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

Schedule of Benefits

Prepared exclusively for:

Policyholder: Nova Southeastern University - Final Year Students Main Campus
Policyholder number: 867897
Student policy effective date: 05/01/2020
Plan effective date: 05/01/2020
Plan issue date: 04/20/2020
Actuarial value and metallic level: 80.43% - Gold

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

*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.

- Call Member Services at the toll-free number on your ID card 1-855-821-9720.

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>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 |

Policy year deductible waiver

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

- In-network care for *Preventive care and wellness*
- In-network care for *Pediatric Preventive Dental Services*
- In-network and out-of-network care for *Prescribed Medicines Expense, Routine Mammograms, and Pediatric Preventive 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.*
<table>
<thead>
<tr>
<th>Maximum out-of-pocket limits</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$5,750 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.

**Referral penalty**

You must get a referral from school health services for off-campus care.

If you do not get a referral, then we won’t pay the provider

**Exceptions**

- Treatment for an emergency medical condition
- Obstetric and gynecological care
- Pediatric care
- The school health services is closed
- You are more than 25 miles from the school health services

The additional percentage or dollar amount which you may pay as a penalty for failure to obtain a referral is not a covered benefit, and will not be applied to a 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>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Covered persons through age 21: Maximum age and visit limits per policy year</td>
<td>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna secure website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or calling the toll-free number on your ID card. in the How to contact us for help section.</td>
<td></td>
</tr>
<tr>
<td>Covered persons age 22 &amp; over: Maximum visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive care immunizations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed in a facility or at a physician's office</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (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>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 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. in the How to contact us for help section.</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.*
## Well woman preventive visits

### Routine gynecological exams (including Pap smears)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Cost Sharing</th>
<th>Deductible Applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed at a physician’s, obstetrician (OB), gynecologist (GYN) or OB/GYN office</td>
<td>100% (of the negotiated charge) per visit</td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>50% (of the recognized charge) per visit</td>
<td></td>
</tr>
<tr>
<td>Maximums</td>
<td>Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
</tbody>
</table>

### Preventive screening and counseling services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Cost Sharing</th>
<th>Deductible Applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity and/or healthy diet counseling office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>50% (of the recognized charge) per visit</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*</td>
<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>Misuse of alcohol and/or drugs counseling office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>50% (of the recognized charge) per visit</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>5 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>Use of tobacco products counseling office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>50% (of the recognized charge) per visit</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>8 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>
</tbody>
</table>

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Cost Sharing Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression screening counseling office visits</td>
<td><strong>100% (of the negotiated charge) per visit</strong>&lt;br&gt;<strong>No copayment or policy year deductible applies</strong>&lt;br&gt;<strong>50% (of the recognized charge) per visit</strong></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td><strong>1 visit</strong></td>
</tr>
<tr>
<td><em>Note:</em> In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.</td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted infection counseling office visits</td>
<td><strong>100% (of the negotiated charge) per visit</strong>&lt;br&gt;<strong>No copayment or policy year deductible applies</strong>&lt;br&gt;<strong>50% (of the recognized charge) per visit</strong></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td><strong>2 visits</strong></td>
</tr>
<tr>
<td><em>Note:</em> In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.</td>
<td></td>
</tr>
<tr>
<td>Genetic risk counseling for breast and ovarian cancer office visits</td>
<td><strong>100% (of the negotiated charge) per visit</strong>&lt;br&gt;<strong>No copayment or policy year deductible applies</strong>&lt;br&gt;<strong>50% (of the recognized charge) per visit</strong></td>
</tr>
<tr>
<td>Age and frequency limitations</td>
<td><strong>Not subject to any age or frequency limitations</strong></td>
</tr>
<tr>
<td>Routine cancer screenings</td>
<td><strong>Performed at a physician’s office, specialist’s office or facility.</strong>&lt;br&gt;<strong>100% (of the negotiated charge) per visit</strong>&lt;br&gt;<strong>No copayment or policy year deductible applies</strong>&lt;br&gt;<strong>50% (of the recognized charge) per visit</strong></td>
</tr>
<tr>
<td>Maximums</td>
<td><strong>Subject to any age; family history; and frequency guidelines as set forth in the most current:</strong>&lt;br&gt;• 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&lt;br&gt;• The comprehensive guidelines supported by the Health Resources and Services Administration.</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage Details</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Lung cancer screening maximums</strong></td>
<td>1 screening every 12 months*</td>
</tr>
<tr>
<td><em>Important note:</em></td>
<td>Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <em>Outpatient diagnostic testing</em> section.</td>
</tr>
</tbody>
</table>

| **Prenatal care**                            |                                                                                  |
| Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN) |                                                                                  |
| Preventive care services only                | 100% (of the negotiated charge) per visit                                        |
|                                              | No copayment or policy year deductible applies                                   |
|                                              | 50% (of the recognized charge) per visit                                        |
| *Important note:*                            |                                                                                  |
| You should review the *Maternity care and Well newborn nursery care* sections. They will give you more information on coverage levels for maternity care under this plan. |

| **Comprehensive lactation support and counseling services** |                                                                                  |
| Lactation counseling services - facility or office visits | 100% (of the negotiated charge) per visit                                        |
|                                                          | No copayment or policy year deductible applies                                   |
|                                                          | 50% (of the recognized charge) per visit                                        |
| 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**         |                                                                                  |
| Breast pump supplies and accessories               | 100% (of the negotiated charge) per item                                        |
|                                                      | No copayment or policy year deductible applies                                |
|                                                      | 50% (of the recognized charge) per item                                       |
| *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 – female contraceptives

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Percentage of Negotiated Charge</th>
<th>Deductible Information</th>
<th>Copayment Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female contraceptive counseling services office visit</td>
<td>100%</td>
<td></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>
<td></td>
</tr>
<tr>
<td>Important note:</td>
<td></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>
<td></td>
</tr>
<tr>
<td>Contraceptives (prescription drugs and devices)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit</td>
<td>100%</td>
<td></td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td>Female voluntary sterilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient provider services</td>
<td>100%</td>
<td></td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td>Outpatient provider services</td>
<td>100%</td>
<td></td>
<td>No copayment or policy year deductible applies</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>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>$30 copayment per visit then the plan pays 70% (of the balance of the negotiated charge)</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Allergy testing and treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Allergy testing performed at a physician’s or specialist’s office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy injections treatment performed at a physician’s or specialist’s office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician and specialist – inpatient surgical services</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>70% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>70% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>70% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Physician and specialist – outpatient surgical services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery performed at a physician’s or specialist’s office or outpatient department of a hospital or surgery center by a surgeon</td>
<td>70% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>70% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>70% (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.*
### In-hospital non-surgical physician services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Cost Sharing 1</th>
<th>Cost Sharing 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-hospital non-surgical physician services</td>
<td>70% (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>Service Description</th>
<th>Cost Sharing 1</th>
<th>Cost Sharing 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant office visits</td>
<td>$30 copayment per visit then the plan pays 70% (of the balance of the negotiated charge)</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

### Second surgical opinion

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Cost Sharing 1</th>
<th>Cost Sharing 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second surgical opinion</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

### Alternatives to physician office visits

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Cost Sharing 1</th>
<th>Cost Sharing 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk-in clinic visits (non-emergency visit)</td>
<td>$30 copayment per visit then the plan pays 70% (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.

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Hospital and other facility care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital care (facility charges)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital (room and board) and other miscellaneous services and supplies</td>
<td>70% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board intensive care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For physician charges, refer to the Physician and specialist-inpatient surgical services benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preadmission testing</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Anesthesia and related facility charges for oral surgery or a dental procedure</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Bone and Joints</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Cleft lip and palate</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Description</td>
<td>In-network</td>
<td>Out-of-network</td>
</tr>
<tr>
<td>Treatment for a congenital cleft lip or cleft palate</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Age limit</td>
<td>Covered persons through age 18</td>
<td>Covered persons through age 18</td>
</tr>
</tbody>
</table>

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

#### Outpatient surgery (facility charges)

<table>
<thead>
<tr>
<th>Facility charges for surgery performed in the outpatient department of a hospital or surgery center</th>
<th>70% (of the negotiated charge)</th>
<th>50% (of the recognized charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For physician charges, refer to the <em>Physician and specialist - outpatient surgical services</em> benefit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Home health care

<table>
<thead>
<tr>
<th>Type</th>
<th>Facility Charges</th>
<th>Physicians Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>70% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

#### Hospice care

<table>
<thead>
<tr>
<th>Type</th>
<th>Facility Charges</th>
<th>Physicians Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient facility (room and board and other miscellaneous services and supplies)</td>
<td>70% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Outpatient</td>
<td>70% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

#### Skilled nursing facility

<table>
<thead>
<tr>
<th>Type</th>
<th>Facility Charges</th>
<th>Physicians Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient facility (room and board) and miscellaneous inpatient care services and supplies</td>
<td>70% (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></td>
<td></td>
</tr>
<tr>
<td>Room and board include intensive care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Maximum days of confinement per policy year | 60 |

---

*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>4. Emergency services and urgent care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital emergency room</td>
<td>$300 copayment per visit then the plan pays 70% (of the balance of the negotiated charge)</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td>Non-emergency care in a hospital emergency room</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Important note:**
- As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment and coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- A separate hospital emergency room copayment will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment will be waived and your inpatient copayment will apply.
- Covered benefits that are applied to the hospital emergency room copayment cannot be applied to any other copayment under the plan. Likewise, a copayment that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment.
- Separate copayment amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment amounts may be different from the hospital emergency room copayment. They are based on the specific service given to you.
- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment amounts that are different from the hospital emergency room copayment amounts.

