, or
  - A service or supply

because we determined it was not medically necessary or the service or supply was not an eligible health service

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

The difference between a complaint and a grievance

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

A Grievance
A grievance is a written complaint when you are dissatisfied about:

- Getting an appointment with a provider
- The quality of the service you received
- An adverse benefit determination or adverse decision
- Getting a claim paid or reimbursement for a payment you made
- Operational issues between you and the plan

You can write to Member Services if you are dissatisfied about:

- Getting an appointment with a provider
- The quality of the service you received, or
- Operational issues between you and the plan

Your grievance should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know in writing within 10 working days that we received your grievance. We will then review your grievance and provide you with a written response within 20 working days of receiving the grievance. We will let you know if we need more information to make a decision and will complete our investigation within 30 working days after we receive all the information we need.
Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your grievance to someone who was not involved in making the original decision. You must file a grievance within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You or your authorized representative can send your written grievance appeal to the address on the notice of adverse benefit determination or by calling Member Services at the toll-free number on your ID card or in the How to contact us for help section. For a written appeal, you need to include:

- Your name
- The policyholder's name
- A copy of the adverse benefit determination
- Your reasons for the grievance
- Any other information you would like us to consider

We will let you know within 10 working days that we received your grievance.

If your adverse benefit determination was based on a medical judgment, we will consult with a health professional who is knowledgeable about your medical condition and who was not involved in making the original decision. The health professional will be a clinical peer of the same or similar specialty in the field of medicine involved in the medical judgment. This individual will be someone who was not involved in the initial decision and who is not the subordinate of the person who made the initial decision.

We will make a determination on your grievance within the timeframes listed in the chart below. We will tell you in writing about our decision and explain this decision in terms that are clear and specific. In addition, we will inform you of your right to submit a second grievance.

If you are unhappy with our decision, you may at any time contact the Missouri Department of Insurance, at:

Missouri Department of Insurance,
Financial Institutions and Professional Registration
Consumer Services Section
P. O. Box 690
Jefferson City, Missouri 65102-0690
Consumer Hotline: 800-726-7390

Urgent care/Emergency care claim or pre-service claim grievances

If your claim is an urgent/emergency care claim or a pre-service claim, your provider may send us a grievance on your behalf.

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

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

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Urgent care claim</th>
<th>Pre-service claim</th>
<th>Post-service claim</th>
<th>Concurrent care claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal determinations at each level (us)</td>
<td>48 hours</td>
<td>20 working days*</td>
<td>20 working days*</td>
<td>As appropriate to type of claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or 5 days after</td>
<td>or 5 days after</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>our investigation</td>
<td>our investigation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>is complete, or</td>
<td>is complete, or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>within 30</td>
<td>within 60</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>calendar days of</td>
<td>calendar days of</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>receipt of</td>
<td>receipt of</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>grievance</td>
<td>grievance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(whichever is</td>
<td>(whichever is</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>earlier).</td>
<td>earlier).</td>
<td></td>
</tr>
<tr>
<td>Extensions</td>
<td>None</td>
<td>30 working days</td>
<td>30 working days</td>
<td></td>
</tr>
</tbody>
</table>

*If we cannot make a decision within the timeframe listed, we will send you a letter telling you why. We will however make a decision within 30 calendar days thereafter.

External review

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

You or your authorized representative may request an external review if:

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

You do not have to exhaust the Plan's internal grievance process before you can request an external review. If you wish to pursue an external review, you may write to:

The Missouri Department of Insurance,
Financial Institutions and Professional Registration
Consumer Services Section
P. O. Box 690
Jefferson City, Missouri 65102-0690

And include any information or documentation to support your request. If you have any questions or concerns during the external review process, you can call the Missouri Department of Insurance, Financial Institutions and Professional Registration Consumer Hotline at 800-726-7390.
You will pay for any information that you send and want reviewed by the ERO. We will pay for information we send to the ERO plus the cost of the review.

The Missouri Department of Insurance (“Department”) will first review your grievance as any other consumer complaint; however, if the grievance remains unresolved after exhausting the Department’s consumer complaint process, then the Department will contact a state-qualified External Review Organization (ERO) that will conduct the review of your claim.

The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Notify the Department of its opinion with 20 calendar days

The ERO may request additional time for its investigation, but not exceeding 5 calendar days.

The Department will tell you in writing of its decision within 25 calendar days of receiving the IRO’s opinion. At no time will the external review decision be longer than 45 calendar days of the date the ERO received your request for an external review and all the necessary information. We will stand by the decision that the Department makes.

**How long will it take to get an ERO decision?**
The Missouri Department of Insurance (“Department”) will tell you of the ERO’s decision not more than 45 calendar days after the ERO received your request for an external review and all the necessary information.

