Student Health Insurance

Open Choice PPO
Medical and Outpatient Prescription Drug Plan

Schedule of Benefits

Prepared exclusively for:

Policyholder: University of California Berkeley - Extension - Continuation Plan
Policyholder number: 686139
Student policy effective date: 01/01/2019
Plan effective date: 01/01/2019
Plan issue date: 01/08/2019
Actuarial value and metallic level: 94.95% - Platinum

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

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.
- At the end of this schedule of benefits you will find detailed explanations about your:
  - **Policy year deductibles**
  - **Copayments**
  - **Coinsurance**
  - **Maximum out-of-pocket limits**

**Important note:**

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

**How to contact us for help**

We are here to answer your questions.

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

The coverage described in this schedule of benefits will be provided under **Aetna's student policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **student policy** for medical and pharmacy coverage. Keep this schedule of benefits with your certificate of coverage.

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

The way the cost sharing works under this plan, you pay the **policy year deductible** first. Then you pay your **copayment** and then you pay your **coinsurance**. Your copayment does not apply towards any policy year deductible.

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

Here’s an example of how cost sharing works:

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

Plan Features

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy year deductibles</td>
<td>$100 per policy year</td>
<td>$200 per policy year</td>
</tr>
<tr>
<td>Student</td>
<td>$100 per policy year</td>
<td>$200 per policy year</td>
</tr>
<tr>
<td>Spouse</td>
<td>$100 per policy year</td>
<td>$200 per policy year</td>
</tr>
<tr>
<td>Each Child</td>
<td>$100 per policy year</td>
<td>$200 per policy year</td>
</tr>
</tbody>
</table>

Policy year deductible waiver

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

- In-Network care for Preventive care and wellness
- In-Network care for Pediatric Dental Care
- In-Network and Out-of-Network care for treatment rendered at the on-campus Student Health Center or referred to an In-Network or Out-of-Network Provider by the SHC, well newborn nursery care, Pediatric Vision Benefits and Outpatient prescription drugs

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

<table>
<thead>
<tr>
<th></th>
<th>In-network Coverage</th>
<th>Out-of-network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$6,350 per policy year</td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>$6,350 per policy year</td>
<td></td>
</tr>
<tr>
<td>Each Child</td>
<td>$6,350 per policy year</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$12,700 per policy year</td>
<td></td>
</tr>
</tbody>
</table>

### Precertification

You do not need to obtain pre-certification for any services. However, your provider is required to obtain pre-certification for certain in-network services. Refer to the Precertification provisions in the Coverage section of the Certificate of Coverage for a complete description of the precertification programs including the types of services, treatments, procedures, visits or supplies that require precertification. No penalty will be applied to you for an in-network service that was not pre-certified.

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

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

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preventive care and wellness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine physical exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed at a physician’s office</td>
<td>100% (of the negotiated charge)</td>
<td>50% (of the recognized charge), after the policy year deductible</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 Navigator® secure website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or calling the toll-free number on your ID card.</td>
<td></td>
</tr>
<tr>
<td>Covered persons age 22 and over: Maximum visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td>Preventive care immunizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed in a facility or at a physician’s office</td>
<td>100% (of the negotiated charge)</td>
<td>50% (of the recognized charge), after the policy year deductible</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 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 Navigator® secure website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or calling the toll-free number on your ID card.</td>
<td></td>
</tr>
</tbody>
</table>

See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefit.
<table>
<thead>
<tr>
<th>Preventive Services</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well woman preventive visits</strong></td>
<td></td>
</tr>
<tr>
<td>Routine gynecological exams (including Pap smears)</td>
<td></td>
</tr>
</tbody>
</table>
| Performed at a physician’s, obstetrician (OB), gynecologist (GYN) or OB/GYN office | 100% (of the negotiated charge)  
No copayment or policy year deductible applies | 50% (of the recognized charge), after the policy year deductible |
| Maximum visits per policy year                          | 1 visit                                                                         |
| Preventive screening and counseling services            |                                                                                  |
| Obesity and/or healthy diet counseling office visits    | 100% (of the negotiated charge)  
No copayment or policy year deductible applies | 50% (of the recognized charge), after the policy year deductible |
| Maximum visits per policy year                          | 26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* |
| (This maximum applies only to covered persons age 22 and older.) |                                                                                  |
| *Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit. |                                                                                  |
| Misuse of alcohol and/or drugs counseling office visits | 100% (of the negotiated charge)  
No copayment or policy year deductible applies | 50% (of the recognized charge), after the policy year deductible |
| Maximum                                                | Subject to any age; family history; and frequency guidelines as set forth in the most current:  
- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and  
- The comprehensive guidelines supported by the Health Resources and Services Administration. |                                                                                  |
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Benefit Coverage</th>
<th>Deductible or Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of tobacco products counseling office visits</td>
<td>100% (of the negotiated charge)</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>Subject to any age; family history; and frequency guidelines as set forth in the most current:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The comprehensive guidelines supported by the Health Resources and Services Administration.</td>
<td></td>
</tr>
<tr>
<td>Depression screening counseling office visits</td>
<td>100% (of the negotiated charge)</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>Subject to any age; family history; and frequency guidelines as set forth in the most current:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The comprehensive guidelines supported by the Health Resources and Services Administration.</td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted infection counseling office visits</td>
<td>100% (of the negotiated charge)</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>Subject to any age; family history; and frequency guidelines as set forth in the most current:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The comprehensive guidelines supported by the Health Resources and Services Administration.</td>
<td></td>
</tr>
<tr>
<td>Genetic risk counseling for breast and ovarian cancer office visits</td>
<td>100% (of the negotiated charge)</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
</tbody>
</table>

Age limitations

Not subject to any age limitations

See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefit.
### Stress management
100% (of the negotiated charge)  
No copayment or policy year deductible applies  
50% (of the recognized charge), after the policy year deductible

### Chronic conditions
100% (of the negotiated charge)  
No copayment or policy year deductible applies  
50% (of the recognized charge), after the policy year deductible

#### Routine cancer screenings
Performed at a physician’s office, specialist’s office or facility

<table>
<thead>
<tr>
<th>Routine cancer screenings</th>
<th>100% (of the negotiated charge)</th>
<th>50% (of the recognized charge), after the policy year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

#### Maximums
Subject to any age; family history; and frequency guidelines as set forth in the most current:
- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and
- The comprehensive guidelines supported by the Health Resources and Services Administration.

For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.

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

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

---

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

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

<table>
<thead>
<tr>
<th>Preventive care services only (includes participation in the California Prenatal Screening Program)</th>
<th>100% (of the negotiated charge)</th>
<th>50% (of the recognized charge), after the policy year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

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

#### First Postnatal Visit

<table>
<thead>
<tr>
<th>100% (of the negotiated charge)</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No copayment or policy year deductible applies</td>
<td>1 visit</td>
</tr>
</tbody>
</table>

#### Comprehensive lactation support and counseling services

<table>
<thead>
<tr>
<th>Lactation counseling services - facility or office visits</th>
<th>100% (of the negotiated charge)</th>
<th>50% (of the recognized charge), after the policy year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>No copayment or policy year deductible applies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Breast feeding durable medical equipment

<table>
<thead>
<tr>
<th>Breast pump supplies and accessories</th>
<th>100% (of the negotiated charge)</th>
<th>50% (of the recognized charge), after the policy year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>No copayment or policy year deductible applies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

---

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

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Benefit Coverage</th>
<th>Amount Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female contraceptive counseling services office visit</td>
<td>100% (of the negotiated charge)</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Covers up to a 12 month supply of FDA-approved prescription contraceptives</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

**Contraceptives (prescription drugs and devices)**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Benefit Coverage</th>
<th>Amount Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit</td>
<td>100% (of the negotiated charge)</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
</tbody>
</table>

**Female voluntary sterilization**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Benefit Coverage</th>
<th>Amount Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient provider services</td>
<td>100% (of the negotiated charge)</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>No copayment or policy year deductible applies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient provider services</td>
<td>100% (of the negotiated charge)</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>No copayment or policy year deductible applies</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 benefit.
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2. Physicians and other health professionals</strong></td>
<td><strong>Physician and specialist services (non-surgical and non-preventive)</strong></td>
<td></td>
</tr>
<tr>
<td>Office hours visits (non-surgical and non-preventive care by a physician and specialist)</td>
<td>100% (of the negotiated charge) per visit, after the policy year deductible</td>
<td>50% (of the recognized charge) per visit, after the policy year deductible</td>
</tr>
<tr>
<td>Telemmedicine consultation by a physician or specialist</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Allergy testing and treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy testing performed at a physician’s or specialist’s office</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Allergy injections treatment performed at a physician’s, or specialist office</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Allergy sera and extracts administered via injection at a physician’s or specialist’s office</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Physician and specialist - inpatient surgical services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>100% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td><strong>Physician and specialist - outpatient surgical services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery performed at a physician’s or specialist’s office or outpatient department of a hospital or surgery center by a surgeon</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</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 benefit.
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Outpatient Services</th>
<th>Inpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthetist</td>
<td>100% of negotiated</td>
<td>100% of recognized</td>
</tr>
<tr>
<td>charge, after the policy year deductible</td>
<td>charge, after the policy year deductible</td>
<td></td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>100% of negotiated</td>
<td>50% of recognized</td>
</tr>
<tr>
<td>charge, after the policy year deductible</td>
<td>charge, after the policy year deductible</td>
<td></td>
</tr>
</tbody>
</table>

**In-hospital non-surgical physician services**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Outpatient Services</th>
<th>Inpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-hospital non-surgical physician services</td>
<td>100% of negotiated</td>
<td>100% of recognized</td>
</tr>
<tr>
<td>charge, after the policy year deductible</td>
<td>charge, after the policy year deductible</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Outpatient Services</th>
<th>Inpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant office visits</td>
<td>100% of negotiated</td>
<td>50% of recognized</td>
</tr>
<tr>
<td>charge, after the policy year deductible</td>
<td>charge, per visit, after the policy year deductible</td>
<td></td>
</tr>
<tr>
<td>Telemedicine consultation by a consultant</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>

**Second opinion services**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Outpatient Services</th>
<th>Inpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second opinion services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

**Alternatives to physician office visits**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Outpatient Services</th>
<th>Inpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk-in clinic visits (non-emergency visit)</td>
<td>100% of negotiated</td>
<td>50% of recognized</td>
</tr>
<tr>
<td>visit)</td>
<td>charge, per visit, after the policy year deductible</td>
<td></td>
</tr>
</tbody>
</table>

**Important note:**

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

See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefit.
<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>3. Hospital and other facility care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital care (facility charges)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital (room and board) and other miscellaneous services and supplies</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</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 includes intensive care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A private room is covered when medically necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For physician charges, refer to the <em>Physician and specialist – inpatient surgical services</em> benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preadmission testing</strong></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><strong>Anesthesia and hospital charges for dental care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia and hospital charges for dental care</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>Alternatives to hospital stays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient surgery (facility charges)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility charges for surgery performed in the outpatient department of a hospital or surgery center</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<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>

See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefit.
<table>
<thead>
<tr>
<th>Home health care</th>
<th>100% (of the negotiated charge), after the policy year deductible</th>
<th>50% (of the recognized charge), after the policy year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient facility</strong></td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>(room and board and other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>miscellaneous services and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A private room is covered when</td>
<td></td>
<td></td>
</tr>
<tr>
<td>medically necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td><strong>Skilled nursing facility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient facility</strong></td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>(room and board and miscellaneous inpatient care services and supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject to semi-private room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>rate unless intensive care unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>is required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board includes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>intensive care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

#### Emergency services

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital emergency room</td>
<td>$75 copayment after the policy year deductible, then the plan pays 100% (of the negotiated charge) per visit thereafter</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td><em>Includes complex imaging services, lab work and radiological services performed during a hospital emergency room visit, and any surgery which results from the hospital emergency room visit</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**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.
- 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.