<table>
<thead>
<tr>
<th>Urgent care</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent medical care provided by an urgent care provider</td>
<td>$150 copayment per visit then the plan pays 70% (of the balance of the negotiated charge)</td>
<td>$150 copayment per visit then the plan pays 50% (of the balance of the recognized charge)</td>
</tr>
<tr>
<td>Non-urgent use of urgent care provider</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Pediatric dental care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to covered persons through the end of the month in which the person turns age 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type A services</td>
<td>100% (of the negotiated charge) per visit</td>
<td>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or deductible applies</td>
<td></td>
</tr>
<tr>
<td>Type B services</td>
<td>70% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Type C services</td>
<td>50% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Orthodontic services</td>
<td>50% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Dental emergency treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

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

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

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

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

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

#### Space maintainers

(Includes all adjustments within 6 months after installation)

<table>
<thead>
<tr>
<th>Space maintainers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Space maintainers - Fixed (unilateral)</td>
<td></td>
</tr>
<tr>
<td>• Space maintainers - Fixed (bilateral, maxillary)</td>
<td></td>
</tr>
<tr>
<td>• Space maintainers - Fixed (bilateral, mandibular)</td>
<td></td>
</tr>
<tr>
<td>• Space maintainers - Removable (unilateral)</td>
<td></td>
</tr>
<tr>
<td>• Space maintainers - Removable (bilateral, maxillary)</td>
<td></td>
</tr>
<tr>
<td>• Space maintainers - Removable (bilateral, mandibular)</td>
<td></td>
</tr>
<tr>
<td>• Re-cementation of space maintainer</td>
<td></td>
</tr>
<tr>
<td>• Removal of fixed space maintainer</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.*
### 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 2 D 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
- Surgical removal of impacted teeth-partial bony
- 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 pericornal 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 in 36 months
- 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
- 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.*
<table>
<thead>
<tr>
<th>Re-cementation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inlay</td>
</tr>
<tr>
<td>• Fabricated-prefabricated post and core</td>
</tr>
<tr>
<td>• Crown</td>
</tr>
<tr>
<td>• Implant/abutment supported crown</td>
</tr>
<tr>
<td>• Implant/abutment supported fixed partial denture</td>
</tr>
<tr>
<td>• Fixed partial denture retainers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prosthodontics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentures and partials:</td>
</tr>
<tr>
<td>• 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)</td>
</tr>
<tr>
<td>• 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)</td>
</tr>
<tr>
<td>• 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)</td>
</tr>
<tr>
<td>• 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)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Repairs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Repair broken complete denture base, mandibular</td>
</tr>
<tr>
<td>• Repair broken complete denture base, maxillary</td>
</tr>
<tr>
<td>• Replace missing or broken tooth-complete denture</td>
</tr>
<tr>
<td>• Repair resin partial denture base, mandibular</td>
</tr>
<tr>
<td>• Repair resin partial denture base, maxillary</td>
</tr>
<tr>
<td>• Repair cast partial framework, mandibular</td>
</tr>
<tr>
<td>• Repair cast partial framework, maxillary</td>
</tr>
<tr>
<td>• Repair or replace broken retentive/clasping materials – per tooth</td>
</tr>
<tr>
<td>• Replace broken tooth-per tooth (partial denture)</td>
</tr>
<tr>
<td>• Add tooth to existing partial denture</td>
</tr>
<tr>
<td>• Add clasp to existing partial denture - per tooth</td>
</tr>
<tr>
<td>• Replace all teeth and acrylic on cast metal framework - upper partial denture</td>
</tr>
<tr>
<td>• Replace all teeth and acrylic on cast metal framework - lower partial denture</td>
</tr>
<tr>
<td>• Special tissue conditioning, per denture - upper</td>
</tr>
<tr>
<td>• Special tissue conditioning, per denture - lower</td>
</tr>
<tr>
<td>• Add metal substructure to acrylic full denture (per arch)</td>
</tr>
<tr>
<td>• Rebase, complete upper denture</td>
</tr>
<tr>
<td>• Rebase, complete lower denture</td>
</tr>
<tr>
<td>• Rebase upper partial denture</td>
</tr>
<tr>
<td>• Rebase lower partial denture</td>
</tr>
<tr>
<td>• Reline complete upper denture (chairside)</td>
</tr>
<tr>
<td>• Reline complete lower denture (chairside)</td>
</tr>
<tr>
<td>• Reline upper partial denture (chairside)</td>
</tr>
<tr>
<td>• Reline lower partial denture (chairside)</td>
</tr>
<tr>
<td>• Reline complete upper denture (laboratory)</td>
</tr>
<tr>
<td>• Reline complete lower denture (laboratory)</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.*
- Reline upper partial denture (laboratory)
- Reline lower partial denture (laboratory)
- Fixed partial denture repair necessitated by material failure

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

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

**Dental service or supply**

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

**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
  - Premolar
  - Molar
  - 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 endosteal 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 noble metal fixed partial denture, limited to 1 every 5 years
- Abutment supported retainer for cast 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

*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

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## 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, 2 surfaces, limited to 1 every 5 years
- Retainer inlay-cast noble metal, 3 or more 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

(Fees for dentures and partial dentures include relines, rebases, and adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)

## Crowns - Fixed partial dentures:

- Retainer crown – porcelain/ceramic, limited to 1 every 5 years
- Retainer crown – porcelain fused to high noble metal, limited to 1 every 5 years
- Retainer crown – porcelain fused to predominantly base metal, limited to 1 every 5 years
- Retainer crown – porcelain fused to noble metal, limited to 1 every 5 years
- Retainer crown –¾ cast high noble metal, limited to 1 every 5 years
- Retainer crown –¾ cast predominantly base metal, limited to 1 every 5 years
- Retainer crown –¾ cast noble metal, limited to 1 every 5 years
- Retainer crown –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

- 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

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Orthodontic services
(Medically necessary orthodontic services include the removal of appliances and construction of retainers.)

<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>

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<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Specific conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birthing center (facility charges)</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>Diabetic services and supplies (including equipment and training)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Family planning services – other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary sterilization for males</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient physician or specialist surgical services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Outpatient physician or specialist surgical services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment</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.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Impacted wisdom teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impacted wisdom teeth</td>
<td>70% (of the negotiated charge)</td>
<td>70% (of the recognized charge)</td>
</tr>
<tr>
<td>Accidental injury to sound natural teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental injury to sound natural teeth</td>
<td>70% (of the negotiated charge)</td>
<td>70% (of the recognized charge)</td>
</tr>
<tr>
<td>Dermatological treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatological treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Maternity care</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well newborn nursery care</td>
<td>70% (of the negotiated charge) No policy year deductible applies</td>
<td>50% (of the recognized charge) No policy year deductible applies</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy complications</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Gender reassignment (sex change) treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Autism spectrum disorder</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Autism spectrum disorder diagnosis and testing</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Autism spectrum disorder treatment (includes physician and specialist office visits)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Applied behavior analysis</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

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### Mental health treatment

#### Mental health treatment – inpatient

<table>
<thead>
<tr>
<th>Description</th>
<th>70% (of the negotiated charge) per admission</th>
<th>50% (of the recognized charge) per admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital mental disorders treatment (room and board and other miscellaneous hospital services and supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental disorder room and board intensive care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Mental health treatment – outpatient

<table>
<thead>
<tr>
<th>Description</th>
<th>70% (of the negotiated charge) per visit</th>
<th>50% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient mental disorder treatment office visits to a physician or behavioral health provider (includes telemedicine consultations)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other outpatient mental disorders treatment (includes skilled behavioral health services in the home)</td>
<td>70% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Partial hospitalization treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive outpatient program</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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## Substance abuse related disorders treatment-inpatient

### Detoxification – inpatient

<table>
<thead>
<tr>
<th>Description</th>
<th>70% (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 detoxification (room and board and other miscellaneous hospital services and supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital substance abuse rehabilitation (room and board and other miscellaneous hospital services and supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient residential treatment facility substance abuse (room and board and other miscellaneous residential treatment facility services and supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance abuse room and board intensive care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Description</th>
<th>70% (of the negotiated charge) per visit</th>
<th>50% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine consultations)</td>
<td>70% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Other outpatient substance abuse services</td>
<td>70% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Partial hospitalization treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Outpatient Program</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Reconstructive surgery and supplies

| Reconstructive surgery and supplies (includes reconstructive breast surgery) | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