But sometimes you can get a faster external review decision. Your provider must call us or send the Missouri Department of Insurance a request for an expedited external review. The Department will choose an ERO that will conduct the expedited external review and inform the Department of its opinion within 72 hours.

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

**For initial adverse determinations**
Your provider tells us that a delay in your receiving health care services would:
- Jeopardize your life, health or ability to regain maximum function or
- Be much less effective if not started right away (in the case of experimental or investigational treatment)

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

If your situation qualifies for this faster review, you will receive a verbal decision within 72 hours of the Department getting your request. The Department will send you written confirmation of its decision by mail or electronic media within 48 hours after a verbal notification.
Recordkeeping
We will keep the records of all complaints and grievance for at least 10 years.

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

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

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

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

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

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

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

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

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

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

**COB rules for dependent children**

<table>
<thead>
<tr>
<th>Child of:</th>
<th>Primary plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Parents who are married or living together</td>
<td>The “birthday rule” applies.</td>
<td>The plan of the parent born later in the year (month and day only)*.</td>
</tr>
<tr>
<td></td>
<td>The plan of the parent whose birthday* (month and day only) falls earlier in the <strong>calendar year</strong>.</td>
<td>*Same birthdays--the plan that has covered a parent longer is primary.</td>
</tr>
<tr>
<td></td>
<td>*Same birthdays--the plan that has covered a parent longer is primary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan of the parent whom the court said is responsible for health coverage.</td>
<td>The plan of the other parent.</td>
</tr>
<tr>
<td></td>
<td>But if that parent has no coverage then their spouse’s plan is primary.</td>
<td>But if that parent has no coverage, then their spouse’s plan is primary.</td>
</tr>
<tr>
<td>Child of:</td>
<td>Primary and secondary coverage is based on the birthday rule.</td>
<td></td>
</tr>
<tr>
<td>• Parents separated or divorced or not living together</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• With court-order</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child of:</td>
<td>The order of benefit payments is:</td>
<td></td>
</tr>
<tr>
<td>• Parents separated or divorced or not living together and there is no court-order</td>
<td>• The plan of the custodial parent pays first</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The plan of the spouse of the custodial parent (if any) pays second</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The plan of the noncustodial parents pays next</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The plan of the spouse of the noncustodial parent (if any) pays last</td>
<td></td>
</tr>
<tr>
<td>Child covered by:</td>
<td>Treat the person the same as a parent when making the order of benefits determination:</td>
<td></td>
</tr>
<tr>
<td>• Individual who is not a parent (i.e. stepparent or grandparent)</td>
<td>See <em>Child of</em> content above.</td>
<td></td>
</tr>
<tr>
<td>Longer or shorter length of coverage</td>
<td>If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.</td>
<td></td>
</tr>
<tr>
<td>Other rules do not apply</td>
<td>If none of the above rules apply, the plans share expenses equally.</td>
<td></td>
</tr>
</tbody>
</table>
### How are benefits paid?

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

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

### How COB works with Medicare

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

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

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

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

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

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

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

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

This plan is secondary to Medicare in all other circumstances.

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

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

### Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly:

- **Online:** Log on to your Aetna secure member website at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com). Select Find a Form, then select Your Other Health Plans.
- **By phone:** Call Member Services at the toll-free number on your ID card or in the How to contact us for help section.

### Right to receive and release needed information

We have the right to release or obtain any information we need for COBpurposes. That includes information we need to recover any payments from your other health plans.
Right to pay another carrier
Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery
If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid or
- Any other plan that is responsible under these COB rules
When coverage ends

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

When your coverage ends under this student policy, you can purchase a similar health plan through a guaranteed issue individual policy either:

- Through the Health Exchange Marketplace or
- Directly from an insurance carrier

When will your coverage end?

Your coverage under this plan will end on the date of the first to occur:

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

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

When will your continuation of coverage plan end?

Your coverage and your dependent’s coverage under the continuation of coverage plan will end:

- The continuation of coverage plan is discontinued
- The student policy ends
- You are no longer eligible for coverage
- The last day for which any required premium contribution has been paid
- The date at the end of your elected period of continued coverage
- The date you are no longer in an eligible class
- The date a dependent is no longer in an eligible class
- We end your coverage

If your continuation of coverage plan ends because you withdraw from school for reasons other than entering the armed forces, we will not refund your premium contributions. You are covered for your elected time period and the premium contribution that you paid.

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

See the Continuation of coverage for other reasons section to learn how you can extend your coverage.
When will coverage end for any dependents?
Coverage for your dependent will end if:
- For a dependent child, on the first premium due date following the child’s 26th birthday.
- Your dependent is no longer eligible for coverage.
- The date dependents are no longer an eligible class.
- You do not make the required premium contribution toward the cost of dependents’ coverage.
- Your coverage ends for any of the reasons listed above.
- For your spouse, the date the marriage ends in divorce or annulment.
- They are covered under a continuation of coverage plan and it ends. Coverage for dependents ends on the date the continuation of coverage plan ends.