<table>
<thead>
<tr>
<th>Non-emergency care in a hospital emergency room</th>
<th>Not covered</th>
<th>Not covered</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost Share 1</th>
<th>Cost Share 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent medical care provided by an urgent care provider</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td><em>Includes complex imaging services, lab work and radiological services performed during an urgent medical care visit</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost Share 1</th>
<th>Cost Share 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent use of urgent care provider</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefit.
<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>Limited to covered persons through the end of the month in which the person turns age 19</td>
<td></td>
</tr>
<tr>
<td>Type A services</td>
<td>100% (of the negotiated charge)</td>
<td>100% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Type B services</td>
<td>70% (of the negotiated charge)</td>
<td>70% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Type C services</td>
<td>50% (of the negotiated charge)</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Orthodontic services</td>
<td>50% (of the negotiated charge)</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td></td>
<td>No copayment or 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 benefit.
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6. Specific conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Birthing center (facility charges)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient (room and board and other miscellaneous services and supplies)</td>
<td>Paid at the same cost-sharing as hospital care.</td>
<td>Paid at the same cost-sharing as hospital care.</td>
</tr>
<tr>
<td><strong>Diabetic services and supplies (including equipment and training)</strong></td>
<td>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>Family planning services – other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Voluntary sterilization for males</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient physician or specialist surgical services</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Outpatient physician or specialist surgical services</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td><strong>Abortion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient physician or specialist surgical services</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Outpatient physician or specialist surgical services</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td><strong>Reversal of voluntary sterilization</strong></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>
</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 benefit.
<table>
<thead>
<tr>
<th><strong>Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment</strong></th>
<th><strong>TMJ and CMJ treatment</strong></th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impacted wisdom teeth</strong></td>
<td><strong>Impacted wisdom teeth</strong></td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>100% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td><strong>Blood and body fluid exposure</strong></td>
<td><strong>Blood and body fluid exposure</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><strong>Dermatological treatment</strong></td>
<td><strong>Dermatological treatment</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><strong>Maternity care</strong></td>
<td><strong>Maternity care (includes delivery and postpartum care services in a hospital or birthing center)</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><strong>Well newborn nursery care</strong></td>
<td><strong>Well newborn nursery care in a hospital or birthing center</strong></td>
<td>100% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

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

See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefit.
<table>
<thead>
<tr>
<th>Pregnancy complications</th>
<th>Inpatient (room and board and other miscellaneous services and supplies)</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Subject to semi-private room rate unless intensive care unit required</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Room and board includes intensive care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender reassignment (sex change) treatment</td>
<td>Surgical, hormone replacement therapy, and counseling 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>Mental health treatment</td>
<td>Mental health treatment – inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient hospital mental disorders treatment (room and board and other miscellaneous hospital services and supplies)</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td></td>
<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></td>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A private room is covered when medically necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental disorder room and board intensive care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health treatment – outpatient</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>100% (of the actual charge), after the policy year deductible</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Outpatient mental disorders treatment office visits to a physician or behavioral health provider* (includes telemedicine cognitive behavioral therapy consultations)</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>100% (of the actual charge), after the policy year deductible</td>
<td></td>
</tr>
<tr>
<td>*Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other outpatient mental disorders treatment (includes skilled behavioral health services in the home)</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
<td></td>
</tr>
<tr>
<td>Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*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, Other outpatient mental health treatment such as: Electro-convulsive therapy (ECT), Mental disorder injectables; Transcranial magnetic stimulation (TMS)</td>
<td></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 benefit.
**Substance abuse related disorders treatment-inpatient**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Co-payment 1</th>
<th>Co-payment 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital substance abuse detoxification (room and board and other</td>
<td>100% (of the negotiated charge), after the policy year</td>
<td>50% (of the recognized charge), after the policy year</td>
</tr>
<tr>
<td>miscellaneous hospital services and supplies)</td>
<td>deductible</td>
<td>deductible</td>
</tr>
<tr>
<td>Inpatient hospital substance abuse rehabilitation (room and board and other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>miscellaneous hospital services and supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient residential treatment facility substance abuse (room and board and other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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>A private room is covered when medically necessary.</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>Service Description</th>
<th>Co-payment 1</th>
<th>Co-payment 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient substance abuse office visits to a physician or behavioral health</td>
<td>100% (of the negotiated charge), after the policy year</td>
<td>100% (of the actual charge), after the policy year</td>
</tr>
<tr>
<td>provider* (includes telemedicine cognitive behavioral therapy consultations)</td>
<td>deductible</td>
<td>deductible</td>
</tr>
</tbody>
</table>

*Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor

---

See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefit.
Other outpatient substance abuse services (includes skilled behavioral health services in the home)

Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment)*

Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment)*

*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, other outpatient substance abuse treatment such as outpatient monitoring of injectable therapy.

### Obesity (bariatric) surgery

<table>
<thead>
<tr>
<th>Service Description</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>Obesity surgery— inpatient and outpatient facility and physician services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Obesity surgery—travel and lodging

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Benefit payable for Travel Expenses for each round trip – 3 round trips covered (one pre-surgical visit, the surgery, and one follow-up visit)</td>
<td>$130</td>
</tr>
<tr>
<td>Maximum Benefit payable for Travel Expenses per companion for each round trip – 2 round trips covered (the surgery, and one follow-up visit)</td>
<td>$130</td>
</tr>
<tr>
<td>Maximum Benefit payable for Lodging Expenses per patient and companion for the pre-surgical and follow-up visits</td>
<td>$100 per day, up to 2 days</td>
</tr>
<tr>
<td>Maximum Benefit payable for Lodging Expenses per companion for surgery stay</td>
<td>$100 per day, up to 4 days</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 benefit.
| 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. |

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

### Transplant services

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

### Transplant services-travel and lodging

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

See the **How to read your schedule of benefits, Important note about your cost sharing and Important notices** sections of this schedule of benefit.
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of infertility</td>
<td>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>Basic infertility services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient and outpatient care - basic infertility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diethylstilbestrol (DES) 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>California Prenatal Screening Program</td>
<td>100% (of the negotiated charge) No copayment or policy year deductible applies</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>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>Genetic Testing</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

See the *How to read your schedule of benefits*, *Important note about your cost sharing and Important notices* sections of this schedule of benefit.
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Specific therapies and tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult dental care for cancer treatments and dental injuries</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>Adult dental care for cancer treatments</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>100% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Adult dental care for dental injuries</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>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Diagnostic lab work and radiological services</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Outpatient infusion therapy</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Outpatient radiation therapy</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</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 benefit.
<table>
<thead>
<tr>
<th>Specialty prescription drugs</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>(Purchased and injected or infused by your provider in an outpatient setting)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient respiratory therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory therapy</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Transfusion or kidney dialysis of blood</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfusion or kidney dialysis of blood</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Cardiac and pulmonary rehabilitation services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Pulmonary rehabilitation</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td><strong>Rehabilitation and habilitation therapy services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient physical, occupational, speech, and cognitive therapies</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Combined for short-term rehabilitation services and habilitation therapy services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</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 benefit.
### Diagnostic testing for learning disabilities

| Diagnostic testing for learning disabilities | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefit.*
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Other services and supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture</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>Ambulance service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency and Non-Emergency ground, air or water ambulance</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td>Clinical trial therapies (experimental or investigational)</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>Clinical trials (routine patient costs)</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>Durable medical equipment (DME)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Enteral and parenteral nutritional supplements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enteral and parenteral 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>Osteoporosis (non-preventive care)</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>Prosthetic and orthotic devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetic and orthotic devices</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</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 benefit.
<table>
<thead>
<tr>
<th>Hearing aids and exams</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hearing aid exams</strong></td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
</tr>
<tr>
<td><strong>Hearing aids</strong></td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Podiatric (foot care) treatment

| Physician and specialist non-routine foot care treatment | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

### Vision care

#### Pediatric vision care
Limited to covered persons through the end of the month in which the person turns age 19

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

<table>
<thead>
<tr>
<th>Performed by a legally qualified ophthalmologist or optometrist</th>
<th>100% (of the negotiated charge)</th>
<th>100% (of the recognized charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
</tr>
</tbody>
</table>

| Maximum visits per policy year | 1 visit |

#### Pediatric comprehensive low vision evaluations

<table>
<thead>
<tr>
<th>Performed by a legally qualified ophthalmologist or optometrist</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Maximum</th>
<th>One comprehensive low vision evaluation every 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4 follow-up visits in any 5-year period</td>
</tr>
</tbody>
</table>

#### Pediatric vision care services and supplies

<table>
<thead>
<tr>
<th>Office visit for fitting of contact lenses</th>
<th>100% (of the negotiated charge)</th>
<th>100% (of the recognized charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
</tr>
</tbody>
</table>

| Maximum visits per policy year | 1 visit |

See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefit.
<table>
<thead>
<tr>
<th>Eyeglass frames, prescription lenses or prescription contact lenses</th>
<th>100% (of the negotiated charge)</th>
<th>100% (of the recognized charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td>Maximum number of eyeglass frames per policy year</td>
<td>One set of eyeglass frames</td>
<td></td>
</tr>
<tr>
<td>Maximum number of prescription lenses per policy year</td>
<td>One pair of prescription lenses</td>
<td></td>
</tr>
<tr>
<td>Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)</td>
<td>Daily Disposables: 1 year supply</td>
<td>Extended Wear Disposable: 1 year supply</td>
</tr>
<tr>
<td></td>
<td>Non-Disposable Lenses: 1 year supply</td>
<td></td>
</tr>
<tr>
<td>Optical devices</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Maximum number of optical devices per policy year</td>
<td>One optical device</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefit.
## Adult vision care
Limited to covered persons age 19 and over

### Adult routine vision exams (including refraction)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coinsurance 1</th>
<th>Coinsurance 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed by a legally qualified ophthalmologist or optometrist</td>
<td>100% (of the negotiated charge), after the policy year deductible</td>
<td>50% (of the recognized charge), after the policy year deductible</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

### Aniridia

<table>
<thead>
<tr>
<th>Aniridia</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>

See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefit.
### 9. Outpatient prescription drugs

#### Plan features

<table>
<thead>
<tr>
<th>Outpatient prescription drug copayment waiver for risk reducing breast cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>The outpatient prescription drug copayment will not apply to risk reducing breast cancer prescription drugs when obtained at a retail or mail order in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient prescription drug copayment waiver for contraceptives</th>
</tr>
</thead>
<tbody>
<tr>
<td>The outpatient prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy.</td>
</tr>
</tbody>
</table>

This means that such contraceptive methods are paid at 100% for:
- All FDA approved 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 outpatient 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 a in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

Covers up to a 12 month supply of FDA-approved prescription contraceptives.
<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>Generic prescription drugs (including specialty drugs)</strong></td>
<td>$10 copayment per supply then the plan pays 100% (of the negotiated charge) per prescription or refill</td>
<td></td>
</tr>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>No policy year deductible applies</td>
<td>Coinsurance is 50% (of the recognized charge) but will be no more than $250 per supply</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td><strong>Preferred brand-name prescription drugs (including specialty drugs)</strong></td>
<td>$35 copayment per supply then the plan pays 100% (of the negotiated charge) per prescription or refill</td>
<td></td>
</tr>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>No policy year deductible applies</td>
<td>Coinsurance is 50% (of the recognized charge) but will be no more than $250 per supply</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Preferred brand-name prescription drugs (including specialty drugs)</strong></td>
<td>$50 copayment per supply then the plan pays 100% (of the negotiated charge) per prescription or refill</td>
<td></td>
</tr>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>No policy year deductible applies</td>
<td>Coinsurance is 50% (of the recognized charge) but will be no more than $250 per supply</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td><strong>Orally administered anti-cancer prescription drugs</strong></td>
<td>100% (of the negotiated charge) per prescription or refill</td>
<td>100% (of the recognized charge) per prescription or refill</td>
</tr>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td><strong>Preventive care drugs and supplements</strong></td>
<td>100% (of the negotiated charge) per prescription or refill</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
</tr>
<tr>
<td>Preventive care drugs and supplements filled at a retail 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>
<tr>
<td><strong>Maximums:</strong></td>
<td>Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. 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 the back of your ID card.</td>
<td></td>
</tr>
</tbody>
</table>

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

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

**Maximums:**

- Coverage 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 the back of your ID card.