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

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

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<tr>
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<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Specific therapies and tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient diagnostic testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic complex imaging services</td>
<td>70% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td>Diagnostic lab work and radiological services</td>
<td>70% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage (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.</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient infusion therapy</strong></td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
<td>Covered according to the type of benefit or the place where the service is received.</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></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient radiation therapy</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Outpatient radiation therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialty prescription drugs</strong> (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.</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
</tr>
<tr>
<td>Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient respiratory therapy</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Respiratory therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transfusion or kidney dialysis of blood</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Transfusion or kidney dialysis of blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Short-term cardiac and pulmonary rehabilitation services</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary rehabilitation</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
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<thead>
<tr>
<th>Short-term rehabilitation and habilitation therapy services</th>
<th>70% (of the negotiated charge) per visit</th>
<th>50% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient physical, occupational, speech, and cognitive therapies</td>
<td>Combined for short-term rehabilitation services and habilitation therapy services</td>
<td></td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>70% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td></td>
</tr>
<tr>
<td>Diagnostic testing for learning disabilities</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td></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.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Ambulance service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency ground, air or water ambulance</td>
<td>70% (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.</td>
<td>Covered according to the type of benefit and the place where the service is received.</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.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Durable medical equipment (DME)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>70% (of the negotiated charge) per item</td>
<td>50% (of the recognized charge) per item</td>
</tr>
<tr>
<td><strong>Enteral formulas and nutritional supplements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enteral formulas and nutritional supplements</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Osteoporosis (non-preventive care)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s or specialist’s office visits</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Prosthetic devices</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td>70% (of the negotiated 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.
**Hearing aids and exams**

<table>
<thead>
<tr>
<th>Hearing aid exams</th>
<th>$30 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit</th>
<th>50% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aid exam maximum</td>
<td>One hearing exam every policy year</td>
<td></td>
</tr>
<tr>
<td>Hearing aids</td>
<td>70% (of the negotiated charge) per item</td>
<td>50% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Hearing aids maximum per ear</td>
<td>One hearing aid per ear every policy year</td>
<td></td>
</tr>
</tbody>
</table>

**Podiatric (foot care) treatment**

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

**Vision care**

**Pediatric vision care**

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

<table>
<thead>
<tr>
<th>Pediatric routine vision exams (including refraction)</th>
<th>100% (of the negotiated charge) per visit</th>
<th>50% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed by a legally qualified ophthalmologist or optometrist</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatric comprehensive low vision evaluations</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed by a legally qualified ophthalmologist or optometrist</td>
<td>Maxium</td>
<td>One comprehensive low vision evaluation every policy year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatric vision care services and supplies</th>
<th>100% (of the negotiated charge) per visit</th>
<th>50% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit for fitting of contact lenses</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Pediatric vision care services and supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eyeglass frames, prescription lenses or prescription contact lenses</strong></td>
</tr>
<tr>
<td>100% (of the negotiated charge) per item</td>
</tr>
<tr>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>50% (of the recognized charge) per item</td>
</tr>
<tr>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td><strong>Maximum number of eyeglass frames per policy year</strong></td>
</tr>
<tr>
<td>One set of eyeglass frames</td>
</tr>
<tr>
<td><strong>Maximum number of prescription lenses per policy year</strong></td>
</tr>
<tr>
<td>One pair of prescription lenses</td>
</tr>
<tr>
<td><strong>Maximum number of prescription contact lenses per policy year</strong> (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)</td>
</tr>
<tr>
<td>Daily disposables: up to 3 month supply</td>
</tr>
<tr>
<td>Extended wear disposable: up to 6-month supply</td>
</tr>
<tr>
<td>Non-disposable lenses: one set</td>
</tr>
<tr>
<td><strong>Optical devices</strong></td>
</tr>
<tr>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Maximum number of optical devices per policy year</strong></td>
</tr>
<tr>
<td>One optical device</td>
</tr>
</tbody>
</table>

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

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

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

**Adult vision care**
Limited to covered persons age 19 and over

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

| Performed by a legally qualified ophthalmologist or optometrist |
| $30 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter |
| 50% (of the recognized charge) per visit |

**Maximum per policy year**
1 visit

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Outpatient prescription drugs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Plan features**

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

**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.

- **policy year deductible and copayment waiver for risk reducing breast cancer**

  The policy year deductible will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, 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 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 female contraceptive methods when obtained at an in-network pharmacy.

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

  The policy year deductible and the prescription drug copayment continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
**Preferred generic prescription drugs (including specialty drugs)**

| For each fill up to a 30 day supply filled at a retail pharmacy | $20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) | $20 copayment per supply then the plan pays 50% (of the balance of the recognized charge) |
| No policy year deductible applies | No policy year deductible applies |

**Non-preferred generic prescription drugs (including specialty drugs)**

| For each fill up to a 30 day supply filled at a retail pharmacy | $75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) | $75 copayment per supply then the plan pays 50% (of the balance of the recognized charge) |
| No policy year deductible applies | No policy year deductible applies |

**Preferred brand-name prescription drugs (including specialty drugs)**

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

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

| For each fill up to a 30 day supply filled at a retail pharmacy | $75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) | $75 copayment per supply then the plan pays 50% (of the balance of the recognized charge) |
| No policy year deductible applies | No policy year deductible applies |

**Orally administered anti-cancer prescription drugs**

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

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

<table>
<thead>
<tr>
<th>Preventive care drugs and supplements filled at a retail pharmacy</th>
<th>100% (of the negotiated charge) per prescription or refill</th>
<th>Paid according to the type of drug per the schedule of benefits, above</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 preventive care drugs and supplements, contact Member Services by calling the toll-free number on your ID card.

### 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.

*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>Tobacco cessation prescription and over-the-counter drugs</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>Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>For each 30 day supply</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Maximums**

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

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

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

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

This section provides detailed explanations about the:

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

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

### Policy year deductible provisions

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>that are subject to the policy year deductible include covered benefits provided under the medical plan and outpatient prescription drug benefits provided under the prescription drug benefit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible health services</td>
<td>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.</td>
</tr>
</tbody>
</table>

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

### Individual

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

### Copayments

**In-network coverage**

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

**Out-of-network coverage**

This is a specified dollar amount or percentage that must be paid by 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.*
<table>
<thead>
<tr>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coinsurance</strong> 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximum out-of-pocket limits provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible health services</strong> 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.</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible health services</strong> applied to the out-of-network maximum out-of-pocket limit will not be applied to satisfy the in-network maximum out-of-pocket limit and eligible health services applied to the in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The maximum out-of-pocket limit is the maximum amount you are responsible to pay for copayments, coinsurance and policy year deductibles for eligible health services during the policy year. This plan has an individual maximum-out-of-pocket limit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once the amount of the copayments, coinsurance and policy year deductibles you have paid for eligible health services during the policy year meets the individual maximum out-of-pocket limits, this plan will pay:</td>
</tr>
</tbody>
</table>

- 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. |

<table>
<thead>
<tr>
<th>Medical and Outpatient Prescription Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-network care</strong></td>
</tr>
<tr>
<td>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:</td>
</tr>
</tbody>
</table>

- 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.

*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: Nova Southeastern University - Final Year Students Main Campus
Policyholder number: 867897
Student policy effective date: 05/01/20
Plan effective date: 05/01/20
Plan issue date: 04/20/20

Underwritten by Aetna Life Insurance Company
IMPORTANT NOTICES:

- THIS CERTIFICATE OF COVERAGE CONTAINS A POLICY YEAR DEDUCTIBLE PROVISION.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy’s out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer’s website or contacting your insurer or agent directly.

**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.
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.
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  Paying for eligible health services - sharing the expense 7
  Disagreements 7
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Let’s get started!

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

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

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. 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 obtain a referral from school health services when required
- You or your provider precertifies the eligible health service when required

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

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

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

Disagreements
We know that people sometimes see things differently.

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

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

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

School health services
School health services can give you some of the care that you need. Contact them first before seeking care from an in-network provider.

If school health services is unable to give you the care that you need, they will give you a referral to an in-network provider.

You must obtain a referral from school health services before you can get services and supplies from in-network providers.
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 Navigator® 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, referral and precertification requirements section.
- Out-of-network providers and any exceptions in the Who provides the care section.
- Cost sharing in the What the plan pays and what you pay section, and your schedule of benefits.
- Claim information in the When you disagree - claim decisions and appeals procedures section.

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

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

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

You can also contact us by:

- Calling our Member Services at the toll-free number 1-855-821-9720
- 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 can use your digital ID card. If you misuse your card by allowing someone else to use it, that is fraud and we may end your coverage. See the Honest mistakes and intentional deception section for details.

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

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

You will find information in this section about:

- Who is eligible?
- When you can join the plan
- Special times you can join the plan

Who is eligible?

You are eligible if you are a:

- Full-time student

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 in a row

Medicare eligibility

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

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

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

When you can join the plan

As a student you can enroll yourself:

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

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

When you can join the continuation of coverage plan

For continuation of coverage plans, you must:

- Enroll within before your coverage ends 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.
Notification of change in status
It is important that you notify us and the policyholder of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us and the policyholder as soon as possible of status changes such as:

- Change of address or phone number
- Change in marital status
- Enrollment in Medicare
- You enroll in any other health plan

Special times you can join the plan
You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another health plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
- You become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your premium contribution for coverage under this plan.
- When you are a victim of domestic abuse or spousal abandonment and you don’t want to be enrolled in the perpetrator’s health plan.

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

Effective date of coverage

Enrollment

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

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

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

Continuation of coverage plan
Your effective date of coverage under a continuation of coverage plan is the later to occur of:

- The date your 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
Medical necessity, referral and precertification requirements

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

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

- The eligible health service is medically necessary
- You get a referral from school health services when required
- You or your provider precertifies the eligible health service when required

This section addresses the medical necessity, referral 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.

Referrals
You may need a referral from school health services for some eligible health services. If you do not have a referral when it is required, then a referral penalty may apply. Refer to the schedule of benefits and the Referral penalty section.