In addition, coverage for your domestic partner or civil union partner will end on the earlier of:
- The date the domestic partnership or civil union ends. For domestic partnerships, you should provide the policyholder a completed and signed Declaration of Termination of Domestic Partnership.

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

Why would we suspend paying claims or end your and your dependents’ coverage?
We will give you 31 days advance written notice if we suspend paying your claims because:
- You or your dependent do not cooperate or give facts that we need to administer the COB provisions.
In addition, we will give you written notice (or such longer notice period as applicable law requires):
  - 90 days if we cease to offer the product line provided by this policy
  - 180 days written notice (or such longer notice period as applicable law requires,) if we act as required by applicable law for uniform termination of coverage

We cannot terminate this policy prior to the first anniversary date except for nonpayment of the required premium or the failure to meet continued underwriting standards.

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

On the date your coverage ends, we will refund to the policyholder any prepayments for periods after the date your coverage ended.
Special coverage options after your plan coverage ends

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

Continuation of coverage plan
If your or your dependent’s coverage under the student policy will end, you can elect to continue coverage under the student policy if:

- You lose eligibility because you are graduating
- You lose eligibility due to another reason or
- Coverage ends for another reason (except fraud or you intentionally misrepresented material facts), and you are receiving treatment for a medical condition under the student policy on the date coverage is to end

See the When you can join the plan section to learn how to enroll in a continuation of coverage plan.

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

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

You are “totally disabled”, because of an illness or injury, if you cannot work at your own occupation for a period of at least 12 months, unless the total benefit period is less than 12 months. After the initial benefit period, you are “totally disabled” if you cannot work at any other occupation, for which you are qualified by education, training or experience.

Your dependent is “totally disabled” if that person cannot engage in most normal activities of a healthy person of the same age and gender.

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:

- When you or your dependents are no longer totally disabled
- When you become covered by another health benefits plan or
- 12 months of coverage

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

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly on you for support and maintenance

Coverage will continue only as long as your child still is disabled and your coverage under the student policy remains in effect.

About 31 days, or as available before your child reaches the plan age limit, we may ask you to send us proof of the disability. You do not have to send us the proof of the disability until 31 days after the date your child reaches the plan age limits. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.
We may ask you to send proof that your child is disabled and depends on you for support and maintenance after coverage is extended. We may only ask for proof at reasonable intervals during the first two years after your child reaches the plan’s age limit. After that, we won’t ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don’t, we can terminate coverage for your dependent child.

Your disabled child’s coverage will end:
- On the date the child is no longer disabled and dependent upon you for support or
- As explained in the When will coverage end for any dependents section
- Failure to give proof that the disability continues

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

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

To request extension of coverage, the dependent or their representative can just call Member Services at the toll-free number on your ID card or in the How to contact us for help section.
General provisions – other things you should know

Entire student policy
The student policy consists of several documents taken together. These documents are:

- The policyholder’s application
- Your enrollment form, if the policyholder requires one
- The student policy
- The certificate(s) of coverage
- The schedule of benefits
- Any riders, endorsement, inserts, attachments, and amendments to the student policy, the certificate of coverage, and the schedule of benefits

Administrative provisions

How you and we will interpret this certificate of coverage
We prepared this certificate of coverage according to federal laws and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this certificate of coverage when we administer your coverage, so long as we use reasonable authority.

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

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

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

Coverage and services

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

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

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

If your dependent status changes the amount of your dependent coverage or benefit levels, the change will take effect on the date of the status change and the amount of coverage or benefit level will be changed to the new amount.
Coordination of care
If you would prefer to have your care coordinated by your physician or school health services, they should contact your physician or school health services who will coordinate your care and direct you to a in-network provider, or out-of-network care provider for medically necessary services or supplies. If you receive eligible health services without contacting your physician or School Health Services, they will not be subject to any penalties and the claims for those eligible health services will be processed according to their applicable in-network provider, or out-of-network provider benefit level. Note that you have full freedom of choice in the selection of any duly licensed health care professional. Coordination of care is not needed for emergency services, or to receive obstetrical and gynecological care from a network provider and mental health and substance abuse services from a network provider.

Special Missouri notice
If you are a member of a group health plan with coverage for elective abortions you have the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to your moral, ethical or religious beliefs.

Your group contract holder has not purchased an optional rider for elective abortions pursuant to §376.805 R.S.Mo.

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

We will try hard to get you access to the services you need even if these things happen. But if we can’t, we may refund you or the policyholder any unearned premium.