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

<table>
<thead>
<tr>
<th>Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy</th>
<th>100% (of the negotiated charge) per prescription or refill</th>
<th>Paid according to the type of drug per the schedule of benefits, above</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each 30 day 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 tobacco cessation prescription drugs, contact Member Services by calling the toll-free number on the back of your ID card.

### Important Information

- Refer to The Prescribed Medicine Expense provision for details about outpatient prescription drug coverage.

- The covered person **may pay less** for prescriptions if they:
  - Use generic prescription drugs rather than brand name prescription drugs;
  - Obtain prescription drugs from in-network pharmacies rather than out-of-network pharmacies;
  - Use prescription drugs that are on the preferred drug list;
  - Obtain injectable, self-injectable, or specialty care prescription drugs from the specialty pharmacy network or in-network pharmacies;

- Step therapy and precertification may be required to obtain certain prescription drugs. The list of drugs subject to precertification and/or step therapy can be accessed at www.aetna.com/formulary.

- Regarding prescription contraceptives, a prescriber may seek a medical exception to obtain coverage for drugs not listed on the preferred drug guide (formulary).

- Coverage includes all FDA-approved, contraceptive drugs, devices, and other products for women, including all FDA-approved, contraceptive drugs, devices, and products available over the counter, as prescribed by the insured’s provider.

- Additionally, if the provider determines a particular service or FDA-approved item is medically necessary, Aetna will cover that service or item without cost sharing. Aetna will defer to your prescriber’s determination and will approve the request within 2 business days of receipt of the completed request.

See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefit.
**Therapeutic Equivalence (TE)**

Drug products classified as therapeutically equivalent can be substituted with the full expectation that the substituted product will produce the same clinical effect and safety profile as the prescribed product. Drug products are considered to be therapeutically equivalent only if they meet these criteria:

- They are pharmaceutical equivalents (contain the same active ingredient(s); dosage form and route of administration; and strength.)
- They are assigned by FDA the same therapeutic equivalence codes starting with the letter "A." To receive a letter "A", FDA
  - Designates a brand name drug or a generic drug to be the Reference Listed Drug (RLD).
  - Assigns therapeutic equivalence codes based on data that a drug sponsor submits in an ANDA to scientifically demonstrate that its product is bioequivalent (i.e., performs in the same manner as the Reference Listed Drug).

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

This section provides detailed explanations about:

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

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

<table>
<thead>
<tr>
<th>Policy year deductible provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible health services</strong> applied to the out-of-network <strong>policy year deductibles</strong> will not be applied to satisfy the in-network <strong>policy year deductibles</strong>. Eligible health services applied to the in-network <strong>policy year deductibles</strong> will not be applied to satisfy the out-of-network <strong>policy year deductibles</strong>.</td>
</tr>
<tr>
<td>The in-network and out-of-network <strong>policy year deductibles</strong> may not apply to certain <strong>eligible health services</strong>. You must pay any applicable <strong>copayments</strong> for <strong>eligible health services</strong> to which the <strong>policy year deductible</strong> does not apply.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Copayments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-network coverage</strong></td>
</tr>
<tr>
<td>This is a specified dollar amount or percentage that must be paid by you when you receive <strong>eligible health services</strong> from an <strong>in-network provider</strong>.</td>
</tr>
<tr>
<td><strong>Out-of-network coverage</strong></td>
</tr>
<tr>
<td>This is a specified dollar amount or percentage that must be paid by you when you receive <strong>eligible health services</strong> from an <strong>out-of-network provider</strong>.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coinsurance</strong> is both the percentage of <strong>eligible health services</strong> that the plan pays and what you pay. The specific percentage that we have to pay for <strong>eligible health services</strong> is listed earlier in the schedule of benefits. <strong>Coinsurance</strong> is not a <strong>copayment</strong>.</td>
</tr>
</tbody>
</table>

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

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

Individual
Once the amount of the copayments, coinsurance and policy year deductibles you and your covered dependents have paid for eligible health services during the policy year meets the individual maximum out-of-pocket limits, this plan will pay:
- 100% of the negotiated charge for in-network covered benefits
- 100% of the recognized charge for out-of-network covered benefits

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

Family
Once the amount of the copayments, coinsurance and policy year deductibles you and your covered dependents have paid for eligible health services during the policy year meets this family maximum out-of-pocket limit, this plan will pay:
- 100% of the negotiated charge for in-network covered benefits
- 100% of the recognized charge for out-of-network covered benefits

that apply towards the limits for the rest of the policy year for all covered family members.

Medical and Outpatient Prescription Drugs

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

Certain costs that you incur do not apply toward the maximum out-of-pocket limit. These include:
- All costs for non-covered services
- All costs for non-emergency use of the emergency room
- All costs incurred for non-urgent use of an urgent care provider

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

Certain costs that you incur do not apply toward the maximum out-of-pocket limit. These include:
- Charges, expenses or costs in excess of the recognized charge
- All costs for non-covered services
- All costs for non-emergency use of the emergency room
- All costs incurred for non-urgent use of an urgent care provider

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. 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 benefit.
Student Health Insurance

Open Choice PPO

Medical and Outpatient Prescription Drug Plan

Certificate of Coverage

Prepared exclusively for:

Policyholder: University of California Berkeley - Extension - Continuation Plan
Policyholder number: 686139
Student policy effective date: 01/01/19
Plan effective date: 01/01/19
Plan issue date: 01/08/19

Underwritten by Aetna Life Insurance Company

IMPORTANT NOTICES:

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

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

• THE INSURANCE DESCRIBED IN THIS CERTIFICATE OF COVERAGE IS A PREFERRED PROVIDER ORGANIZATION (PPO) PLAN. YOU WILL BE COVERED FOR IN-NETWORK AND OUT-OF-NETWORK BENEFITS REGARDLESS OF WHERE YOU LIVE. WE WILL PAY FOR EMERGENCY SERVICES AT THE IN-NETWORK LEVEL.
GENERALLY, SERVICES WILL NOT BE PAID AT THE IN-NETWORK LEVEL IF THEY ARE RECEIVED FROM AN OUT-OF-NETWORK PROVIDER. ANY SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER:

- WILL BE PAID AT A LOWER PERCENTAGE
- MAY BE SUBJECT TO HIGHER OUT-OF-POCKET LIMIT AND DEDUCTIBLE AMOUNTS

SEE THE IMPORTANT EXCEPTION - SURPRISE BILLS SECTION FOR EXCEPTIONS TO THIS RULE.

A LISTING OF ALL NETWORK PROVIDERS IN YOUR SERVICE AREA MAY BE ACCESSED AT ANY TIME IN OUR DIRECTORY. YOU CAN SEARCH THE DIRECTORY AT WWW.AETNA.COM UNDER THE DOCFIND® LABEL.

Right to examine the student policy
You have 30 days after you receive this student policy to read and review it. During that 30-day period, if you decide you do not want the student policy, you may return it to Aetna Life Insurance Company. As soon as it is returned, this student policy will be void from the beginning. Premium paid will be returned to you.
NOTICE

If you have a complaint because you cannot access medical care in a timely manner, you can contact us at the number shown on your ID card. You can also write to us at:

Customer Service
Aetna Life Insurance Company
151 Farmington Avenue
Hartford CT 06156
1-888-802-3862

You may also contact the California Department of Insurance with your concerns. You can contact them at:

California Department of Insurance
Consumer Services Division
300 Spring Street
South Tower
Los Angeles CA 90013
1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4833)
WWW.INSURANCE.CA.GOV
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.
# Table of contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Let’s get started!</td>
<td>7</td>
</tr>
<tr>
<td>- Some notes on how we use words</td>
<td>7</td>
</tr>
<tr>
<td>- What your plan does – providing covered benefits</td>
<td>7</td>
</tr>
<tr>
<td>- How your plan works – starting and stopping coverage</td>
<td>7</td>
</tr>
<tr>
<td>- Eligible health services</td>
<td>7</td>
</tr>
<tr>
<td>- Paying for eligible health services - the general requirements</td>
<td>8</td>
</tr>
<tr>
<td>- Paying for eligible health services - sharing the expense</td>
<td>8</td>
</tr>
<tr>
<td>- Disagreements</td>
<td>8</td>
</tr>
<tr>
<td>- How your plan works while you are covered for in-network coverage</td>
<td>8</td>
</tr>
<tr>
<td>- How your plan works while you are covered for out-of-network coverage</td>
<td>9</td>
</tr>
<tr>
<td>- How to contact us for help</td>
<td>9</td>
</tr>
<tr>
<td>- Your ID card</td>
<td>9</td>
</tr>
<tr>
<td>Who the plan covers</td>
<td>10</td>
</tr>
<tr>
<td>- Who is eligible</td>
<td>10</td>
</tr>
<tr>
<td>- Medicare eligibility</td>
<td>10</td>
</tr>
<tr>
<td>- When you can join the plan</td>
<td>10</td>
</tr>
<tr>
<td>- When you can join the continuation of coverage plan</td>
<td>11</td>
</tr>
<tr>
<td>- Who can be on your plan (who can be your dependents)</td>
<td>11</td>
</tr>
<tr>
<td>- Adding new dependents</td>
<td>12</td>
</tr>
<tr>
<td>- Special times you and your dependents can join the plan</td>
<td>13</td>
</tr>
<tr>
<td>- Effective date of coverage</td>
<td>14</td>
</tr>
<tr>
<td>Medical necessity and precertification requirements</td>
<td>15</td>
</tr>
<tr>
<td>- Medically necessary; medical necessity</td>
<td>15</td>
</tr>
<tr>
<td>- Precertification</td>
<td>15</td>
</tr>
<tr>
<td>- How can I request a medical exception</td>
<td>19</td>
</tr>
<tr>
<td>Eligible health services under your plan</td>
<td>20</td>
</tr>
<tr>
<td>- Preventive care and wellness</td>
<td>20</td>
</tr>
<tr>
<td>- Physicians and other health professionals</td>
<td>26</td>
</tr>
<tr>
<td>- Hospital and other facility care</td>
<td>29</td>
</tr>
<tr>
<td>- Emergency services and urgent care</td>
<td>32</td>
</tr>
<tr>
<td>- Pediatric dental care</td>
<td>34</td>
</tr>
<tr>
<td>- Specific conditions</td>
<td>49</td>
</tr>
<tr>
<td>- Specific therapies and tests</td>
<td>57</td>
</tr>
<tr>
<td>- Other services</td>
<td>61</td>
</tr>
<tr>
<td>- Outpatient prescription drugs</td>
<td>67</td>
</tr>
<tr>
<td>What your plan doesn’t cover - eligible health service exceptions and exclusions</td>
<td>74</td>
</tr>
<tr>
<td>- General exceptions and exclusions (Exceptions)</td>
<td>74</td>
</tr>
<tr>
<td>- Exceptions and exclusions that apply to outpatient prescription drugs (Exceptions)</td>
<td>85</td>
</tr>
<tr>
<td>Who provides the care</td>
<td>87</td>
</tr>
<tr>
<td>- In-network providers</td>
<td>87</td>
</tr>
<tr>
<td>- Out-of-network providers</td>
<td>87</td>
</tr>
<tr>
<td>- Keeping a provider you go to now (continuity of care)</td>
<td>87</td>
</tr>
</tbody>
</table>
What the plan pays and what you pay
The general rule
Important exception – when your plan pays all
Important exceptions – when you pay all
Important exception – surprise bills
Special financial responsibility
Where your schedule of benefits fits in

When you disagree - claim decisions and appeals procedures
Types of claims and communicating our claim decisions
Adverse benefit determinations
The difference between a complaint and an appeal
Appeals of adverse benefit determinations
Timeframes for deciding appeals
Independent medical review from the California Department of Insurance
Recordkeeping
Fees and expenses

Coordination of benefits (COB)
Key terms
Here’s how COB works
Determining who pays
How COB works with Medicare

Other health coverage updates – contact information
Right to receive and release needed information
Right to pay another carrier
Right of recovery

When coverage ends
When will your coverage end?
When will your continuation of coverage plan end?
When will coverage end for any dependents?
What happens to your dependent coverage if you die?
Why would we suspend paying claims or end your and your dependents’ coverage?