In some situations, school health services may refer you to an out-of-network provider. When this happens, we will pay the cost-sharing that applies to the in-network level of coverage.

If the service or supply requires precertification, you must obtain precertification before receiving the service or supply. If precertification:

- Is obtained when it is required, you will pay the cost sharing that applies to in-network coverage.
- Is not obtained when it is required, you may be subject to higher out-of-pocket expenses.
**Precertification**
You need **precertification** from us for some eligible health services.

**Precertification for medical services and supplies**

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

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

**Precertification call**
**Precertification** should be secured within the timeframes specified below. To obtain **precertification**, call Member Services at the toll-free number on your ID card. This call must be made for:

<table>
<thead>
<tr>
<th>Non-emergency admissions:</th>
<th>You, your <strong>physician</strong> or the facility will need to call and request <strong>precertification</strong> at least 15 days before the date you are scheduled to be admitted.</th>
</tr>
</thead>
<tbody>
<tr>
<td>An emergency admission:</td>
<td>You, your <strong>physician</strong> or the facility must call within 24 hours or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>An urgent admission:</td>
<td>You, your <strong>physician</strong> or the facility will need to call before you are scheduled to be admitted. An <strong>urgent admission</strong> is a hospital admission by a <strong>physician</strong> due to the onset of or change in an <strong>illness</strong>, the diagnosis of an <strong>illness</strong>, or an <strong>injury</strong>.</td>
</tr>
<tr>
<td>Outpatient non-emergency services requiring <strong>precertification</strong>:</td>
<td>You or your <strong>physician</strong> must call at least 15 days before the outpatient care is provided, or the treatment or procedure is scheduled.</td>
</tr>
<tr>
<td>Delivery:</td>
<td>You, your <strong>physician</strong>, or the facility must call within 24 hours of the birth or as soon thereafter as possible. No penalty will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery.</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.

| 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. |
| Notification call for prenatal care: | As soon as possible after your physician confirms pregnancy so that we can enroll you in our Healthy Beginnings program. |

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. If your precertified services are approved, the approval is valid for 30 days as long as you remain enrolled in the plan.

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

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

If precertification determines that the stay or outpatient services and supplies are not covered benefits, the notification will explain why and how you can appeal our decision. You or your provider may request a review of the precertification decision. See the When you disagree - claim decisions and appeals procedures section.

What if you don't obtain the required precertification?
If you don’t obtain the required precertification:

- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits Precertification covered benefit penalty section.
- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your out-of-network policy year deductibles or maximum out-of-pocket limits.

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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>Obesity (bariatric) surgery</td>
<td>Certain prescription drugs and devices*</td>
</tr>
<tr>
<td>Stays in a hospice facility</td>
<td>Complex imaging</td>
</tr>
<tr>
<td>Stays in a hospital</td>
<td>Comprehensive infertility services</td>
</tr>
<tr>
<td>Stays in a rehabilitation facility</td>
<td>Cosmetic and reconstructive surgery</td>
</tr>
<tr>
<td>Stays in a residential treatment facility for treatment of mental disorders and substance abuse</td>
<td>Emergency transportation by airplane</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>Stays in a skilled nursing facility</td>
<td>Kidney dialysis</td>
</tr>
<tr>
<td>Stays in a skilled nursing facility</td>
<td>Medical injectable drugs, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, botox, hepatitis C medications)*</td>
</tr>
<tr>
<td>Stays in a skilled nursing facility</td>
<td>Outpatient back surgery not performed in a physician’s office</td>
</tr>
<tr>
<td>Stays in a skilled nursing facility</td>
<td>Outpatient detoxification</td>
</tr>
<tr>
<td>Stays in a skilled nursing facility</td>
<td>Partial hospitalization treatment – mental disorder and substance abuse diagnoses</td>
</tr>
<tr>
<td>Stays in a skilled nursing facility</td>
<td>Private duty nursing services</td>
</tr>
<tr>
<td>Stays in a skilled nursing facility</td>
<td>Psychological testing/neuropsychological testing</td>
</tr>
<tr>
<td>Stays in a skilled nursing facility</td>
<td>Sleep studies</td>
</tr>
<tr>
<td>Stays in a skilled nursing facility</td>
<td>Transcranial magnetic stimulation (TMS)</td>
</tr>
<tr>
<td>Stays in a skilled nursing facility</td>
<td>Wrist surgery</td>
</tr>
</tbody>
</table>

*For a current listing of the prescription drugs and medical injectable drugs that require precertification, contact Member Services by calling the toll-free number on your ID card or by logging onto the Aetna website at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).
Precertification for prescription drugs and devices

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

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

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

Step therapy

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

You can obtain the most up-to-date information about step therapy prescription drugs by calling Member Services at the toll-free number on your ID card or by logging on to your Aetna Navigator® 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 or step therapy. You or your prescriber can contact us and will need to provide us with the required clinical documentation. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case determination, and will not apply or extend to other covered persons.

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 Navigator® secure website at www.aetnastudenthealth.com or by calling the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.

5. We may use reasonable medical management techniques to determine the frequency, method, treatment, or setting of preventive care and wellness benefits when not specified in the recommendations and guidelines of the:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
   - United States Preventive Services Task Force
   - Health Resources and Services Administration
   - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

Routine physical exams
Eligible health services include office visits to your physician or other health professional for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:
   - Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
   - Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents
   - Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
     - Screening and counseling services on topics such as:
       - Interpersonal and domestic violence
       - Sexually transmitted diseases
       - Human Immune Deficiency Virus (HIV) infections
     - 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

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, such as those required due to your employment or travel.
Well woman preventive visits

Eligible health services include your routine:
- Well woman preventive exam office visit to your physician, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes Pap smears. 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.

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.

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

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

**Prenatal care**
Eligible health services include your routine prenatal physical exams as Preventive Care and wellness, which is the initial and subsequent history and physical exam such as:
- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height
- Preeclampsia screening

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

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

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

Breast feeding durable medical equipment

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

Breast pump

Eligible health services include:

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

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

Breast pump supplies and accessories

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

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

Family planning services – female contraceptives

Eligible health services include family planning services such as:

Counseling services

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

Contraceptives

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

Voluntary sterilization

Eligible health services include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.
Important note:
See the following sections for more information:
- Family planning services - other
- Maternity care
- Well newborn nursery care
- Treatment of basic infertility
- Outpatient prescription drugs
2. Physicians and other health professionals

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

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

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

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

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

When your surgery requires two or more surgical procedures:
- Using the same approach and at the same time or
- Right after each other
we will pay for the one that costs the most.

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

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

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

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

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

Physician and specialist – outpatient surgical services

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

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

In-hospital non-surgical physician services

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

Consultant services (non-surgical and non-preventive)

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

Covered benefits include treatment by the consultant.

The consultation may happen by way of telemedicine.

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

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

Second surgical opinion

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

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

We must receive a written report from a specialist on the second surgical opinion.
Alternatives to physician and specialist office visits

Walk-in clinic (non-emergency visit)

Eligible health services include health care services provided at walk-in clinics for:

- Unscheduled, non-medical emergency illnesses and injuries
- The administration of immunizations administered within the scope of the clinic’s license
3. Hospital and other facility care

Hospital care (facility charges)

Eligible health services include inpatient and outpatient hospital care.

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

Preadmission testing

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

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

Anesthesia and related facility charges for oral surgery or a dental procedure

Eligible health services include:
- General anesthesia
- Charges made by an anesthetist
- Related hospital or surgery center charges

for your oral surgery or a dental procedure.

The following conditions must be met:
- Your dental provider cannot safely perform the dental procedure or oral surgery in a dental office setting, and
- You are a child age 26 or under, or
- You are developmentally disabled

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

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

Important note:
Some surgeries can be done safely in a physician’s office. For those surgeries, your plan will pay only for physician services and not a separate facility fee.

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

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

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

Home health care services do not include custodial care.

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

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

- Room and board
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a hospital
- 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

**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.
- School health services coordinates the care by giving you a referral.
- 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.

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
  - Craniostenosis 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?
Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan’s “replacement rule”. The replacement rule is that certain replacements of, or additions to, existing crowns, inlays, onlays and veneers, dentures or bridges are covered only when you give us proof that:

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

When does your plan cover missing teeth that are not replaced?
The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

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

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

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

1. Ask your dental provider to write down a full description of the treatment you need, using either an Aetna claim form or an American Dental Association (ADA) approved claim form
2. Before treating you, your dental provider should send the form to us
3. We may request supporting images and other diagnostic record.
4. Once all of the information has been gathered, we will review the proposed treatment plan and provide you and your dental provider with a statement outlining the benefits payable
5. You and your dental provider can then decide how to proceed
The advance claim review is voluntary. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

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

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

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

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

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

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

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

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

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

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

Bones and joints of the facial region
Eligible health services include medically necessary charges you incurred for diagnostic and surgical procedures involving bones or joints of the facial region to treat conditions caused by congenital or developmental deformity, disease or injury.

Cleft lip/cleft palate
Eligible health services include medically necessary charges you incurred for services given to a covered dependent child under age 18 for a congenital cleft lip or cleft palate.

Diabetic services and supplies (including equipment and training)
Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Insulin preparations
  - Hypodermic needles and syringes used for the treatment of diabetes
  - Injection aids for the blind
  - Diabetic test agents
  - Lancets/lancing devices
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Injectable glucagons
  - Lancets/lancing devices
  - 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, and postnatal visits. Coverage includes eligible health services provided by a licensed mid-wife.