Legal action
You are encouraged to complete the grievance process before you take any legal action against us for any expense or bill. See the When you disagree - claim decisions and appeals procedures section. You cannot take any action until 60 days after we receive written submission of claim or later than 3 years after the deadline for filing the claim.

Physical examinations and evaluations
At our expense, we have the right to have a physician of our choice examine you. This will be done so often as it may reasonably require during the pending of a claim for benefits.

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

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

Honest mistakes
You or the policyholder may make an honest mistake when you share facts with us. Except for fraud, all statements made by you are considered representations and not warranties. No statement will void this policy or reduce the benefits after the coverage has been in force for 2 years from its effective date, unless the statement was in a written application or enrollment form signed by you, and you received a copy of the application or enrollment form.

If you or the policyholder make a mistake about your age, we may make a fair change in premium contribution when we learn of this mistake. If we do, we will tell you what the mistake was. We won’t make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception
If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage as follows:

- We will give you 30 days advanced written notice of any rescission of coverage
- You have the right submit a grievance to Aetna
- You have the right to a third party review conducted by an independent external review organization

Some other money issues

We will pay for claims submitted by a public (government operated) hospital or clinic for eligible health services without assignment, as long as you have not already received payment of such benefits prior to us receiving the claim.

Grace period
You will be allowed a grace period of 31 days after the due date for the payment of each contribution due after the first contribution payment. The policy will remain in force during the grace period. If contributions are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period.

Payment of premiums
The first premium payment for this policy is due on or before your effective date of coverage. Your next premium payment will be due the 1st of each month (“premium due date”). Each premium payment is to be paid to us on or before the premium due date.
Recovery of overpayments
We sometimes pay too much for eligible health services or pay for something that this plan doesn’t cover. If we do, we can require the person we paid – you or your provider – to return what we paid. If we don’t do that we have the right to reduce any future benefit payments by the amount we paid by mistake. We will not, however, request a refund or offset against a claim more than 12 months after paying the claim, except in cases of fraud or intentional misrepresentation by the provider.

Worker’s Compensation
If benefits are paid by Aetna and Aetna determines you received Worker’s Compensation benefits for the same incident, Aetna has the right to recover as described under the Right of Recovery provision. Aetna will exercise its right to recover against you.

The Recovery Rights will be applied even though:

- The Worker’s Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily injury or illness was sustained in the course of or resulted from your employment;
- The amount of Worker’s Compensation due to medical or health care is not agreed upon or defined by you or the Worker’s Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Worker’s Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this policy, you will notify Aetna of any Worker’s Compensation claim you make, and that you agree to reimburse Aetna as described above.

If benefits are paid under this policy and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, Aetna has a right to recover from you or your covered dependent an amount equal to the amount Aetna paid.

Your health information
We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your providers’ claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call Member Services at the toll-free number on your ID card or in the How to contact us for help section.

When you accept coverage under this plan, you agree to let your providers share information with us. We need information about your physical and mental condition and care.

Effect of benefits under other plans
Effect of a Health Maintenance Organization plan (an HMO Plan) or a Preferred Provider Organization plan (PPO plan) on coverage

If you have coverage under another group medical plan (such as an HMO or PPO plan) and that other plan denies coverage of benefits because you received the services or supplies outside of the plan’s network geographic area, this student plan will cover those denied benefits as long as they are covered benefits under this plan. Covered benefits will be paid at the applicable level of benefits under the student plan.
**Glossary A-M**

**Accident or accidental**
An injury to you that is not planned or anticipated. An illness does not cause or contribute to an accident.

**Advanced practice registered nurse (APRN)**
A nurse who has education beyond the basic nursing education and is certified by a nationally recognized professional organization as a certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or a certified clinical nurse specialist.

**Aetna**
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with Aetna.

**Ambulance**
A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

**Behavioral health provider**
An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for mental disorders and substance abuse under the laws of the jurisdiction where the individual practices.

**Brand-name prescription drug**
A U.S. Food and Drug Administration (FDA) approved prescription drug marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

**Calendar year**
A period of 12 months beginning January 1st and ending on December 31st.

**Clinical related injury**
As used within the Blood and body fluid exposure covered benefit, this is any incident which exposes you, acting as a student in a clinical capacity, to an illness that requires testing and treatment. Incident means unintended:
- Needlestick pricks
- Exposure to blood and body fluid
- Exposure to highly contagious pathogens

**Coinsurance**
Coinsurance is both the percentage of eligible health services that the plan pays and what you pay. The specific percentage that we have to pay for eligible health services is listed in the schedule of benefits.

**Copayments**
The specific dollar amount or percentage you have to pay for a health care service listed in the schedule of benefits.