Special coverage options after your plan coverage ends
Continuation of coverage plan
Continuation of coverage for other reasons

General provisions – other things you should know
Entire student policy
Administrative provisions
Coverage and services
Honest mistakes and intentional misrepresentation
Some other money issues
Your health information
Effect of benefits under other plans

Glossary

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

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

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

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

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

This plan provides medical and pharmacy insurance coverage at the in-network and out-of-network benefit level.

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

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

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

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

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

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

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

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

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

Disagreements
We know that people sometimes see things differently.

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

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

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

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

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. See www.aetna.com/docfind or call 1-866-529-2517 for a list of in-network providers

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

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

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

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

Your out-of-network coverage:

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

You will find details on:

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

How to contact us for help

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

- Logging onto your Aetna 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 1-877-480-4161
- Writing us at Aetna Life Insurance Company, 151 Farmington Ave, Hartford, CT 06156

Your ID card

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

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

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

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

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

**Who is eligible?**

You are eligible if you are a:
- A student, visiting faculty, scholar, or other person with a current passport and non-immigrant visa temporarily located outside his or her home country or country of residence who has not been granted permanent residency status in the United States while engaged in educational activities through his or her University is required to be insured under the Policy. The University may grant a waiver to people already insured under other government- or embassy-sponsored plans.
- Students engaged in Optional Practical Training (OPT) or Curricular Practical Training (CPT) can also be covered under this policy, provided: 1) the student’s OPT/CPT immediately follows a course of study; and 2) the student’s OPT/CPT is no longer than 12 months in duration.

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

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

For continuation of coverage plans, you must:

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

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

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

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

If your plan includes dependent coverage, you can enroll the following family members on your plan. They are referred to in this certificate of coverage as your “covered dependents” or “dependents”).

- Your legal spouse that resides with you
- Your civil union partner that resides with you
- Your domestic partner that resides with you.
- Your dependent children – your own or those of your spouse, civil union partner or domestic partner
  - The children must be under 26 years of age

A dependent does not include:

- An eligible student listed above in the Who is eligible section

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

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

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

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

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

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

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

• A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your health plan.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by the policyholder.
  - Ask the policyholder when benefits for your domestic partner will begin. It will be either:
    o No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    o Within 31 days of the date of your Domestic Partnership.

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

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

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

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

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

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

Enrollment

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

If you enroll after the effective date of the student policy and you are eligible for health benefits at the time, your coverage will take effect as of that date as long as:
- We receive your completed request for enrollment
- You pay any premium contribution.

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

Continuation of coverage plan
Your and your dependent’s effective date of coverage under a continuation of coverage plan is the later to occur of:
- The date your and your dependent’s coverage under the student policy ends, or
- The date we receive your premium contribution.

Late enrollment
If we receive your enrollment application and premium contribution more than 31 days after the date you become eligible, coverage will only become effective if, and when:
- You enroll during the policyholder’s late enrollment period, or
- You enroll because you lost coverage for any reason under another health plan with similar health coverage

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

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

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

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

This section addresses the medical necessity and precertification requirements.

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

The medical necessity requirements are stated in the Glossary section, where we define “medically necessary, medical necessity”. That is where we also explain physician consider when determining if an eligible health service is medically necessary.

Precertification
You need precertification from us for some eligible health services.

Precertification for medical services and supplies

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

Out-of-network care
When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify, there may be a penalty. 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 physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.</th>
</tr>
</thead>
<tbody>
<tr>
<td>An emergency admission:</td>
<td>You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>An urgent admission:</td>
<td>You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is an admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.</td>
</tr>
<tr>
<td>Outpatient non-emergency services requiring precertification:</td>
<td>You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.</td>
</tr>
</tbody>
</table>

Notification calls for certain medical conditions

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

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

Written notification of precertification decisions

We will provide a written notification to you and your physician of the precertification decision, within:

- 5 business days for a non-urgent request
- 72 hours for urgent requests
- 30 days for retrospective requests

If your precertified services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

Inpatient and outpatient precertification

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

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

You do not need precertification for the following inpatient stays:
- Following a mastectomy and/or lymph node dissection (your physician will determine the length of your stay)
- Pregnancy related stay following the delivery of a baby that is less than 48 hours for a normal vaginal delivery or a 96 hour stay for delivery by caesarean section.

What if you don’t obtain the required precertification?
If you don’t obtain the required precertification:
- There may be a benefit penalty. See the schedule of benefits Precertification covered benefit penalty section.
- Any benefit penalty incurred will not count toward your policy year deductibles or maximum out-of-pocket limits.

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

<table>
<thead>
<tr>
<th>Inpatient services and supplies</th>
<th>Outpatient services and supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>ART services</td>
<td>Certain prescription drugs and devices*</td>
</tr>
<tr>
<td>Obesity (bariatric) surgery</td>
<td>Complex imaging</td>
</tr>
<tr>
<td>Stays in a hospice facility</td>
<td>Comprehensive infertility services</td>
</tr>
<tr>
<td>Stays in a hospital</td>
<td>Cosmetic and reconstructive surgery</td>
</tr>
<tr>
<td>Stays in a rehabilitation facility</td>
<td>Kidney dialysis</td>
</tr>
<tr>
<td>Stays in a residential treatment facility for treatment of mental disorders and substance abuse</td>
<td>Knee surgery</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></td>
<td>Outpatient back surgery not performed in a physician’s office</td>
</tr>
<tr>
<td></td>
<td>Private duty nursing services</td>
</tr>
<tr>
<td></td>
<td>Sleep studies</td>
</tr>
<tr>
<td></td>
<td>Wrist surgery</td>
</tr>
</tbody>
</table>

*For a current listing of the prescription drugs and medical injectable drugs that require precertification, contact Member Services by calling the toll-free number on your ID card or by logging onto the Aetna website at www.aetnastudenthealth.com.
How can I get a drug precertified?

When you use a network pharmacy, your prescriber is responsible for obtaining any necessary precertification. You, someone who represents you or your prescriber may submit a request for a precertification 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

The chart below shows the different types of precertification requests for prescription drugs and how much time we have to tell you about our decision.

<table>
<thead>
<tr>
<th>Type of request</th>
<th>Standard (non-urgent)</th>
<th>Exigent circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial decision by us</td>
<td>72 hours</td>
<td>As soon as possible, but not longer than 24 hours</td>
</tr>
<tr>
<td>If we need more information, we will notify you within</td>
<td>Not applicable</td>
<td>24 hours</td>
</tr>
<tr>
<td>Once we have more information, our decision will be made</td>
<td>Not applicable</td>
<td>24 hours</td>
</tr>
<tr>
<td>How long the drug will be covered if request is approved</td>
<td>As long as it is prescribed, including refills</td>
<td>As long as it is prescribed, including refills</td>
</tr>
</tbody>
</table>

A request under exigent circumstances can be made when:

- Your condition may seriously affect your life, health, or ability to get back maximum function
- You are going through a current course of treatment using a non-preferred drug

What if my precertification request is denied?

If precertification is denied, we will notify you and your provider and let you know how the decision can be appealed. You can also request an external review by an independent organization. For more information see the When you disagree - claim decisions and appeals procedures section.

What if you do not respond to my precertification request?

If we do not respond to your completed precertification request in the time frames above, your request will be deemed approved.
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 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.

<table>
<thead>
<tr>
<th>Important note:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex-specific eligible health services are covered when medically appropriate, regardless of identified gender.</td>
</tr>
</tbody>
</table>

1. Preventive care and wellness

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

<table>
<thead>
<tr>
<th>Important notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You will see references to the following recommendations and guidelines in this section:</td>
</tr>
<tr>
<td>• Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>• United States Preventive Services Task Force</td>
</tr>
<tr>
<td>• Health Resources and Services Administration Women’s Preventive Services Guidelines</td>
</tr>
<tr>
<td>• American Academy of Pediatrics/Bright Futures Guidelines for Preventive Pediatric Health Care/Health Resources and Services Administration guidelines for children and adolescents</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>
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 Guidelines for Preventive Pediatric Health Care /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 Women’s Preventive Services Guidelines. 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
   - Bone density scans (CT and DEXA)
   - 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, including Acquired Immune Deficiency Syndrome (AIDS), 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.
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, for women with a family history of certain cancers, 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
  - Health education programs

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

You can refer to the Outpatient prescription drugs- Preventive care tobacco cessation prescription and over-the-counter drugs section for information on coverage for preventive care tobacco cessation drugs.
- **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.

- **Stress management**
  
  **Eligible health services** include health education programs and counseling services to help you:
  - Identify the life events that cause you stress
  - Learn ways to change behavior to reduce stress

- **Chronic conditions**
  
  **Eligible health services** include counseling and health education services related to chronic conditions such as diabetes and asthma.

**Routine cancer screenings**

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

- 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
- Cervical cancer screening

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
- Diagnosis of fetal genetic disorders
- Preeclampsia screening
Eligible health services also include participation in the California Prenatal Screening Program. This program is administered by the State Department of Health Services.

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 the renting or buying of:

- A hospital grade electric pump
- A hospital grade double breast pump
- An electric breast pump (non-hospital grade)
- A manual breast pump

#### Breast pump supplies and accessories

Eligible health services include breast pump supplies and accessories.

Coverage for the purchase of breast pump equipment is for the duration of breast feeding for each birth. 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 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 female voluntary sterilization procedures and related services and supplies including tubal ligation and sterilization implants.

Follow up services
Eligible health services include follow up services related to the contraceptive drugs, devices, products, and procedures. This includes, but is not limited to:

- Management of side effects
- Counseling for continued adherence
- Device insertion and removal

Important note:
See the following sections for more information:

- Specific conditions - Family planning services - other
- Specific conditions - Maternity care
- Specific conditions - Well newborn nursery care
- Specific conditions - Treatment of basic infertility – 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. See www.aetna.com/docfind or call 1-866-529-2517 for a list of providers.

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
- Allergy sera and extracts administered via injection

Physician and specialist – inpatient surgical services

Eligible health services include the services of:

- The surgeon who performs your surgery while you are confined in a hospital or birthing center
- Your surgeon who you visit before and after the surgery

When your surgery requires one or more incidental surgical procedures that would not have been performed in the absence of the primary surgical procedure, and the primary and incidental procedures are performed:

- 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. See www.aetna.com/docfind or call 1-866-529-2517 for a list of providers.

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

Second opinion services
Eligible health services, when requested by the covered person or in-network provider, include a second opinion by a physician or other health professional. The reasons for a second opinion include, but are not limited to, the following:
- You are not sure if a recommended surgical procedure is reasonably necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- Your physician is unable to diagnose the medical condition and you request an additional diagnosis
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have tried to follow a plan of care or asked your physician about serious concerns about the diagnosis or plan of care
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
- Blood, blood products, and their administration
- 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 hospital charges for dental care
Eligible health services include anesthesia for dental care only if you have a condition that requires that a dental procedure be done in a hospital or outpatient surgery center and you are one of the following:
- Under 7 years old
- Developmentally disabled (at any age)
- In poor health and have a medical need for general anesthesia (at any age)

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 speech, physical or occupational therapy
- **Home health aide** services are provided under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist.
- Medical social services are provided by or supervised by a **physician** or social worker

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 Rehabilitation and habilitation therapy services section 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.
- Part-time or intermittent **home health aide** services to care for you
- 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**
- Care during a period of crisis

**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
  - Speech therapy
  - Respiratory therapy
  - Medical supplies
- Durable medical equipment
- Outpatient prescription drugs
- Psychological counseling
- Dietary counseling
- Social counseling

Respite care is:
- Short-term inpatient care provided to you only when necessary to relieve your family members or other caregivers
- Limited to an occasional basis and to no more than five consecutive days at a time

**Eligible health services** during a period of crisis include 24 hour continuous coverage. The care will be mostly nursing care but can also include homemaker or home health aide services. A period of crisis is a time when you require continuous care to:
- Receive palliative care (care which controls pain and relieves symptoms but does not cure)
- Manage acute medical symptoms

Once a prognosis has been made, hospice care will continue to be covered as long as medically necessary (i.e., until you die or until your diagnosis or prognosis changes).