After your child is born, eligible health services include:
- 48 hours of inpatient care in a hospital or birthing center after a vaginal delivery
- 96 hours of inpatient care in a hospital or birthing center after a cesarean delivery
- A shorter stay if the attending physician, with the consent of the mother, discharges the mother or newborn earlier
- The mother could be discharged earlier. If so, the plan will pay for 1 post-delivery home visit by a health care provider

Well newborn nursery care
Eligible health services include routine care of your well newborn child in a hospital or birthing center such as:
- Well newborn nursery care during the mother’s stay but for not more than four days for a normal delivery
- Hospital or birthing center visits and consultations for the well newborn by a physician but for not more than 1 visits per day
Pregnancy complications

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

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

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

Gender reassignment (sex change) treatment

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

Eligible health services include:

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

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

Autism spectrum disorder

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

Eligible health services include the services and supplies provided by a physician or behavioral health provider for the diagnosis, testing and treatment of autism spectrum disorders. We will only cover this treatment if a physician or behavioral health provider orders it as part of a treatment plan.
We will cover certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior
- That are responsible for observable improvements in behavior

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

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

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

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

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

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

- **Outpatient treatment** received while not confined as an inpatient in a general medical hospital, psychiatric hospital, or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (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)
- Mental health injectables
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- 23 hour observation

**Substance abuse related disorders treatment**

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

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

A general medical hospital is not usually equipped to treat substance 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 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
  - 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
  - Treatment of withdrawal symptoms
  - Substance use disorder injectables
  - 23 hour observation

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.

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

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

Organ means:
- Solid organ
- Hematopoietic stem cell
- Bone marrow

Aetna’s network of transplant specialist facilities
When you get transplant services from an in-network provider, the amount you will pay for covered transplant services is determined by where you get the in-network transplant services.

For in-network services, you must get services from an Institutes of Excellence™ (IOE) facility we designate to perform the transplant you need. Coverage is not available for services from an in-network non-IOE facility.

You can choose in-network transplant services from either:
- An Institutes of Excellence™ (IOE) facility we designate to perform the transplant you need or
- A Non-IOE facility

The National Medical Excellence Program® will coordinate all solid organ and bone marrow transplants and other specialized care you need.

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

You will not be reimbursed unless we have approved you for this program before you incur the costs.

Your approval notification for this program will describe the process to follow for reimbursement. You must send us the receipts of your expenses.

For details about this program, contact Member Services at the toll-free number on your ID card.

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.

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

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

You can access the list of preferred infusion locations by contacting Member Services at the toll-free number on your ID card or by logging onto your Aetna Navigator® 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 by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com to determine if coverage is under the outpatient prescription drug benefit of this certificate of coverage.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care maximums.
Outpatient radiation therapy
Eligible health services include the following radiology services provided by a health professional:
- Radiological services
- Gamma ray
- Accelerated particles
- Mesons
- Neutrons
- Radium
- Radioactive isotopes

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

You can access the list of specialty prescription drugs by contacting Member Services at the toll-free number on your ID card or by logging onto your Aetna Navigator® 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 services**
Eligible health services include chiropractic services to correct a muscular or skeletal problem.

Your provider must establish or approve a treatment plan that details the treatment, and specifies frequency and duration.
Diagnostic testing for learning disabilities

Eligible health services include diagnostic testing for:

- Attention deficit disorder
- Attention deficit hyperactive disorder

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

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

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

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

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

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

Clinical trial therapies (experimental or investigational)
Eligible health services include experimental or investigational drugs, devices, treatments or procedures from a provider under an “approved clinical trial” only when you have cancer or terminal illnesses and all of the following conditions are met:
- Standard therapies have not been effective or are not appropriate
- 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.

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

Your **physician** must give you a written order for these supplies.

**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 external body part lost or impaired as a result of illness or injury or congenital defects

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

**Hearing aids and exams**

*Eligible health services* include hearing care that includes hearing exams, prescribed hearing aids and hearing aid services as described below.

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

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

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

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

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

Vision care

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

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

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

**Routine vision exams** include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.
9. Outpatient prescription drugs

What you need to know about your outpatient prescription drug benefits
Read this section carefully so that you know:
• How to access in-network pharmacies
• How to access out-of-network pharmacies
• Eligible health services under your outpatient prescription drug benefit
• What outpatient prescription drugs are covered
• Other services
• How you get an emergency prescription filled
• Where your schedule of benefits fits in
• What precertification requirements apply
• How do I request a medical exception

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

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

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 Navigator® secure website at www.aetnastudenthealth.com.
• By phone: Call Member Services at the toll-free number on your ID card. During regular business hours, a Member Services representative can assist you. Our automated telephone assistant can give you this information 24 hours a day.

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

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

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

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

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

Eligible health services under your outpatient prescription drug benefit

What does your outpatient prescription drug benefit cover?

Eligible health services under your outpatient prescription drug benefit include:

Any pharmacy service that meets these three requirements:

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

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

- You need a prescription from your prescriber
- Your drug needs to be medically necessary for your illness or injury. See the Medical necessity, referral and precertification requirements section
- You need to show your ID card to the pharmacy when you get a prescription filled

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

Your outpatient prescription drug benefit includes drugs listed in the preferred drug guide. Prescription drugs listed on the formulary exclusions list are excluded unless a medical exception 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.
Medication synchronization
If you receive medication for a chronic condition, refills may be able to be synchronized. Synching medication means fewer trips to the pharmacy for refills. To see if you qualify, contact Member Services at the toll-free number on your ID card in the How to contact us for help section or by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com.

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

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

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

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

Specialty pharmacy
Specialty prescription drugs often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. Each prescription is limited to a maximum 30 day supply. You can access the list of specialty prescription drugs by contacting Member Services at the toll-free number on your ID card or by logging onto your Aetna Navigator® 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 Navigator® 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.

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

**Preventive care drugs and supplements**

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

**Risk-reducing breast cancer prescription drugs**

**Eligible health services** include prescription drugs used to treat people who are at:
- Increased risk for breast cancer
- Low risk for adverse medication side effects

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

**Eligible health services** include FDA-approved prescription drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing.
How you get an emergency prescription filled
You may not have access to an in-network pharmacy in an emergency or urgent care situation, or you may be traveling outside of the plan's service area. If you must fill a prescription in either situation, we will reimburse you as shown in the table below.

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

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

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

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

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

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

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

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

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

You will find the step therapy prescription drugs on the preferred drug guide. For the most up-to-date information, call Member Services at the toll-free number on your ID card or log on to your Aetna Navigator® 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 pain
- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

**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.

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

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

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

Bones and joints of the facial region expense
- Care or treatment of the teeth or gums
- Intraoral prosthetic device
- Surgical procedures for cosmetic purposes

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

Cleft lip/cleft palate
- Oral prosthesis, dentures or bridgework ordered before the covered dependent child becomes covered or ordered while covered but installed or delivered more than 60 days after termination of coverage
- Services given to treat speech development unless his/her speech is impaired because of a cleft lip or cleft palate or any condition developed because of cleft lip or cleft palate
- Services performed before the covered dependent child becomes covered or after termination of coverage:
  - Hearing aid evaluation tests
  - Oral or facial surgery
  - Cleft orthodontic therapy
  - Diagnostic or rehabilitative
- Special education for a covered dependent child whose ability to speak or hear is lost or impaired including lessons in sign language
  - Hearing examinations required as a condition of employment
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

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
- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

Custodial care
Examples are:
- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care adult (or child) day care or convalescent care except in connection with hospice care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

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

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

**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**

**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

Experimental or investigational
- Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs). See the Eligible health services under your plan – Other services section.

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)

Family planning services - other
- Abortion except when the pregnancy is the result of rape or incest or if it places the woman’s life in serious danger
- Reversal of voluntary sterilization procedures, including related follow-up care
- Family planning services received while confined as an inpatient in a hospital or other facility
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

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

Foot care
- 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
- Leperoplasty
- Breast augmentation
- Liposuction of the waist (body contouring)
- Reduction thyroid chondroplasty (tracheal shave)
- Hair removal (including electrolysis of face and neck)
- Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which are used in feminization
- Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic

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

Hearing aids and exams
The following services or supplies:
- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 12 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- Cochlear implants
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries, amplifiers, and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Home health care
- Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Homemaker or housekeeper services
- Food or home delivered services
- Maintenance therapy
Hospice care
- Funeral arrangements
- Pastoral counseling
- Respite care
- Bereavement counseling
- Financial or legal counseling which includes estate planning and the drafting of a will
- Homemaker or caretaker services that are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

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

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

Motor vehicle accidents
- Services and supplies given by a provider for injuries sustained from a motor vehicle accident but only when benefits are 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.

Non-U.S. citizen
- Services and supplies received by a covered person (who is not a United States citizen) within the covered person's home country but only if the home country has a socialized medicine program.
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.

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

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

Private duty nursing (outpatient only)
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
- Cochlear implants

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

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

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

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

the policyholder.