**Cosmetic**
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.
Covered benefits
Eligible health services that meet the requirements for coverage under the terms of this plan, including:

- They are medically necessary
- You received precertification

Covered dependent
A person who is insured under the student policy as a dependent of a covered student.

Covered person
A covered student or a covered dependent of a covered student for whom all of the following applies:

- The person is eligible for coverage as defined in the certificate of coverage
- The person has enrolled for coverage and paid any required premium contribution
- The person’s coverage has not ended

Covered student
A student who is insured under the student policy.

Craniomandibular joint dysfunction (CMJ)
This is a disorder of the jaw joint.

Custodial care
Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be custodial care even if it prescribed by a physician or given by trained medical personnel.

Dental emergency
Any dental condition that:

- Occurs unexpectedly
- Requires immediate diagnosis and treatment in order to stabilize the condition, and
- Is characterized by symptoms such as severe pain and bleeding

Dental emergency services
Services and supplies given by a dental provider to treat a dental emergency.

Dental provider
Any individual legally qualified to provide dental services or supplies. This may be any of the following:

- Any dentist
- Group
- Organization
- Dental facility
- Other institution or person

Dentist(s)
A legally qualified dentist licensed to do the dental work he or she performs.
**Detoxification**
The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This can be done by metabolic or other means as determined by a **physician** or a nurse practitioner working within the scope of their licenses. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

**Directory**
The list of **in-network providers** for your plan. The most up-to-date directory for your plan appears at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) under the DocFind® label. When searching DocFind®, you need to make sure that you are searching for **providers** that participate in your specific plan. **In-network providers** may only be considered for certain Aetna plans. When searching for **in-network** dental providers, you need to make sure you are searching under Pediatric Dental plan.

**Durable medical equipment (DME)**
Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an **illness** or **injury**
- Suited for use in the home
- Not normally used by people who do not have an **illness** or **injury**
- Not for altering air quality or temperature
- Not for exercise or training

**Effective date of coverage**
The date your and your dependent's coverage begins under this certificate of coverage as noted in Aetna's records.

**Elective treatment**
Services and supplies provided to you when there is no evidence of pathology, dysfunction, or **illness** in any part of your body. Examples of elective treatment are:

- Breast reduction
- Sub mucous resection and/or other surgical correction for deviated nasal septum, other than for the treatment of a covered medical condition

**Eligible health services**
The health care services and supplies and outpatient **prescription drugs** listed in the Eligible health services under your plan section and not carved out or limited in the Exceptions section of this certificate of coverage or in the schedule of benefits.

**Emergency admission**
An admission to a hospital or treatment facility ordered by a **physician** within 24 hours after you receive emergency services.
Emergency medical condition
A recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, illness, or injury is of a severe nature. And that if you don’t get immediate medical care it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus
- Inadequately controlled pain or
- Endangering the health or safety of a woman in labor or her unborn child if transfer is attempted, or there is not enough time to transfer to another hospital before delivery

Emergency services
Treatment given in an ambulance and a hospital’s emergency room for an emergency medical condition. This includes evaluation of, and treatment to stabilize an emergency medical condition.

Experimental or investigational
A drug, device, procedure, or treatment that we find is experimental or investigational because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility provider state that it is experimental or investigational.

Formulary exclusions list
A list of prescription drugs not covered under the plan. This list is subject to change.

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

Health professional
A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, physicians, nurses, dental providers, vision care providers, and physical therapists.

Home health aide
A health professional that provides services through a home health care agency. The services that they provide are not required to be performed by an RN, LPN, or LVN. A home health aide primarily aids you in performing the normal activities of daily living while you recover from an injury or illness.
**Home health care agency**
An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

**Home health care plan**
A plan of services prescribed by a [physician](#) (or other [health professional](#)) to be provided in the home setting. These services are usually provided after your discharge from a [hospital](#) or if you are [homebound](#).

**Homebound**
This means that you are confined to your home because:
- Your [physician](#) has ordered that you stay at home because of an [illness](#) or [injury](#)
- The act of transport would be a serious risk to your life or health

You are not homebound if:
- You do not often travel from home because you are feeble or insecure about leaving your home
- You are confined to a wheelchair but you can be transported by a vehicle that can safely transport you in a wheelchair

**Hospice benefit period**
A period that begins on the date your [physician](#) certifies that you have a [terminal illness](#). It ends after 6 months (or later for which your treatment is certified) or on your death; if sooner.

**Hospice care**
Care designed to give supportive care to people in the final phase of a [terminal illness](#) and focus on comfort and quality of life, rather than cure.

**Hospice care agency**
An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care. These services may be available in your home or inpatient setting.

**Hospice care program**
A program prescribed by a [physician](#) or other [health professional](#) to provide hospice care and supportive care to their families.