**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. Your plan will cover the extra expense of a private room when it is appropriate because of your medical condition
- Services and supplies that are provided during your stay in a **skilled nursing facility** including, but not limited to:
  - Prescription drugs prescribed by your physician if they are administered by a health professional
  - Durable medical equipment (DME) normally provided by a **skilled nursing facility**
  - Radiological services and laboratory testing
  - Medical social services
  - Blood, blood products, and their administration
  - Medical supplies
  - Respiratory therapy

**Important note:**
We cover home physical, speech, or occupational therapy when the **skilled nursing facility** criteria above are met.
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
- Ambulance 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 a in-network provider if you need more care.

For follow-up care, visit:
- Your in-network physician

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.

For emergency services, we will pay out-of-network claims (hospital and emergency medical transportation) at the in-network benefit level. Your cost sharing for the emergency services will accrue to your in-network maximum out-of-pocket limit.

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 a in-network or out-of-network dental provider.

Type A services: diagnostic and preventive care

- D0120 Periodic oral exam
- D0140 Limited oral evaluation - problem focused
- D0145 Oral evaluation - child under 3
- D0150 Comprehensive oral exam
- D0160 Detailed and extensive oral evaluation - by report
- D0170 Reevaluation - limited, problem focused
- D0180 Comprehensive periodontal evaluation
- D0210 Complete full mouth images
- D0220 Periapical - first image
- D0230 Periapical - each additional image
- D0270 Bitewing - single image
- D0272 Bitewing - two images
- D0273 Bitewing – three images
- D0274 Bitewing - four images
- D0277 Vertical bitewings - 7 to 8 images
- D0310 Sialography
- D0320 TMJ arthrogram, including injection
- D0322 Tomographic survey
- D0330 Panoramic image (once in a 36-month period per provider)
- D0340 2D cephalometric radiographic image – acquisition, measurement and analysis
- D0350 2D oral/facial photographic image obtained intra-orally or extra-orally
- D0999 Unspecified diagnostic procedure, by report
- D1110 Prophylaxis - adult (2 per year)
- D1120 Prophylaxis - child (2 per year)
- D1206 Topical fluoride varnish (2 per year)
- D1208 Topical application of fluoride - excluding varnish (2 per year)
- D1351 Sealant - per tooth (for 1st, 2nd & 3rd, permanent molars - no limit)
- D1352 Preventive resin restoration - permanent (for 1st, 2nd & 3rd, permanent molars - no limit)
- D1353 Sealant repair - per tooth
- D1354 Interim caries arresting medicament application (for 1st, 2nd & 3rd, permanent molars - no limit)
- D1510 Space maintainer - fixed - unilateral
- D1515 Space maintainer - fixed - bilateral
- D1520 Space maintainer - removable - unilateral
- D1525 Space maintainer - removable - bilateral
- D1550 Recementation of space maintainer
- D1555 Removal of fixed space maintainer
- D1575 Distal shoe space maintainer – fixed – unilateral
- D2990 Resin infiltration of lesion (once per tooth every 3 years, permanent molars only)
- D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation
- D9110 Palliative treatment of dental pain, minor
Type B services: basic restorative care

- D0240  Occulusal image
- D0250  Extra-oral – 2D projection radiographic image
- D0251  Extra-oral posterior dental radiographic image
- D0260  Extra-oral – each additional radiographic image
- D0290  Posterior – anterior or lateral skull and facia bone survey radiographic image
- D0460  Pulp vitality tests
- D0502  Other oral path procedures, by report
- D2140  Amalgam - 1 surface
- D2150  Amalgam - 2 surfaces
- D2160  Amalgam - 3 surfaces
- D2161  Amalgam - 4 or more surfaces
- D2330  Resin - 1 surface - anterior
- D2331  Resin - 2 surfaces - anterior
- D2332  Resin - 3 surfaces - anterior
- D2335  Resin - 4 or more surfaces - anterior
- D2390  Resin-based composite crown, anterior
- D2391  Resin one surface - posterior
- D2392  Resin - two surfaces - posterior
- D2393  Resin - three surfaces - posterior
- D2394  Resin - four or more surfaces - posterior
- D2910  Recement or re-bond inlay, onlay, veneer or partial coverage restoration
- D2915  Recement or re-bond indirectly fabricated or prefabricated post and core
- D2920  Recement crown
- D2921  Reattachment of tooth fragment, incisal edge or cusp
- D2929  Prefabricated porcelain/ceramic crown - primary tooth
- D2930  Stainless steel crown - primary
- D2931  Stainless steel crown - permanent
- D2932  Prefabricated resin crown
- D2933  Stainless steel crown with resin window
- D2934  Prefabricated stainless crown - primary tooth
- D2940  Protective restoration
- D2941  Interim therapeutic restoration – primary dentition
- D2951  Pin retention - per tooth in addition to restoration
- D2999  Unspecified restorative procedure, by report
- D3110  Pulp cap - direct
- D3120  Pulp cap - indirect
- D3220  Pulpotomy (therapeutic)
- D3221  Gross pulpal debridement primary and permanent
- D3222  Partial pulpotomy for apexogenesis
- D3230  Pulpal therapy - anterior primary tooth
- D3240  Pulpal therapy - posterior primary tooth
- D3310  Root canal - anterior excluding final restoration
- D3320  Root canal - bicuspid excluding final restoration
- D3331  Treatment of root canal obstruct-non surgical access
- D3332  Incomplete endodontic therapy inoperable or fractured tooth
- D3333  Internal root repair of perforation defects
- D3346  Retreatment-root canal treatment - anterior
- D3347  Retreatment-root canal treatment - bicuspid
• D3351  Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
• D3352  Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
• D3353  Apexification/recalcification - final
• D3355  Pulpal regeneration - initial visit
• D3356  Pulpal regeneration – interim medication replacement
• D3357  Pulpal regeneration – completion of treatment
• D3355  Pulpal regeneration - initial visit
• D3356  Pulpal regeneration – interim medication replacement
• D3357  Pulpal regeneration – completion of treatment
• D3410  Apicoectomy - anterior
• D3421  Apicoectomy- bicuspid (first root)
• D3425  Apicoectomy- molar (first root)
• D3426  Apicoectomy- each additional root
• D3427  Periradicular surgery without apicoectomy
• D3430  Retrograde filling - per root
• D3450  Root amputation - per root
• D3920  Hemisection - not including root canal therapy
• D3999  Unspecified Endodontic procedure, by report
• D4210  Gingivectomy/gingivoplasty, 4+ teeth (1 per quadrant/tooth every 3 years)
• D4211  Gingivectomy/gingivoplasty, 1 To 3 teeth (1 per quadrant/tooth every 3 years)
• D4212  Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth (1 per quadrant/tooth every 3 years)
• D4240  Gingival flap –with root planing, 4 or more contiguous teeth (1 per quadrant/tooth every 3 years)
• D4241  Gingival flap - includes root planing, 1-3 teeth (1 per quadrant/tooth every 3 years)
• D4245  Apically positioned flap
• D4268  Surgical revision procedure per tooth
• D4341  Periodontal scaling and root planing, 4 or more teeth per quadrant (1 per quadrant every 2 rolling years)
• D4342  Periodontal scaling and root planing, 1-3 teeth (1 per separate quadrant every 2 rolling years)
• D4910  Periodontal maintenance - procedures (2 per calendar year following active periodontal treatment)
• D4920  Unscheduled dressing change (by someone other than treating dentist or their staff)
• D4999  Unspecified periodontal procedure, by report
• D6092  Recement implant/abutment supported crown
• D6093  Recement implant/abutment supported partial
• D6930  Recement or re-bond fixed partial denture retainers
• D7111  Extract coronal remnants - deciduous tooth
• D7140  Extraction - erupted tooth or exposed root
• D7210  Surgical removal of erupted tooth
• D7220  Removal of impacted tooth - soft tissue
• D7250  Surgical removal of residual tooth roots
• D7260  Oroantral fistula closure
• D7261  Primary closure of a sinus perforation
• D7270  Tooth re-implantation of accidental displaced tooth
• D7272  Tooth transplantation
• D7280  Surgical access of unerupted tooth
• D7282  Mobilization of erupted or malpositioned tooth to aid eruption
• D7283  Device to aid eruption of impacted tooth
• D7285  Incisional biopsy of oral tissue-hard (bone/tooth)
• D7286  Incisional biopsy of oral tissue-soft
• D7310  Alveoloplasty in conjunction with extraction
• D7311 Alveoloplasty in conjunction with extraction, 1-3 teeth
• D7320 Alveoloplasty not in conjunction with extraction
• D7321 Alveoloplasty not in conjunction with extraction, 1-3 teeth
• D7450 Removal of odontogenic cyst/tumor up to 1.25 cm
• D7451 Removal of odontogenic cyst/tumor greater than 1.25 cm
• D7471 Removal of lateral exostosis, upper or lower
• D7472 Removal of torus palatinus
• D7473 Removal of torus mandibularis
• D7485 Surgical reduction of osseous tuberosity
• D7510 Incision and drainage of abscess intraoral
• D7511 Incision and drainage of abscess - intraoral soft tissue, complex
• D7520 Incision and drainage of abscess - extraoral, soft tissue
• D7521 Incision and drainage - extraoral complex
• D7530 Removal foreign body, mucosa, skin, tissue
• D7540 Removal of reaction producing foreign body
• D7550 Partial ostectomy/sequestrectomy
• D7910 Suture of recent small wound less than 5 cm
• D7911 Complicated suture - up to 5 cm
• D7912 Complicated suture - greater than 5 cm
• D7960 Frenulectomy
• D7963 Frenuloplasty
• D7970 Excision of hyperplastic tissue - per arch
• D7971 Excision of pericoronal gingiva
• D7972 Surgical reduction of fibrous tuberosity
• D7999 Unspecified oral surgery procedure
• D9410 House call
• D9430 Office visit for observation (during regular hours)
• D9440 Office visit after hours
• D9930 Treatment of complications post-surgical
• D9950 Occlusial analysis
• D9951 Occlusial adjustment - limited
• D9952 Occlusial adjustment - complete