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

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

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
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests
- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy 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, or 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, except to the extent coverage is required by applicable laws

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 (freezing) of eggs, embryos or sperm
  - Storage of eggs, embryos, or sperm
  - Thawing of cryopreserved (frozen) 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 from a person not covered under this plan for ART services
- Home ovulation prediction kits or home pregnancy tests
- The purchase of donor embryos, donor oocytes, or donor sperm
- Reversal of voluntary sterilizations, including follow-up care
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures
• In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)
• ART services are not provided for out-of-network care

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

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

Biological sera

Cosmetic drugs
- Medications or preparations used for cosmetic purposes

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

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 shape or appearance of a sex organ
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies

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

Immunization or immunological agents

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 equipment, supplies and education 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)

We reserve the right to exclude:
- A manufacturer’s product when a same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the preferred drug guide.
- Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our preferred drug guide.
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.

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

You may select an in-network provider from the directory through your Aetna Navigator® 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
However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

<table>
<thead>
<tr>
<th>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>Request for approval</td>
<td>You need to complete a Transition Coverage Request form and send it to us. You can get this form by contacting Member Services at the toll-free number on your ID card.</td>
</tr>
<tr>
<td>Length of transitional period</td>
<td>Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.</td>
</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, referral and precertification requirements section.

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

- When you get an eligible health service without a referral from school health services when your plan requires a referral. See the Medical necessity, referral and precertification requirements section.

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit a claim</td>
<td>• You should notify and request a claim form from the policyholder.</td>
<td>• You must send us notice and proof as soon as reasonably possible.</td>
</tr>
<tr>
<td></td>
<td>• The claim form will provide instructions on how to complete and where to send the form(s).</td>
<td>• If you are unable to complete a claim form, you may send us:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- A 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>Proof of loss (claim)</td>
<td>• A completed claim form and any additional information required by us.</td>
<td>• You must send us notice and proof as soon as reasonably possible.</td>
</tr>
<tr>
<td>Benefit payment</td>
<td>• Written proof must be provided for all benefits.</td>
<td>• Benefits will be paid as soon as the necessary proof to support the claim is received but no more than 45 days after receipt of written proof unless we contest any portion of the claim.</td>
</tr>
<tr>
<td></td>
<td>• If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss.</td>
<td>• Benefits will be paid within 60 days after the date that we received the additional information.</td>
</tr>
<tr>
<td></td>
<td>• We will send you a notice when we contest a claim. The notice will tell you the reason and it may request that you send us more information.</td>
<td>• Benefits will be paid within 120 days from the original date of the claim.</td>
</tr>
</tbody>
</table>
Types of claims and communicating our claim decisions
You or your provider is required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the provider or to you as appropriate.

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

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

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

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

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

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

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

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

The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

We may need to tell your physician about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the hospital.
<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Urgent care claim</th>
<th>Pre-service claim</th>
<th>Post-service claim</th>
<th>Concurrent care claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial determination (us)</td>
<td>72 hours</td>
<td>15 days</td>
<td>30 days</td>
<td>24 hours for urgent request*</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>15 days</td>
<td>15 days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Additional information request (us)</td>
<td>72 hours</td>
<td>15 days</td>
<td>30 days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Response to additional information request (you)</td>
<td>48 hours</td>
<td>45 days</td>
<td>45 days</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

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

**Adverse benefit determinations**

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

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

**The difference between a complaint and an appeal**

**A Complaint**

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

**An Appeal**

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us by calling Member Services at the toll-free number on your ID card.
Appeals of adverse benefit determinations
You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination or by calling Member Services at the toll-free number on your ID card. For a written appeal, you need to include:

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

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

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

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

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

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

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Urgent care claim</th>
<th>Pre-service claim</th>
<th>Post-service claim</th>
<th>Concurrent care claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal determinations at each level (us)</td>
<td>36 hours</td>
<td>15 days</td>
<td>30 days</td>
<td>As appropriate to type of claim</td>
</tr>
<tr>
<td>Extensions</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Exhaustion of appeals process
In most situations you must complete the appeal process with us before you can take these other actions:

- Contact the Florida Department of Financial Services to request an investigation of a complaint or appeal
- File a complaint or appeal with the Florida Department Financial Services
- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding

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

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.
- We did not follow all of the claim determination and appeal requirements of the state of Florida or Federal Department of Health and Human Services. But, you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you.
  - The violation was for a good cause or beyond our control.
  - The violation was part of an ongoing, good faith exchange between you and us.

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

You have a right to external review only if:

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

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

You must submit the Request for External Review Form:

- To Aetna
- Within 123 calendar days of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

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

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

**How long will it take to get an ERO decision?**
We will tell you of the ERO decision not more than 45 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

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

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

**For initial adverse determinations**
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 decision within 72 hours of us getting your request.

**Recordkeeping**
We will keep the records of all complaints and appeals for at least 10 years.
Coordination of benefits (COB)

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Plans</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary plan</td>
<td>The primary plan pays your claims as if there is no other health plan involved.</td>
</tr>
<tr>
<td>Secondary plan</td>
<td>The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that was not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.</td>
</tr>
<tr>
<td>Benefit reserve</td>
<td>The benefit reserve:</td>
</tr>
<tr>
<td></td>
<td>• Is made up of the amount that the secondary plan saved due to COB</td>
</tr>
<tr>
<td></td>
<td>• Is used to cover any unpaid allowable expenses</td>
</tr>
<tr>
<td></td>
<td>• Balance is erased at the end of each policy year</td>
</tr>
</tbody>
</table>

### How COB works with Medicare

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

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

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

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.

How are benefits paid?

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

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

Other health coverage updates – contact information

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

- **Online:** Log on to your Aetna Navigator® secure member website at www.aetnastudenthealth.com. Select Find a Form, then select Your Other Health Plans.
- **By phone:** Call Member Services at the toll-free number on your ID card.

Right to receive and release needed information

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

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

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

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

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

Coverage may also end on any date requested by you.

Additional, in the event of cancellation or death, we will return any unearned portion of premium paid. Cancellations shall be without prejudice to any claims originating prior to the effective date of cancellation.

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

If you withdraw from school because you have entered the armed forces, any unearned 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 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
- 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.
**Why would we suspend paying claims or end your coverage?**

We will give you 45 days advance written notice if we suspend paying your claims because:

- You do not cooperate or give facts that we need to administer the COB provisions.

We may immediately end your coverage if:

- You commit an act or practice that constitutes 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 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 are totally disabled when coverage ends. Only the medical condition which caused the total disability is covered during your extension.

You are “totally disabled” if you cannot work at your own occupation or any other occupation for pay or profit engage in most normal activities of a healthy person of the same age and gender.

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

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

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

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

You can continue to get care for this condition until the first to occur of:

- When you are discharged. Coverage will not end if you are transferred to another hospital or a skilled nursing facility.
- When you no longer need inpatient care.
- When you become covered by another health benefits plan.
- 3 months of coverage.
How can you extend coverage if you are pregnant when coverage ends?
If your coverage ends while you are pregnant, your coverage may be extended provided the pregnancy started while you are covered under the student policy. Benefits are extended only for the services or supplies to treat that pregnancy.

You may extend coverage but not beyond:
- The end of the pregnancy, or
- The date of the birth of the child
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. 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 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 cannot take any action until 60 days after we receive written proof of loss.

No legal action can be brought to recover payment after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

**Physical examinations and evaluations**
At our expense, we have the right to have a physician of our choice examine you. This will be done at all reasonable times while certification or a claim for benefits is pending or under review.

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

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

**Honest mistakes and intentional deception**

**Honest mistakes**
You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may adjust premiums based on the true facts. 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 performed an act or practice that constitutes fraud us or you intentionally misrepresented material facts in the enrollment form or a claim, 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 45 days advanced written notice of any rescission of coverage
- You have the right to an Aetna appeal
- You have the right to a third party review conducted by an independent external review organization
Some other money issues

Grace period
You will be allowed a grace period of 31 days after the due date for the payment of each contribution due after the first contribution payment. If contributions are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period.

Payment of premiums
The first premium payment for this policy is due on or before your effective date of coverage. Your next premium payment will be due the 1st of each month (“premium due date”). Each premium payment is to be paid to us on or before the premium due date.

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

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

To help us get paid back, you are doing four things now:
- You are agreeing to repay us from money you receive because of your injury.
- You are giving us a right to seek money in your name, from any person who causes you injury and from your own insurance. We can seek money only up to the amount we paid for your care.
- You are agreeing to cooperate with us so we can get paid back in full. For example, you’ll tell us within 30 days of when you seek money for your injury or illness. You’ll hold any money you receive until we are paid in full. And you’ll give us the right to money you get, ahead of everyone else.
- You are agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money.

We don’t have to reduce the amount we’re due for any reason, even to help pay your lawyer or pay other costs you incurred to get a recovery.

Your health information
We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your providers’ claims and manage your plan.

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

When you accept coverage under this plan, you agree to let your providers share information with us. We need information about your physical and mental condition and care.
Effect of benefits under other plans

Effect of a Health Maintenance Organization plan (an HMO Plan) or a Preferred Provider Organization plan (PPO plan) on coverage

If you have coverage under another group medical plan (such as an HMO or PPO plan) and that other plan denies coverage of benefits because you received the services or supplies outside of the plan’s network geographic area, this student plan will cover those denied benefits as long as they are covered benefits under this plan. Covered benefits will be paid at the applicable level of benefits under the student plan.
Glossary A-M

**Accident or accidental**
An injury to you that is not planned or anticipated. An illness does not cause or contribute to an accident.