**Hospice facility**
An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care.
Hospital
An institution licensed or otherwise authorized as a hospital by applicable state and federal laws, that:
- Provides, on its premises, inpatient medical, surgical and diagnostic services for the care and treatment of sick and injured persons
Is supervised by a staff of one (1) or more physicians
- Provides twenty-four (24) hour-a-day R.N. service

Hospital does not include a:
- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- Psychiatric hospital
- Residential treatment facility for substance abuse
- Residential treatment facility for mental disorders
- Extended care facility
- Intermediate care facility
- Skilled nursing facility

Hospital stay
This is your stay of 18 or more hours in a row as a resident bed patient in a hospital.

Illness or illnesses
Poor health resulting from disease of the body or mind.

In-network dental provider
A dental provider listed in the directory for your plan.

In-network pharmacy
A retail pharmacy, mail order pharmacy or specialty pharmacy that has contracted with Aetna, an affiliate, or a third party vendor, to provide outpatient prescription drugs to you.

In-network provider
A provider listed in the directory for your plan. However, a NAP provider listed in the NAP directory is not an in-network provider.

Infertile or infertility
A disease defined by the failure to become pregnant:
- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart
Injectable drug(s)
These are prescription drugs when an oral alternative drug is not available.

Injury or injuries
Physical damage done to a person or part of their body.

Institutes of excellence™ (IOE) facility
A facility designated by Aetna in the provider directory as Institutes of Excellence in-network provider for specific services or procedures.

Intensive care unit
A hospital unit permanently equipped and staffed to provide care that is more extensive for critically ill or injured patients than available in other hospital rooms or wards. Care includes close observation by trained and qualified personnel whose duties are primarily confined to the part of the hospital for which an additional charge is made.

Intensive outpatient program (IOP)
The clinical treatment provided must be:
- No more than 5 days per week
- No more than 19 hours per week
- A minimum of 2 hours each treatment day

Services must be medically necessary and delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a mental disorder or substance abuse issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder
This is:
- A disorder of the jaw joint
- A Myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

L.P.N.
A licensed practical nurse or a licensed vocational nurse.

Lifetime maximum
This is the most this plan will pay for eligible health services incurred by a covered person during their lifetime. Lifetime maximums do not apply to essential health benefits as classified by the Accountable Care Act (ACA) unless permitted.

Mail order pharmacy
A pharmacy where prescription drugs are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit
The maximum out-of-pocket amount for payment of copayments and coinsurance including any policy year deductible, to be paid by you or any covered dependents per policy year for eligible health services.
Medically necessary/ Medical necessity
Health care services that we determine a provider exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness or injury, or its symptoms, and that we determine are:

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

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Consistent with the standards set forth in policy issues involving clinical judgment

Medicare
As used in this plan, Medicare means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

Mental disorder
A mental disorder is a condition or disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.
Glossary N-Z

**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.

We may enter into arrangements with in-network providers or others related to:

- The coordination of care for covered persons
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing

These arrangements will not change the negotiated charge under this plan.

*Prescription drug coverage from an in-network pharmacy*

**In-network pharmacy**

The amount we established for each prescription drug obtained from an in-network pharmacy under this plan. This negotiated charge may reflect amounts we agreed to pay directly to the in-network pharmacy or to a third party vendor for the prescription drug, and may include a rebate, an additional service or risk charge set by us.

We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may change the negotiated charge under this plan.

**Non-preferred drug**

A prescription drug or device that may have a higher out-of-pocket cost than a preferred drug.

**Out-of-network dental provider**

A dental provider who is not an in-network dental provider and does not appear in the directory for your plan.

**Out-of-network pharmacy**

A pharmacy that is not an in-network pharmacy, a National Advantage Program (NAP) provider and does not appear in the directory for your plan.

**Out-of-network provider**

A provider who is not an in-network provider or National Advantage Program (NAP) provider and does not appear in the directory for your plan.
Partial hospitalization treatment
Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. Services must be medically necessary and provided by a behavioral health provider with the appropriate license or credentials. Services are designed to address a mental disorder or substance abuse issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Care is delivered according to accepted medical practice for the condition of the person.

Pharmacy
An establishment where prescription drugs are legally dispensed. This includes an in-network retail pharmacy, mail order pharmacy and specialty pharmacy. It also includes an out-of-network retail pharmacy and mail order pharmacy.

Physician
A skilled health professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Policyholder
The school named on the front page of the student policy and your certificate of coverage and schedule of benefits for the purpose of coverage under the student policy.

Policy year
This is the period of time from anniversary date to anniversary date of the student policy except in the first year when it is the period of time from the effective date to the first anniversary date.