**Type C services: major restorative care**
• D2510 Inlay - metallic - 1 surface (1 per tooth every 5 years)
• D2520 Inlay - metallic - 2 surfaces (1 per tooth every 5 years)
• D2530 Inlay - metallic - 3 or more surfaces (1 per tooth every 5 years)
• D2542 Onlay - metallic - 2 surfaces (1 per tooth every 5 years)
• D2543 Onlay - metallic - 3 surfaces (1 per tooth every 5 years)
• D2544 Onlay - metallic - 4 or more surfaces (1 per tooth every 5 years)
• D2610 Inlay - porcelain/ceramic - 1 surface (1 per tooth every 5 years)
• D2620 Inlay - porcelain/ceramic - 2 surfaces (1 per tooth every 5 years)
• D2630 Inlay - porcelain/ceramic - 3 or more surfaces (1 per tooth every 5 years)
• D2642 Onlay - porcelain/ceramic - 2 surfaces (1 per tooth every 5 years)
• D2643 Onlay - porcelain/ceramic - 3 surfaces (1 per tooth every 5 years)
• D2644 Onlay - porcelain/ceramic - in addition to inlay (1 per tooth every 5 years)
• D2650 Inlay - composite/resin - 1 surface (1 per tooth every 5 years)
• D2651 Inlay - composite/resin - 2 surfaces (1 per tooth every 5 years)
• D2652 Inlay - composite/resin - 3 surfaces (1 per tooth every 5 years)
• D2662 Onlay - composite/resin - 2 surfaces (1 per tooth every 5 years)
- D2663 Onlay - composite/resin - 3 surface (1 per tooth every 5 years)
- D2664 Onlay - composite/resin - 4 or more surfaces (1 per tooth every 5 years)
- D2710 Crown - resin-based composite, indirect (1 per tooth every 5 years)
- D2712 Crown – ¾ resin-based composite, indirect (1 per tooth every 5 years)
- D2720 Crown - resin with high noble metal (1 per tooth every 5 years)
- D2721 Crown - resin with predominantly base metal (1 per tooth every 5 years)
- D2722 Crown - resin with noble metal (1 per tooth every 5 years)
- D2740 Crown - porcelain/ceramic substrate (1 per tooth every 5 years)
- D2750 Crown - porcelain fused high noble metal (1 per tooth every 5 years)
- D2751 Crown -porcelain fused predominantly base metal (1 per tooth every 5 years)
- D2752 Crown - porcelain fused to noble metal (1 per tooth every 5 years)
- D2780 Crown - 3/4 cast high noble metal (1 per tooth every 5 years)
- D2781 Crown -3/4 cast predominantly base metal (1 per tooth every 5 years)
- D2782 Crown - 3/4 cast noble metal (1 per tooth every 5 years)
- D2783 Crown – 3/4 porcelain/ceramic (1 per tooth every 5 years)
- D2790 Crown - full cast high noble metal (1 per tooth every 5 years)
- D2791 Crown - full cast predominantly based metal (1 per tooth every 5 years)
- D2792 Crown - full cast noble metal (1 per tooth every 5 years)
- D2794 Crown - titanium (1 per tooth every 5 years)
- D2950 Core buildup, including any pins when required
- D2952 Cast post and core in addition to crown
- D2953 Cast post - each Additional - same tooth
- D2954 Prefab post and core in addition to crown
- D2957 Prefabricated post - each add - same tooth
- D2960 Labial veneer – chairside (1 per tooth every 5 years)
- D2961 Labial veneer -lab (1 per tooth every 5 years)
- D2962 Labial veneer porcelain – lab (1 per tooth every 5 years)
- D2970 Crown - provisional
- D2971 Additional procedures - new crown under partial
- D2980 Crown repair
- D2981 Inlay repair - material failure
- D2982 Onlay repair - material failure
- D2983 Veneer repair - material failure
- D3330 Root canal treatment - molar excluding final restoration
- D3348 Retreatment - root canal treatment - molar
- D4249 Clinical crown lengthening hard tissue
- D4260 Osseous surgery, including elevation of a full thickness flap and closure – four or more contiguous teeth or tooth bounded spaces per quadrant (1 per quadrant/tooth every 3 years)
- D4261 Osseous surgery, including elevation of a full thickness flap and closure – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant (1 per quadrant/tooth every 3 years)
- D4270 Pedicle soft tissue graft procedure
- D4273 Connective tissue graft procedures, including donor and recipient surgical sites - first tooth, implant, or edentulous tooth position in graft
- D4275 Non-autogenous connective tissue graft, including recipient site and donor material - first tooth, implant, or edentulous tooth position in graft
- D4276 Connective tissue/pedicile graft - tooth
- D4277 Free soft tissue graft procedure, including recipient and donor surgical site - first tooth, implant, or edentulous tooth position in graft
- D4278 Free soft tissue graft procedure, including recipient and donor surgical sites - each additional contiguous tooth, implant or edentulous tooth position in same graft site
• D4283 Autogenous connective tissue graft procedure, including donor and recipient surgical sites – each additional contiguous tooth, implant or edentulous tooth position in same graft site
• D4285 Non-autogenous connective tissue graft procedure, including recipient surgical site and donor material – each additional contiguous tooth, implant or edentulous tooth position in same graft site
• D4355 Full mouth debridement (1 per lifetime)
• D5110 Complete denture - maxillary (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
• D5120 Complete denture - mandibular (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
• D5130 Immediate denture – maxillary (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
• D5140 Immediate denture – mandibular (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
• D5211 Maxillary partial denture - resin base (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
• D5212 Mandibular partial denture - resin base (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
• D5213 Maxillary partial denture - cast base (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
• D5214 Mandibular partial denture cast base (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
• D5221 Immediate maxillary partial denture – resin base, including any conventional clasps, rests and teeth (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
• D5222 Immediate mandibular partial denture – resin base, including any conventional clasps, rests and teeth (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
• D5223 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 (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
• D5224 Immediate mandibular partial denture – cast metal framework with resin denture bases, including any conventional clasps, rests and teeth (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
• D5225 Maxillary partial denture – flexible base (1 every 5 years)
• D5226 Mandibular partial denture – flexible base (1 every 5 years)
• D5281 Removable unilateral partial denture (1 every 5 years)
• D5410 Adjustments maxillary complete denture (not eligible within 6 months of denture placement, then no limit)
• D5411 Adjustments mandibular complete denture (not eligible within 6 months of denture placement, then no limit)
• D5421 Adjustments partial denture - maxillary (not eligible within 6 months of denture placement, then no limit)
• D5422 Adjustments partial denture - mandibular (not eligible within 6 months of denture placement, then no limit)
• D5510 Repair broken complete denture base
• D5520 Replace missing or broken teeth, complete denture
• D5610 Repair resin denture base
• D5620 Repair cast framework
• D5630 Repair or replace broken clasp – per tooth
• D5640 Replace broken teeth - per tooth
• D5650 Add tooth to existing partial denture
• D5660 Add clasp to existing partial denture – per tooth
• D5670 Replace all teeth - upper partial
• D5671 Replace all teeth - lower partial
• D5710 Rebase complete maxillary denture (not eligible within 6 months of denture placement, then no limit)
• D5711 Rebase complete mandibular denture (not eligible within 6 months of denture placement, then no limit)
• D5720 Rebase partial maxillary denture (not eligible within 6 months of denture placement, then no limit)
• D5721 Rebase partial mandibular denture (not eligible within 6 months of denture placement, then no limit)
• D5730 Reline complete maxillary denture, chairside (not eligible within 6 months of denture placement, then no limit)
• D5731 Reline complete mandibular denture, chairside (not eligible within 6 months of denture placement, then no limit)
• D5740 Reline complete maxillary denture, chairside (not eligible within 6 months of denture placement, then no limit)
• D5741 Reline complete mandibular partial denture, chairside (not eligible within 6 months of denture placement, then no limit)
• D5750 Reline complete maxillary denture, laboratory (not eligible within 6 months of denture placement, then no limit)
• D5751 Reline complete mandibular denture, laboratory (not eligible within 6 months of denture placement, then no limit)
• D5760 Reline maxillary partial denture, laboratory (not eligible within 6 months of denture placement, then no limit)
• D5761 Reline mandibular partial denture, laboratory (not eligible within 6 months of denture placement, then no limit)
• D5820 Interim partial denture - upper (maxillary)
• D5821 Interim partial denture - lower (mandibular)
• D5850 Tissue conditioning, upper
• D5851 Tissue conditioning, lower
• D5863 Overdenture – complete maxillary (1 every 5 years)
• D5864 Overdenture - partial maxillary (1 every 5 years)
• D5865 Overdenture -complete mandibular (1 every 5 years)
• D5866 Overdenture – partial mandibular (1 every 5 years)
• D5899 Unspecified removable prosthodontic procedure, by report
• D5911 Facial moulage - sectional, by report
• D5912 Facial moulage - complete, by report
• D5913 Nasal prosthesis, by report
• D5914 Auricular prosthesis, by report
• D5915 Orbital prosthesis, by report
• D5916 Ocular prosthesis, by report
• D5919 Facial prosthesis, by report
• D5922 Nasal septal prosthesis, by report
• D5923 Ocular prosthesis, interim, by report
• D5924 Cranial prosthesis, by report
• D5925 Facial augmentation implant prosthesis, by report
• D5926 Nasal prosthesis, replacement, by report
• D5927 Auricular prosthesis, replacement, by report
• D5928 Orbital prosthesis, replacement, by report
• D5929 Facial prosthesis, replacement, by report
• D5931 Obturator prosthesis, surgical, by report
• D5932 Obturator prosthesis, definitive, by report
• D5933 Obturator prosthesis, modification, by report
• D5934 Mandibular resection prosthesis with flange, by report
• D5935 Mandibular resection prosthesis without flange, by report
• D5936 Obturator prosthesis, interim, by report
• D5937 Trismus appliance (not for TMJ), by report
• D5951 Feeding aid, by report
• D5952 Speech aid prosthesis, pediatric, by report
• D5953 Speech aid prosthesis, adult, by report
• D5954 Palatal augmentation prosthesis, by report
• D5955 Palatal lift prosthesis, definitive, by report
• D5958 Palatal lift prosthesis, interim, by report
• D5959 Palatal lift prosthesis, modification, by report
• D5960 Speech aid prosthesis, modification, by report
• D5982 Surgical stent, by report
• D5983 Radiation carrier, by report
• D5984 Radiation shield, by report
• D5985 Radiation cone locator, by report
• D5986 Fluoride gel carrier, by report
• D5987 Commissure splint, by report
• D5988 Surgical splint, by report
• D5991 Topical vesiculobullous disease medicament carrier, by report
• D5992 Adjust maxillofacial prosthetic appliance, by report
• D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report
• D5999 Unspecified maxillofacial prosthesis, by report
• D6010 Surgical placement of implant body endosteal implant
• D6013 Surgical placement of mini implant
• D6040 Surgical placement eposteal implant
• D6050 Surgical placement transosteal implant
• D6055 Dental implant supported connecting bar
• D6056 Prefabricated abutment
• D6057 Custom abutment
• D6058 Abutment supported porcelain/ceramic crown (1 every 5 years)
• D6059 Abutment supported porcelain fused metal crown high (1 every 5 years)
• D6060 Abutment supported porcelain fused metal crown base (1 every 5 years)
• D6061 Abutment supported porcelain fused metal crown noble (1 every 5 years)
• D6062 Abutment supported cast metal crown high noble (1 every 5 years)
• D6063 Abutment supported cast metal crown base noble (1 every 5 years)
• D6064 Abutment supported cast metal crown noble metal (1 every 5 years)
• D6065 Implant supported porcelain/ceramic crown (1 every 5 years)
• D6066 Implant supported porcelain fused metal crown high (1 every 5 years)
• D6067 Implant supported metal crown high (1 every 5 years)
• D6068 Abutment supported retainer for porcelain/ceramic (1 every 5 years)
• D6069 Abutment supported retainer for porcelain fused metal high (1 every 5 years)
• D6070  Abutment supported retainer for porcelain fused metal base (1 every 5 years)
• D6071  Abutment supported retainer for porcelain fused metal noble (1 every 5 years)
• D6072  Abutment supported retainer for cast metal full partial denture high (1 every 5 years)
• D6073  Abutment supported retainer for cast metal full partial denture base (1 every 5 years)
• D6074  Abutment supported retainer for cast metal full partial denture noble (1 every 5 years)
• D6075  Implant supported retainer for ceramic full partial denture (1 every 5 years)
• D6076  Implant supported retainer for porcelain fused metal high noble metal (1 every 5 years)
• D6077  Implant supported retainer for cast metal high (1 every 5 years)
• D6080  Implant maintenance procedures, when prostheses are removed and reinserted, including cleansing of prosthesis and abutments
• D6090  Repair implant supported prosthesis
• D6091  Replace precision attachment
• D6094  Abutment supported crown – titanium (1 every 5 years)
• D6095  Repair implant abutment prosthesis (1 every 5 years)
• D6100  Implant removal, by report (1 every 5 years)
• D6110  Implant/abutment supported removable denture for completely edentulous arch – maxillary (1 every 5 years)
• D6111  Implant/abutment supported removable denture for completely edentulous arch – mandibular (1 every 5 years)
• D6112  Implant/abutment supported removable denture for partially edentulous arch – maxillary (1 every 5 years)
• D6113  Implant/abutment supported removable denture for partially edentulous arch – mandibular (1 every 5 years)
• D6114  Implant/abutment supported fixed denture for completely edentulous arch – maxillary (1 every 5 years)
• D6115  Implant/abutment supported fixed denture for completely edentulous arch – mandibular (1 every 5 years)
• D6116  Implant/abutment supported fixed denture for partially edentulous arch – maxillary (1 every 5 years)
• D6117  Implant/abutment supported fixed denture for partially edentulous arch – mandibular (1 every 5 years)
• D6194  Abutment supported retainer crown for full partial denture (1 every 5 years)
• D6199  Unspecified implant procedure, by report
• D6205  Pontic - indirect resin based composite (1 every 5 years)
• D6210  Pontic - cast high noble metal (1 every 5 years)
• D6211  Pontic - cast predominantly base metal (1 every 5 years)
• D6212  Pontic - cast noble metal (1 every 5 years)
• D6214  Pontic – titanium (1 every 5 years)
• D6240  Pontic - porcelain fused to high noble (1 every 5 years)
• D6241  Pontic - porcelain fused to base metal (1 every 5 years)
• D6242  Pontic - porcelain fused to noble metal (1 every 5 years)
• D6245  Pontic - porcelain/ceramic (1 every 5 years)
• D6250  Pontic - resin with high noble metal (1 every 5 years)
• D6251  Pontic - resin with predominantly base metal (1 every 5 years)
• D6252  Pontic - resin with noble metal (1 every 5 years)
• D6545  Retainer - cast metal for resin bonded for fixed prosthesis (1 every 5 years)
• D6548  Retainer - porcelain/ceramic resin bonded for fixed prosthesis (1 every 5 years)
• D6600  Inlay – porcelain/ceramic, 2 surfaces (1 every 5 years)
• D6601  Inlay – porcelain/ceramic, 3 or more surfaces (1 every 5 years)
• D6602  Inlay - cast high noble metal, 2 surfaces major (1 every 5 years)
• D6603 Inlay - cast high noble metal, 3 or more surfaces (1 every 5 years)
• D6604 Inlay - cast predominately base metal 2 surfaces (1 every 5 years)
• D6605 Inlay - cast predominately base metal 3 or more surfaces (1 every 5 years)
• D6606 Inlay - cast noble metal, 2 surfaces (1 every 5 years)
• D6607 Retainer inlay - cast noble metal, three or more surfaces (1 every 5 years)
• D6608 Retainer onlay - porcelain/ceramic, 2 surfaces (1 every 5 years)
• D6609 Retainer onlay - porcelain/ceramic, 3 or more surfaces (1 every 5 years)
• D6610 Retainer onlay - cast high noble metal, 2 surfaces (1 every 5 years)
• D6611 Retainer onlay - cast high noble metal, 2 or more surfaces (1 every 5 years)
• D6612 Retainer onlay - cast predominately base metal, 2 surfaces (1 every 5 years)
• D6613 Retainer onlay - cast predominantly base metal, 3 or more surfaces (1 every 5 years)
• D6614 Retainer onlay - cast noble metal, 2 surfaces (1 every 5 years)
• D6615 Retainer onlay - cast noble metal, 3 or more surfaces (1 every 5 years)
• D6624 Retainer inlay – titanium (1 every 5 years)
• D6634 Retainer onlay - titanium (1 every 5 years)
• D6710 Retainer crown - indirect resin based composite (1 every 5 years)
• D6720 Retainer crown - resin with high noble metal (1 every 5 years)
• D6721 Retainer crown - resin with predominantly base metal (1 every 5 years)
• D6722 Retainer crown - resin with noble metal (1 every 5 years)
• D6740 Retainer crown - porcelain/ceramic (1 every 5 years)
• D6750 Retainer crown - porcelain fused to high noble metal (1 every 5 years)
• D6751 Retainer crown - porcelain fused to predominantly base metal (1 every 5 years)
• D6752 Retainer crown - porcelain fused to noble metal (1 every 5 years)
• D6780 Retainer crown - 3/4 cast high noble metal (1 every 5 years)
• D6781 Retainer crown - 3/4 cast predominantly base metal (1 every 5 years)
• D6782 Retainer crown - 3/4 cast noble metal (1 every 5 years)
• D6783 Retainer crown - 3/4 porcelain/ceramic (1 every 5 years)
• D6790 Retainer crown - full cast high noble metal (1 every 5 years)
• D6791 Retainer crown - full cast predominantly base metal (1 every 5 years)
• D6792 Retainer crown - full cast noble metal (1 every 5 years)
• D6794 Retainer crown – titanium (1 every 5 years)
• D6940 Stress breaker
• D6980 Fixed partial denture repair
• D6985 Pediatric partial denture, fixed
• D6999 Unspecified fixed prosthodontic procedure, by report
• D7230 Removal of impacted tooth - partial bony
• D7240 Removal of impacted tooth - full bony
• D7241 Removal of impacted tooth - complication
• D7251 Coronectomy
• D7290 Surgical repositioning of teeth
• D7291 Transseptal fiberotomy, by report
• D7340 Vestibuloplasty - ridge extension (1 every 5 years)
• D7350 Vestibuloplasty - ridge extension including soft tissue grafts (once per arch)
• D7410 Excision of benign lesion up to 1.25 cm
• D7411 Excision of benign lesion more than 1.25 cm
• D7412 Excision of benign lesion, complicated
• D7413 Excision of malignant lesion up to 1.25 cm
• D7414 Excision of malignant lesion more than 1.25 cm
• D7415 Excision of malignant lesion complicated
• D7440 Excision of malignant lesion up to 1.25 cm
• D7441 Excision of malignant lesion greater than 1.25 cm
• D7460 Removal non-odontogenic cyst/tumor up to 1.25 cm
• D7461 Removal nonodontogenic cyst/tumor greater than 1.25 cm
• D7465 Destruction of lesion(s) by physical or chemical methods
• D7490 Radical resection of maxilla/mandible with bone graft
• D7560 Maxillary sinusotomy for removal of tooth
• D7610 Maxilla - open reduction
• D7620 Maxilla - closed reduction
• D7630 Mandible - open reduction
• D7640 Mandible - closed reduction
• D7650 Malar and/or zygomatic arch - open reduction
• D7660 Malar and/or zygomatic arch - closed reduction
• D7670 Alveolus - closed reduction
• D7671 Alveolus - open reduction
• D7680 Facial bones complicated reduction
• D7710 Maxilla - open reduction
• D7720 Maxilla - closed reduction
• D7730 Mandible - open reduction
• D7740 Mandible - closed reduction
• D7750 Malar and/or zygomatic arch - open
• D7760 Malar and/or zygomatic arch - closed
• D7770 Alveolus - open reduction stabilization of teeth
• D7771 Alveolus - closed reduction stabilization of teeth
• D7780 Facial bones - complicated reduction
• D7810 Open reduction of dislocation
• D7820 Closed reduction of dislocation
• D7830 Manipulation under anesthesia
• D7840 Condylectomy
• D7850 Surgical discectomy, with/without implant
• D7852 Disc repair
• D7854 Synovectomy
• D7856 Myotomy
• D7858 Joint reconstruction
• D7860 Arthrotomy
• D7865 Arthroplasty
• D7870 Arthrocentesis
• D7872 Arthroscopy - diagnosis with/without biopsy
• D7873 Arthroscopy - surgical lavage
• D7874 Arthroscopy - surgical disc reposition
• D7875 Arthroscopy - surgical synovectomy
• D7876 Arthroscopy - surgical discectomy
• D7877 Arthroscopy - surgical debridement
• D7880 Oclusal orthotic device, by report
• D7899 Unspecified temporomandibular joint dysfunctions (TMD) therapy, by report
• D7920 Skin graft
• D7940 Osteoplasty for orthognathic deformities
• D7941 Osteotomy - mandibular rami
• D7943 Osteotomy - ramus, opened with bone graft
• D7944 Osteotomy - segmented or subapical
• D7945 Osteotomy - body of mandible
• D7946  Lefort I - (maxilla -total)
• D7947  Lefort I - (maxilla - segmented)
• D7948  Lefort II/III - osteoplasty of facial bones without graft
• D7949  Lefort II/LLL - with bone graft
• D7950  Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or non autogenous, by report
• D7951  Sinus augmentation
• D7952  Sinus augmentation - vertical approach
• D7955  Repair of maxillofacial soft/hard tissue
• D7980  Sialolithotomy
• D7981  Excision of salivary gland, by report
• D7982  Sialodochoplasty
• D7983  Closure of salivary fistula
• D7990  Emergency tracheotomy
• D7991  Coronoidectomy
• D7995  Synthetic graft
• D7997  Appliance removal including removal of arch bar
• D8210  Removable appliance therapy
• D8220  Fixed or cemented appliance therapy
• D9120  Partial denture sectioning
• D9210  Local anesthesia not in conj with surg
• D9219  Evaluation - deep sedation or general anesthesia
• D9220  Deep sedation/general anesthesia – first 30 minutes
• D9223  Deep sedation/general anesthesia – each 15 minute increment
• D9230  Analgesia
• D9241  Intravenous moderate (conscious) sedation/analgesia – first 30 minutes
• D9243  Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment
• D9248  Non-intravenous conscious sedation (includes non-Iv minimal and moderate sedation)
• D9420  Hospital call
• D9610  Therapeutic drug injection
• D9612  Therapeutic parenteral drugs
• D9910  Application of desentive medication
• D9932  Cleaning and inspection of removable complete denture, maxillary
• D9933  Cleaning and inspection of removable complete denture, mandibular
• D9934  Cleaning and inspection of removable partial denture, maxillary
• D9935  Cleaning and inspection of removable partial denture, mandibular
• D9940  Occlusal guards
• D9942  Repair and/or reline of occlusal guard
• D9943  Occlusal guard adjustment (not eligible within first 6 months after placement of appliance)
• D9999  Unspecified adjunctive procedure, by report
Orthodontic services (covered as medically necessary)