**Aetna**
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with Aetna.

**Ambulance**
A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

**Behavioral health provider**
An individual professional that is 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 and/or a referral from school health services, if required

Covered person

A covered student for whom all of the following applies:

- The person is eligible for coverage as defined in the certificate of coverage
- The person has enrolled for coverage and paid any required premium contribution
- The person’s coverage has not ended

Covered student

A student who is insured under the student policy.

Craniomandibular joint dysfunction (CMJ)

This is a disorder of the jaw joint.

Custodial care

Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be custodial care even if it prescribed by a physician or given by trained medical personnel.

Dental emergency

Any dental condition that:

- Occurs unexpectedly
- Requires immediate diagnosis and treatment in order to stabilize the condition, and
- Is characterized by symptoms such as severe pain and bleeding

Dental emergency services

Services and supplies given by a dental provider to treat a dental emergency.

Dental provider

Any individual legally qualified to provide dental services or supplies. This may be any of the following:

- Any dentist
- Group
- Organization
- Dental facility
- Other institution or person

Dentist(s)

A legally qualified dentist licensed to do the dental work he or she performs.
Detoxification
The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:
- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This can be done by metabolic or other means as determined by a physician or a nurse practitioner working within the scope of their licenses. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Directory
The list of in-network providers for your plan. The most up-to-date directory for your plan appears at www.aetnastudenthealth.com under the DocFind® label. When searching DocFind®, you need to make sure that you are searching for providers that participate in your specific plan. In-network providers may only be considered for certain Aetna plans. When searching for in-network dental providers, you need to make sure you are searching under Pediatric Dental plan.

Durable medical equipment (DME)
Equipment and the accessories needed to operate it, that is:
- Made to withstand prolonged use
- Mainly used in the treatment of an illness or injury
- Suited for use in the home
- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

Effective date of coverage
The date your coverage begins under this certificate of coverage as noted in Aetna’s records.

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

Eligible health services
The health care services and supplies and outpatient prescription drugs listed in the Eligible health services under your plan section and not carved out or limited in the Exceptions section of this certificate of coverage or in the schedule of benefits.
Emergency admission
An admission to a hospital or treatment facility ordered by a physician within 24 hours after you receive emergency services.

Emergency medical condition
A recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, illness, or injury is of a severe nature. And that if you don’t get immediate medical care it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus
- In the case of a pregnant woman:
  - Serious jeopardy to the health of the fetus
  - One who is having contractions and there is inadequate time to effect a safe transfer to another hospital before delivery or
  - A transfer may pose a threat to the health or safety of the woman or unborn child

Emergency services
Treatment given in an ambulance and a hospital’s emergency room for an emergency medical condition. This includes evaluation of, and treatment to stabilize an emergency medical condition.

Experimental or investigational
A drug, device, procedure, or treatment that we find is experimental or investigational because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility provider state that it is experimental or investigational.

Formulary exclusions list
A list of prescription drugs not covered under the plan. This list is subject to change.

Generic prescription drug
A prescription drug with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.
**Health professional**
A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, physicians, nurses, dental providers, vision care providers, and physical therapists.

**Home health aide**
A health professional that provides services through a home health care agency. The services that they provide are not required to be performed by an RN, LPN, or LVN. A home health aide primarily aids you in performing the normal activities of daily living while you recover from an injury or illness.

**Home health care agency**
An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

**Home health care plan**
A plan of services prescribed by a physician (or other health professional) to be provided in the home setting. These services are usually provided after your discharge from a hospital or if you are homebound.

**Homebound**
This means that you are confined to your home because:
- Your physician has ordered that you stay at home because of an illness or injury
- The act of transport would be a serious risk to your life or health

You are not homebound if:
- You do not often travel from home because you are feeble or insecure about leaving your home
- You are confined to a wheelchair but you can be transported by a vehicle that can safely transport you in a wheelchair

**Hospice benefit period**
A period that begins on the date your physician certifies that you have a terminal illness. It ends after 6 months (or later for which your treatment is certified) or on your death; if sooner.

**Hospice care**
Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure.

**Hospice care agency**
An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care. These services may be available in your home or inpatient setting.

**Hospice care program**
A program prescribed by a physician or other health professional to provide hospice care and supportive care to their families.

**Hospice facility**
An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care.
**Hospital**
An institution licensed as a **hospital** by applicable state and federal laws and is accredited as a **hospital** by The Joint Commission (TJC).

**Hospital** does not include a:
- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility for substance 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**
A condition of being unwell or sick caused by a disease of the body or mind.

**In-network dental provider**
A **dental provider** listed in the **directory** for your plan.

**In-network pharmacy**
A **retail pharmacy** or **specialty pharmacy** that has contracted with **Aetna**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** to you.

**In-network provider**
A **provider** listed in the **directory** for your plan. However, a NAP provider listed in the NAP directory is not an **in-network provider**.

**Infertile or infertility**
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 which was caused by an accident and not due to or contributed by illness or disease.

Institutes of excellence™ (IOE) facility
A facility designated by Aetna in the provider directory as Institutes of Excellence in-network provider for specific services or procedures.

Intensive care unit
A ward, unit, or area in a hospital which is set aside to provide continuous specialized or intensive care services to you because your illness or injury is severe enough to require such care.

Intensive outpatient program (IOP)
The clinical treatment provided must be:
- No more than 5 days per week
- No more than 19 hours per week
- A minimum of 2 hours each treatment day

Services must be medically necessary and delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a mental disorder or substance 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 Affordable Care Act (ACA) unless permitted.

Maximum out-of-pocket limit
The maximum out-of-pocket amount for payment of copayments and coinsurance including any policy year deductible, to be paid by you per policy year for eligible health services.
**Medically necessary/Medical necessity**

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

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

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Consistent with the standards set forth in policy issues involving clinical judgment

**Medicare**

As used in this plan, **Medicare** means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of **Medicare**.

**Mental disorder**

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

The negotiated charge does not reflect any amount an affiliate or we may receive under a rebate arrangement between us or an affiliate and a drug manufacturer for any prescription drug. The rebates 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 an additional service or risk charge set by us.

The negotiated charge does not reflect any amount an affiliate or we may receive under a rebate arrangement between us, an affiliate or a third party vendor and a drug manufacturer for any prescription drug, including prescription drugs on the preferred drug guide.

We may receive rebates from the manufacturers of prescription drugs and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not 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 and specialty pharmacy. It also includes an out-of-network retail pharmacy.

Physician
A skilled health professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Policyholder
The school named on the front page of the student policy and your certificate of coverage and schedule of benefits for the purpose of coverage under the student policy.

Policy year
This is the period of time from anniversary date to anniversary date of the student policy except in the first year when it is the period of time from the effective date to the first anniversary date.

Policy year deductible
The amount you pay for eligible health services per policy year before your plan starts to pay as listed in the schedule of benefits.

Precertification, precertify
A requirement that you or your physician contact Aetna before you receive coverage for certain services. This may include a determination by us as to whether the service is medically necessary and eligible for coverage.

Preferred drug
A prescription drug or device that may have a lower out-of-pocket cost than a non-preferred drug.

Preferred drug guide
A list of prescription drugs and devices established by Aetna or an affiliate. It does not include all prescription drugs and devices. This list can be reviewed and changed by Aetna or an affiliate. A copy of the preferred drug guide is available at your request. You can also find it on the Aetna website at www.aetnastudenthealth.com/formulary.

Preferred in-network pharmacy
A network retail pharmacy that Aetna has identified as a preferred in-network pharmacy.
**Premium**
The amount you or the *policyholder* are required to pay to *Aetna* to continue coverage.

**Prescriber**
Any *provider* acting within the scope of his or her license, who has the legal authority to write an order for outpatient *prescription drugs*.

**Prescription**
*As to hearing care:*
A written order for the dispensing of *prescription* electronic hearing aids by otolaryngologist, otologist or audiologist.

*As to prescription drugs:*
A written order for the dispensing of a *prescription drug* or device by a *prescriber*. If it is a verbal order, it must promptly be put in writing by the *in-network pharmacy*.

*As to vision care:*
A written order for the dispensing of *prescription* lenses or *prescription* contact lenses by an ophthalmologist or optometrist.

**Prescription drug**
An FDA approved drug or biological which can only be dispensed by *prescription*.

**Provider(s)**
A *physician*, other *health professional*, *hospital*, *skilled nursing facility*, *home health care agency*, *pharmacy*, or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all *Medicare* accreditation standards (even if it does not participate in *Medicare*).

**Psychiatric hospital**
An institution specifically licensed as a *psychiatric hospital* by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of *substance 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>
</tbody>
</table>

**Important note:** If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.

Special terms used
- Average wholesale price (AWP) is the current average wholesale price of a prescription drug listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by Aetna).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other providers charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply
- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.

Our reimbursement policies
We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the recognized charge. These policies consider:
- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider
Our reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

R.N.
A registered nurse.

Referral
This is an oral, written or electronic authorization made by school health services to direct you to a provider for medically necessary services and supplies.

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. And is credentialed by Aetna or accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)
In addition to the above requirements, an institution must meet the following for substance 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. 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 Navigator® 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. 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

Temporomandibular joint dysfunction (TMJ)
This is a disorder of the jaw joint.

Terminal illness
A medical prognosis that you are not likely to live more than 12 months.

Urgent care facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an urgent condition.

Urgent condition
An illness or injury that requires prompt medical attention but is not an emergency medical condition.
**Urgent admission**
This is an admission to the hospital due to an illness or injury that is severe enough to require a stay in a hospital within 2 weeks from the date the need for the stay becomes apparent.