Policy year deductible
The amount you pay for eligible health services per policy year before your plan starts to pay as listed in the schedule of benefits.

Precertification, precertify
A requirement that you or your physician contact Aetna before you receive coverage for certain services. This may include a determination by us as to whether the service is medically necessary and eligible for coverage. A precertification review, also called a “Utilization Management Review”, is performed before we make a determination. This review is a formal evaluation (pre-service, concurrent or post-service) of the effectiveness, efficiency or appropriateness of the requested service or treatment.

This requirement does not apply to obstetrical and gynecological care from network provider. You may go directly to a network OB, GYN or OB/GYN.

Preferred drug
A prescription drug or device that may have a lower out-of-pocket cost than a non-preferred drug.
Preferred drug guide
A list of prescription drugs and devices established by Aetna or an affiliate. It does not include all prescription drugs and devices. This list can be reviewed and changed by Aetna or an affiliate. A copy of the preferred drug guide is available at your request. You can also find it on the Aetna website at www.aetnastudenthealth.com/formulary.

Preferred in-network pharmacy
A network retail pharmacy that Aetna has identified as a preferred in-network pharmacy.

Premium
The amount you or the policyholder are required to pay to Aetna to continue coverage.

Prescriber
Any provider acting within the scope of his or her license, who has the legal authority to write an order for outpatient prescription drugs.

Prescription
As to hearing care:
A written order for the dispensing of prescription electronic hearing aids by otolaryngologist, otologist or audiologist.

As to prescription drugs:
A written order for the dispensing of a prescription drug or device by a prescriber. If it is a verbal order, it must promptly be put in writing by the in-network pharmacy.

As to vision care:
A written order for the dispensing of prescription lenses or prescription contact lenses by an ophthalmologist or optometrist.

Prescription drug
An FDA approved drug or biological which can only be dispensed by prescription.

Provider(s)
A physician, other health professional, hospital, skilled nursing facility, home health care agency, pharmacy, or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric hospital
An institution specifically licensed as a psychiatric hospital by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of substance abuse and mental disorders.

Mental disorder includes related substance abuse disorders.

Psychiatrist
A psychiatrist generally provides evaluation and treatment of mental, emotional, or behavioral disorders.
Recognized charge

The amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The recognized charge depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the recognized charge for specific services or supplies:

<table>
<thead>
<tr>
<th>Service or supply</th>
<th>Recognized charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional services and other services or supplies not mentioned below</td>
<td>105% of the Medicare allowed rate</td>
</tr>
<tr>
<td>Services of hospitals and other facilities</td>
<td>140% of the Medicare allowed rate</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>100% of the average wholesale price (AWP)</td>
</tr>
<tr>
<td>Dental expenses</td>
<td>80% of the prevailing charge rate</td>
</tr>
<tr>
<td>Prescription drugs for gene-based, cellular and other innovative therapies (GCIT)</td>
<td>100% of the average wholesale price (AWP)</td>
</tr>
</tbody>
</table>

**Important note:** If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a prescription drug listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by Aetna).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other providers charge or accept as payment?
  - How much work it takes to perform a service?
  - Other things as needed to decide what rate is reasonable for a particular service or supply

When the recognized charge is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to providers under Medicare programs.

Our reimbursement policies

We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the recognized charge. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider
Our reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

**R.N.**
A registered nurse.

**Residential treatment facility (mental disorders)**
- An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by Aetna or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating mental disorders:

- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)

**Residential treatment facility (substance abuse)**
An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for substance abuse residential treatment programs. Or is credentialed by Aetna or accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for substance abuse residential treatment programs:

- A behavioral health provider or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a physician
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)
In addition to the above requirements, for **substance abuse detoxification** programs within a residential setting:
- An R.N. must be onsite 24 hours per day for 7 days a week within a residential setting
- Residential care must be provided under the direct supervision of a **physician**

**Respite care**
This is care provided to you when you have a **terminal illness** for the sole purpose of providing temporary relief to your family (or other care givers) from the daily demands of caring for you.

**Retail pharmacy**
A community **pharmacy** that dispenses outpatient **prescription drugs** at retail prices.

**Room and board**
A facility’s charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

**School health services**
Any:
- Organization
- Facility
- Clinic
- Pharmacy

that is operated, maintained, or supported by the **policyholder** (or other entity under contract to the **policyholder** which provides health care services to **covered students** and their **covered dependents**. **School health services** will either provide or coordinate the care provided to **covered students**.

**Semi-private room rate**
An institution’s **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, **Aetna** will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

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

**Skilled nursing facility**
A facility specifically licensed as a **skilled nursing facility** by applicable state and federal laws to provide skilled nursing care.