- D0470 Diagnostic casts
- D8010 Limited orthodontic treatment of primary dentition
- D8020 Limited orthodontic treatment - transitional dentition
- D8030 Limited orthodontic treatment - adolescent dentition
- D8040 Limited orthodontic treatment - adult dentition
- D8050 Interceptive treatment - primary dentition
- D8060 Interceptive treatment - transitional dentition
- D8070 Comprehensive treatment - transitional dentition
- D8080 Comprehensive treatment - adolescent dentition
- D8090 Comprehensive treatment - adult dentition
- D8660 Pre-orthodontic treatment examination to monitor growth and development
- D8670 Periodic orthodontic treatment visit
- D8680 Orthodontic retention
- D8681 Removable orthodontic retainer adjustment
- D8691 Repair of orthodontic appliance
- D8692 Replacement of lost or broken retainer (once per arch)
- D8693 Rebonding or recementing and/or repair, as required, of fixed retainers
- D8694 Repair of fixed retainers, includes reattachment
- D8999 Unspecified orthodontic treatment, by report

IMPORTANT: If you choose to receive dental services that are not covered benefits under this plan, an in-network dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Member Services at the toll-free number on your ID card. To fully understand your coverage, you should carefully review this certificate of coverage.

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
- When diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet form
- To prevent disease
- To promote oral health
- To restore oral structures to health
- To provide medically necessary treatment for a severe, dysfunctional, disabling condition, such as:
  - Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement
  - Craniofacial anomalies
  - Anomalies of facial bones and/or oral structures
  - Facial trauma resulting in functional difficulties

If you suffer from one of these conditions, the orthodontic services that are eligible for coverage include:
- Pre-orthodontic treatment visit
- Comprehensive orthodontic treatment
- Orthodontic retention (removal of appliances, construction and placement of retainers(s))

When does your plan cover replacements?
The plan’s “replacement rule” applies to crowns, veneers, complete dentures, and removable partial dentures when:
- The repair or replacement of a crown is limited to once every 36 consecutive months, except when the crown is no longer functional. Complete upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
- Partial dentures will not be replaced within 36 consecutive months unless:
  - You lost teeth and the addition or replacement of teeth to the existing partial is not feasible, or
  - The denture is unsatisfactory and cannot be fixed
- 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.

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 tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years. The extraction of a third molar tooth does not qualify
- 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 records.
4. Once all of the information has been gathered, we will review the proposed treatment plan and provide you and your **dental provider** with a statement outlining the benefits payable.
5. You and your **dental provider** can then decide how to proceed.

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

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

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

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

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

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

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

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

Birthing center (facility charges)

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

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

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

Diabetic services and supplies (including equipment and training)

Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Podiatric devices to prevent or treat complications
  - Insulin preparations
  - Hypodermic needles and syringes used for the treatment of diabetes
  - Injection aids for the visually impaired
  - Diabetic test agents (including blood glucose and ketone urine testing strips)
  - Lancets/lancing devices
  - Pen delivery systems for the administration of insulin
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Injectable glucagons
  - Glucagon emergency kits

- Equipment
  - External insulin pumps
  - Blood glucose meters without special features, unless required due to visual impairment (includes visual aids for the visually impaired for proper insulin dosing)

- Training
  - Self-management training provided by a health care provider certified in diabetes self-management training for you and your family

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

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

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

- Voluntary sterilization for males
- Abortion
- Reversal of voluntary sterilization including related follow-up care

You can refer to the Preventive care and wellness - Family planning services – female contraceptives section for information on coverage for female contraceptives.