**Walk-in clinic**
A free-standing health care facility. Neither of the following should be considered a walk-in clinic:
- An emergency room
- The outpatient department of a hospital
The student policy has changed. The certificate of coverage is revised to reflect this. The changes are effective on the date shown above.

The changes are as follows:

1. The following provision is added to the *How to contact us for help* provision in the *Let’s get started!* section:

For health information provided by the Agency for Health Care Administration, you can visit their website at [http://ahca.myflorida.com/](http://ahca.myflorida.com/)

2. The *Medically necessary; medical necessity* provision in the *Medical necessity, referral and precertification requirements* section is replaced by the following:

**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](https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html).

3. The following item is added to the list of services requiring inpatient and outpatient precertification in the *What types of services and supplies require precertification* provision in the *Medical necessity, referral and precertification requirements* section:

Gene-based, cellular and other innovative therapies (GCIT)
4. The following paragraph is added to the *Precertification for medical services and supplies* provision in the *Medical necessity, referral and precertification requirements* 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**.

5. The *Walk-in clinic* provision in the *Eligible health services under your plan – Physicians and other health professionals – Alternatives to physician and specialist office visits* section is replaced by the following:

**Alternatives to physician and specialist office visits**

**Walk-in clinic (non-emergency visit)**

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

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

6. The following provision is added to the *Eligible health services under your plan – Specific therapies and tests* section:

**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 immunotheapies.
- 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.

Important note:
You must get GCIT eligible health services from the GCIT-designated facility/provider. If there are no GCIT-designated facilities/providers assigned in your local network, we will arrange for and coordinate your care at a GCIT-designated facility/provider. If you don’t get your GCIT services at the facility/provider we designate, the services will not be covered.

7. The following paragraph is added after the What outpatient prescription drugs are covered provision in the Eligible health services under your plan – Outpatient prescription drugs section:

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.

8. The Mental health treatment exclusion in the What your plan doesn’t cover – Eligible health service exceptions and exclusions – General exceptions and exclusions section is renamed as Behavioral health treatment and is replaced by the following:

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):
  - Stay in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
  - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation
9. The following exclusions are removed from the *What your plan doesn’t cover – Eligible health service exceptions and exclusions – General exceptions and exclusions* section:

**Counseling**
- Marriage, religious, family, career, social adjustment, pastoral, or financial counseling

**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

10. The “Court-ordered services and supplies,” “Educational services,” and “Wilderness treatment programs” exclusions in the *What your plan doesn’t cover – Eligible health service exceptions and exclusions – General exceptions and exclusions* section are replaced by the following:

**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

**Educational services**
Examples of these services are:
- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services under your plan – Diabetic services and supplies (including equipment and training)* section. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

**Wilderness treatment programs**
See *Educational services* within this section

11. The following exclusions are added to the *What your plan doesn’t cover – Eligible health service exceptions and exclusions – General exceptions and exclusions* section:

**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, referral and precertification requirements* section.
Mental health and substance abuse related disorders 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
  - Pathological gambling, kleptomania, pyromania
  - Specific developmental disorders of scholastic skills (learning disorders/learning disabilities)
  - Specific developmental disorder of motor functions
  - Specific developmental disorders of speech and language
  - Other disorders of psychological development

12. The **Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps** exclusion in the What your plan doesn’t cover – Eligible health service exceptions and exclusions – Exceptions and exclusions that apply to outpatient prescription drugs section is replaced by the following:

**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

13. The **When will your coverage end** provision in the When coverage ends section is replaced by the following:

**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

Coverage may also end on any date requested by you.

Also, in the event of cancellation or death, we will return any unearned portion of **premium** paid. Cancellations shall be without prejudice to any claims originating prior to the effective date of cancellation.

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

If you withdraw from school because you have entered the armed forces, any unearned **premiums** will be refunded, on a pro-rata basis, when we receive your application within 90 days from the date of the withdrawal.
14. Definitions for the terms “Mental disorder,” “Negotiated charge,” “Telemedicine,” and “Walk-in clinic” in the Glossary section are replaced by the following:

**Mental disorder**
A constitutional disorder is, in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of mental disorder is in the most recent edition of *The International Classification of Diseases, Tenth Edition (ICD-10)*.

**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.

**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
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

15. The explanation for “Medicare allowed rates” in the Glossary – Recognized charge – Special terms used section is replaced by the following:

- 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.

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

How to contact us for help
You can contact us by:
- Calling us at 1-800-872-3862
- Writing us at Aetna Life Insurance Company, 151 Farmington Ave, Hartford, CT 06156

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

FL Cert Amendment1
Amendment 1
Issue Date 04/20/2020
Aetna Life Insurance Company

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

Policyholder: Nova Southeastern University - Final Year Students Main Campus

Student policy number: 867897

Effective date: 05/01/2020

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

How to contact us for help
You can contact us by:
- Calling us at 1-855-821-9720
- Writing us at Aetna Life Insurance Company, 151 Farmington Ave, Hartford, CT 06156

The changes are as follows:

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

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

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

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

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

You must obtain a referral from school health services before you can get services and supplies from other providers.

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

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

2. The Referrals provision in the Medical necessity, referral and precertification requirements section is replaced with the following:

Referrals
You may need a referral from school health services. If you do not have a referral when it is required, then a referral penalty may apply. Refer to the schedule of benefits and the Referral penalty section.

3. The following changes apply to the list of services requiring precertification, as shown in the Precertification – What types of services and supplies require precertification section:
   - “Home health care” is added to the outpatient services list
   - “Hospice services” is added to the outpatient services list
   - “Outpatient detoxification” is removed from the list

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

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

Your plan does not cover immunizations that are not considered preventive care

5. The Well woman preventive visits benefit in the Eligible health services under your plan – Preventive care and wellness section is replaced by the following:

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

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.

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

When does your plan cover missing teeth that are not replaced?
The installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services if:

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

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

Well newborn nursery care
Eligible health services include routine care of your well newborn child in a hospital or birthing center such as:

- Well newborn nursery care during the mother’s stay but for not more than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery
- Hospital or birthing center visits and consultations for the well newborn by a physician but for not more than 1 visit per day

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

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

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

**Substance abuse related disorders treatment**

- Outpatient treatment received while not confined as an inpatient in a general medical hospital, psychiatric hospital 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.
11. The Transplant services benefit in the Eligible health services under your plan – Specific conditions section is replaced by the following:

**Transplant services**

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

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

**Network of transplant facilities**

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

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the **IOE facility** we designate to perform the transplant you need. You may also get transplant services at a non-**IOE facility**, but your cost share will be higher.

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

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

**Custodial care**

**Examples are:**
- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- **Respite care** except in connection with hospice care, adult (or child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training
13. The Transplant services exclusion in the What your plan doesn’t cover – eligible health service exceptions and exclusions section is replaced by the following:

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

14. The first paragraph of the Who provides the care section is replaced by the following paragraphs:

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

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.

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

In-network providers
We have contracted with providers to provide eligible health services to you. These providers make up the network for your plan. For you to receive the in-network level of benefits you must use in-network providers for eligible health services. There are some exceptions:
- Emergency services – refer to the description of emergency services and urgent care in the Eligible health services under your plan section
- Urgent care – refer to the description of emergency services and urgent care in the Eligible health services under your plan section
- Transplants – see the description of transplant services in the Eligible health services under your plan – Specific conditions section

You may select an in-network provider from the directory through your Aetna secure website at www.aetnastudenthealth.com. You can search our online directory for names and locations of providers or contact Member Services at the toll-free number on your ID card. You will not have to submit claims for treatment received from in-network providers. Your in-network provider will take care of that for you. And we will directly pay the in-network provider for what the plan owes.

16. The first paragraph of Your coverage can change in the General provisions – other things you should know section is replaced by the following:

Your coverage can change
Your coverage is defined by the student policy. This document may have amendments or riders too. Under certain circumstances, we or the policyholder or the law may change your plan according to requirements of the student policy. When an emergency or epidemic is declared, we may modify or waive precertification, prescription quantity limits or your cost share if you are affected. Only Aetna may waive a requirement of your plan. No other person – including the policyholder or provider – can do this.
17. Definitions for the terms “Negotiated charge” and “School health services” in the Glossary section are replaced by the following:

**Negotiated charge**

*Health coverage*

This is either:

- The amount an in-network provider has agreed to accept
- The amount we agree to pay directly to an in-network provider or third-party vendor (including any administrative fee in the amount paid)

for providing services, prescription drugs or supplies to covered persons in the plan. This does not include prescription drug services from an in-network pharmacy.

*Prescription drug coverage from an in-network pharmacy*

**In-network pharmacy**

The amount we established for each prescription drug obtained from an in-network pharmacy under this plan. This negotiated charge may reflect amounts we agreed to pay directly to the in-network pharmacy or to a third-party vendor for the prescription drug, and may include a rebate, an additional service or risk charge set by us.

We may receive or pay additional amounts from or to third parties underprice guarantees. These amounts may change the negotiated charge under this plan.

**School health services**

The policyholder’s school’s student health center or a provider or organization that is identified as a school health services provider.

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

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

FL Cert Amendment2
Amendment 2
Issue Date 04/20/2020
Assistive Technology

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

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

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

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

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

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


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<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>English</strong></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 jwen sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat identifikasyon 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 قید شده روزی 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 acceder 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>
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</tbody>
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