**Skilled nursing facilities** also include rehabilitation **hospitals**, and portions of a rehabilitation **hospital** and a **hospital** designated for skilled or rehabilitation therapy services.

**Skilled nursing facility** does not include institutions that provide only:
- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of **mental disorders** or **substance abuse**.
Skilled nursing services
Services provided by an R.N. or L.P.N. within the scope of his or her license.

Sound natural teeth
These are natural teeth. If there is a filling in a tooth, the major portion of the tooth must be present. A tooth cannot be decayed, abscessed, or defective. Sound natural teeth are not capped teeth, implants, crowns, bridges, or dentures.

Specialist
A physician who practices in any generally accepted medical or surgical sub-specialty and is board-certified.

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

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

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

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

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

Student policy
The student policy consists of several documents taken together. The list of documents can be found in the Entire student policy section of this certificate of coverage.

Substance abuse
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. This dependency is marked by drug tolerance or withdrawal and impairment of social and/or occupational functioning. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a mental disorder that are a focus of attention or treatment. Or an addiction to nicotine products, food or caffeine intoxication.

Surgery center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient surgery services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).
Surgery, surgeries or surgical procedures
The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution or
- Otherwise physically changing body tissues and organs

Telemedicine
A consultation between you and a provider who is performing a clinical medical or behavioral health service.

Services can be provided by:

- Two-way audiovisual teleconferencing
- Any other method required by state law

Temporomandibular joint dysfunction (TMJ)
This is a disorder of the jaw joint.

Terminal illness
A medical prognosis that you are not likely to live more than 12 months.

Urgent admission
This is an admission to the hospital due to an illness or injury that is severe enough to require a stay in a hospital within 2 weeks from the date the need for the stay becomes apparent.

Urgent care facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an urgent condition.

Urgent condition
An illness or injury that requires prompt medical attention but is not an emergency medical condition.

Utilization review
A formal evaluation (preservice, concurrent or postservice) of the effectiveness, efficiency or appropriateness of a requested service or treatment.
Walk-in clinic
A health care facility that provides limited medical care on a scheduled and unscheduled basis. A walk-in clinic may be located in, near, or within a:

- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a walk-in clinic:

- Ambulatory surgical center
- Emergency room
- Hospital
- Outpatient department of a hospital
- Physician’s office
- Urgent care facility
Discount programs

Wellness and Other Incentives

We may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services, and to continue your participation in the Aetna plan through incentives. You and your physician can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, including but not limited to financial wellness programs, we may provide incentives based on your participation.

Incentives may include but are not limited to:

- Modifications to copayment, coinsurance, or policy year deductible amounts
- Premium discounts or rebates
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards or
- Any combination of the above.

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon your health status.

The amounts of any such incentives are shown in the schedule of benefits.
**Assistive Technology**

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

**Smartphone or Tablet**

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

**Non-Discrimination**

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

Aetna:

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

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

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


**Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.**
<table>
<thead>
<tr>
<th>Language</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>To access language services at no cost to you, call the number on your ID card.</td>
</tr>
<tr>
<td>Spanish</td>
<td>Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.</td>
</tr>
<tr>
<td>Chinese Traditional</td>
<td>如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼</td>
</tr>
<tr>
<td>Arabic</td>
<td>للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.</td>
</tr>
<tr>
<td>French</td>
<td>Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.</td>
</tr>
<tr>
<td>French Creole (Haitian)</td>
<td>Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.</td>
</tr>
<tr>
<td>Albanian</td>
<td>Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit.</td>
</tr>
<tr>
<td>German</td>
<td>Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.</td>
</tr>
<tr>
<td>Italian</td>
<td>Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.</td>
</tr>
<tr>
<td>Japanese</td>
<td>無料の言語サービスは、IDカードにある番号にお電話ください。</td>
</tr>
<tr>
<td>Korean</td>
<td>무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.</td>
</tr>
<tr>
<td>Persian Farsi</td>
<td>برای دسترسی به خدمات زبان به طور رایگان، با شماره گذه شده روی کارت شناسایی خود تماس بگیرید.</td>
</tr>
<tr>
<td>Polish</td>
<td>Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.</td>
</tr>
<tr>
<td>Portuguese</td>
<td>Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.</td>
</tr>
<tr>
<td>Russian</td>
<td>Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.</td>
</tr>
<tr>
<td>Tagalog</td>
<td>Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.</td>
</tr>
</tbody>
</table>
This notice provides a brief summary of the Missouri Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Missouri law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Missouri law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are as follows:

- **Life Insurance**
  - $300,000 in death benefits
  - $100,000 in cash surrender and withdrawal values
- **Health Insurance**
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- **Annuities**
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance
- $5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Missouri law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mo-iga.org, or contact:
Insurance companies and agents are not allowed by Missouri law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Missouri law, then Missouri law will control.