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 for adults.

Blood and body fluid exposure

When you are acting as a student in a clinical capacity, eligible health services include services and supplies for the treatment of your clinical related injury under this benefit.

When you are not acting as a student in a clinical capacity, eligible health services to treat blood and body fluid exposure will be covered under the plan according to the type of service or supply and the place where you receive them.

Eligible health services under this covered benefit only include those needed for your immediate treatment of a wound and the diagnosis of an illness that results from your clinical related injury such as:

- Prophylactic medications
- Physician and specialist office visits
- Outpatient department of a hospital visits
- Walk-in clinic visits
- Urgent care services
- Emergency services
- Diagnostic lab work and radiological services
- Any other eligible health services

Eligible health services for the person who is the source of the clinical related injury only include those diagnostic lab work and radiological services needed for your diagnosis.

If you come down with an illness due to the wound, eligible health services to treat the illness will be covered under the plan according to the type of service or supply and the place where you receive them.
**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:

- A minimum of 48 hours of inpatient care in a **hospital** or **birthing center** after a vaginal delivery
- A minimum of 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**

**Important note:**

You should review the **Prenatal care** benefit under the **Preventive care and wellness** section of this certificate of coverage for more information on prenatal care coverage.

**Well newborn nursery care**

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

- A minimum of 48 hours of inpatient care in a **hospital** after a vaginal delivery
- A minimum of 96 hours of inpatient care in a **hospital** after a cesarean delivery
- Services and supplies needed for circumcision by a **provider**
- **Hospital** or **birthing center** visits and consultations for the well newborn by a **physician**
- A shorter **stay** if the attending **physician**, with the consent of the mother, discharges the newborn earlier

In the case of a shorter **stay**, a follow-up visit for the mother and newborn will be provided within 48 hours after discharge. The visit includes the following **eligible health services**:

- Parent education
- Assistance and training in breast or bottle feeding

Any necessary maternal or neonatal physical exams

**Pregnancy complications**

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

Pregnancy complications means a health problems that is caused by, or related to, pregnancy. It can involve the mother’s health, the baby’s health, or both such as:

- 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
- Puerperal infection following childbirth or miscarriage
- Eclampsia
- Ectopic pregnancy
- 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
- Vocal training

Mental health treatment

Eligible health services include the diagnosis and all medically necessary treatment of mental disorders, including, but not limited to, severe mental illnesses and serious emotional disturbances of a child, 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 (including prescription drugs) related to your condition that are provided during your stay in a general medical hospital, psychiatric hospital, or residential treatment facility. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.

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

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 including:
    o Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician
    o Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician
    o Behavioral health treatment for pervasive developmental disorder or autism
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

Severe mental illness means the following:

- Anorexia/bulimia nervosa
- Bipolar disorder
- Major depressive disorder
- Obsessive compulsive disorder
- Panic disorder
- Pervasive developmental disorder (including autism)
- Psychotic disorders/delusional disorder
- Schizoaffective disorder
- Schizophrenia

A child suffering from serious emotional disturbances means a child who:

- Has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (other than a primary substance use disorder or developmental disorder)
- Has inappropriate behavior for the child's age according to expected developmental norms
- Meets the criteria in California’s Welfare and Institutions Code (section 5600.3(a)(2))

Behavioral health treatment means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore the functioning of any individual with pervasive developmental disorder or autism. Behavioral health treatment must:

- Be prescribed by a physician or psychologist
- Be provided under a treatment plan prescribed by a qualified autism service provider
- Be administered by qualified autism service providers, qualified autism service professionals or qualified autism service paraprofessionals

The treatment plan must:

- Have measurable goals
- Be reviewed at least every six months
- Change whenever appropriate
- Describe the conditions that need to be treated
- Include the service type, number of hours, and parent participation needed
- End when treatment goals are met or no longer appropriate
A treatment plan is not used for custodial care or educational services. We can ask for a copy of the treatment plan.

**Important note:**
You may also be eligible for additional mental health treatment services under state law, including the Lanterman Developmental Disabilities Services Act, California Early Intervention Services Act, and services delivered as part of an individualized education program for individuals with exceptional needs.

---

**Substance abuse related disorders treatment**

**Eligible health services** include the treatment of substance abuse and chemical dependency 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. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.

  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

  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.

- **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 or chemical dependency provided under the direction of a physician
    - Intensive outpatient program provided in a facility or program for treatment of substance abuse or chemical dependency 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 or chemical dependency. All in-person physician or behavioral health provider office visits that are covered benefits are also covered if you use telemedicine instead. See www.aetna.com/docfind or call 1-866-529-2517 for a list of providers.

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

**Obesity (bariatric) surgery**
**Eligible health services** include the treatment of morbid obesity and include:
- Bariatric surgical procedures
- Related inpatient and outpatient services
- Travel and lodging expenses for you and a companion (if you live 50 miles or more from the facility)

**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 corrects or repairs abnormal structures of your body caused by:
  - Congenital defects
  - Developmental abnormalities
  - Trauma
  - Infection
  - Tumors
  - Disease
  - Cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate (includes necessary dental or orthodontic services)
- Your surgery is to implant or attach a covered prosthetic device.
- Your surgery creates a normal appearance
Transplant services

Eligible health services include organ transplant services provided by a physician and hospital. These services are also available if you are infected with the human immunodeficiency virus (HIV).

Transplant services include:
- Donation services for organ, tissue or bone marrow
- Harvesting of organs, tissue or bone marrow
- Treatment of complications

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 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

Adult dental care for cancer treatments and dental injuries

Eligible health services include the following dental services and supplies provided by a dental provider:

- Dental services and supplies:
  - That prepare the mouth for medical services and treatments such as radiation therapy to treat cancer
  - Provided due to transplants or surgery on the jawbone

  These include:
  - Evaluation
  - Fluoride treatments
  - Dental x-rays
  - Extractions, including surgical extractions
  - Anesthesia

- Dental services and supplies provided due to accidental injury to sound natural teeth such as:
  - Evaluation
  - Dental x-rays
  - Dental work
  - Surgery
  - Implants
  - Orthodontic treatment
  - Dental appliances

Outpatient diagnostic testing

Diagnostic complex imaging services

Eligible health services include the following complex imaging services by a provider:

- Computed tomography (CT) scans
- Dual-energy x-ray absorptiometry (DXA) scans
- Electrocardiography (ECG)
- Electroencephalography (EEG)
- 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
- Ultrasound
- Ultraviolet light treatment

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. Chemotherapy is covered as outpatient care when received in an outpatient setting. There may be separate charges for the chemotherapy drugs and a facility fee for the administration. Chemotherapy administered during a hospital stay is covered as an inpatient benefit.
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

See www.aetna.com/docfind or call 1-866-529-2517 for a list of preferred infusion locations.

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 you can find it on the Aetna website at www.aetna.com/formulary 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

Eligible health services also include preparation of the jaw (dental evaluation, x-ray, fluoride treatment, extractions) for radiation therapy for head or neck cancer.

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 you can find it on the Aetna website at www.aetna.com/formulary to determine if coverage is under the outpatient prescription drug benefit of this certificate of coverage.

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 you can find it on the Aetna website at www.aetna.com/formulary 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
- Dialysis treatment;
- Purchase or rental of dialysis equipment
- Necessary medical supplies
- Blood tests required as part of dialysis treatment whether they are performed in a hospital or dialysis center

Cardiac and pulmonary rehabilitation services
Eligible health services include 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.

Rehabilitation and habilitation therapy services

Rehabilitation therapy services
Rehabilitation therapy services help you restore or develop skills and functioning for daily living.

Eligible health services include 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

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 to diagnose and treat physical and behavioral health condition
- Occupational therapy (except for vocational rehabilitation or employment counseling) to diagnose and treat physical and behavioral health conditions
- Speech therapy
- Cognitive rehabilitation therapy associated with physical rehabilitation when the therapy is part of a treatment plan intended to acquire and restore previous cognitive function.

Habilitation therapy services

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

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**

*Eligible health services* include acupuncture treatment provided by a health care provider who is a legally qualified **physician** practicing within the scope of their license.

**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:
- To or from non-emergency covered services, if an **ambulance** is the only safe way to transport you.

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 a life-threatening disease or condition and all of the following conditions are met:
- You are eligible to participate in the approved clinical trial
- Your participation is appropriate to treat the disease or condition based on your **provider’s** conclusion or based on medical and scientific information provided by you

An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.

A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred to you by 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. An approved clinical trial must satisfy one of the following:

- Federally funded trials:
  - The study or investigation is approved or funded by one or more of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare & Medicaid Services
    - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy
  - For those approved by the Departments of Veterans Affairs, Defense or Energy, the study or investigation must have been reviewed and approved through a system of peer review that the federal Secretary of Health and Human Services determines:
    - To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health
    - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

“Routine patient costs” include:

- Health care services provided absent a clinical trial
- Health care services required solely for the provision of the investigational drug, item, device, or service
- Health care services required for the monitoring of the investigational item or service
- Health care services provided for the prevention, diagnosis, or treatment of complications from the provision of the investigational drug, item, device, or service
- Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service (including diagnosing and treating complications)
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 are described in the Glossary. But there are some DME items Medicare covers that your plan does not. We list examples of those in the Exceptions section.

Important note:

See the following sections for more information:

- Breast feeding durable medical equipment
- Enteral and parenteral nutritional supplements
- Prosthetic and orthotic devices

Enteral and parenteral nutritional supplements

Eligible health services include enteral formulas, additives and specially modified food products ordered by a physician for the treatment of inherited metabolic illnesses (including Phenylketonurial).

For purposes of this benefit, “specially modified food products” means foods intended to be replacements for normal food products and used under the direction of a physician for the dietary treatment of any inherited metabolic illnesses. Modified food products do not include foods that are naturally low in protein.

Covered benefits also include:

- Enteral feeding supply kits
- Enteral nutrition infusion pump and enteral tubing
- Gastrostomy/jejunostomy tube and tubing adaptor
- Nasogastric tubing
- Parenteral nutrition infusion pump and solutions
- Stomach tube
- Supplies for self-administered injections
Osteoporosis (non-preventive care)

Eligible health services include the diagnosis, treatment and management of osteoporosis by a physician. The services include Food and Drug Administration approved technologies, including bone mass measurement.

Prosthetic and orthotic devices

Eligible health services include the initial provision and subsequent replacement of a prosthetic and orthotic 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

Orthotic device means:
- A mechanical supportive device for the treatment of weak or muscle deficient parts of the body

Coverage includes:
- The prosthetic device
- The orthotic 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

Covered devices include, but are not limited to:
- Internally implanted devices (such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints)
- Post-mastectomy external breast prosthesis and adhesive skin support attachments and 3 post mastectomy brassieres every 12 months to hold prosthesis
- Ostomy supplies, urinary catheters external urinary collection devices and incontinence supplies for hospice patients
- Speech generating device (does not include electronic voice-producing machines)
- A durable brace that is custom made for and fitted for you
- Diabetic shoes and inserts
- Compression burn garment, lymphedema gradient compression stocking, light compression bandage, manual compression garment, moderate compression bandage
- Prosthetic devices to replace all or part of an external facial body part that has been removed or impaired as a result of illness, injury, or congenital defect

Eligible health services also include special footwear if you suffer from a foot disfigurement caused by:
- Cerebral palsy
- Arthritis
- Polio
- Spinabifida
- Diabetes
- Accident
- Developmental disability
Hearing exams
Eligible health services include hearing care that includes hearing exams.

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.

Coverage includes routine pedicure services care such as cutting of nails, corns and calluses when required to treat or prevent complications of diabetes.

Vision care

Pediatric vision care
Routine vision exams
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, and dilation (if indicated).

Vision care services and supplies
Eligible health services include:
- Office visits to an ophthalmologist, optometrist or optician related to the evaluation, fitting and follow-up care of prescription contact lenses.
- Eyeglass frames, prescription lenses or prescription contact 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, telescopes, and follow-up care. Low vision aids are limited to 1 per policy year.
- Coatings and special lenses:
  - Ultraviolet protective coating
  - Standard progressives
  - Plastic photosensitive lenses (Transitions)
  - Blended segment lenses
  - Intermediate vision lenses
  - Premium progressive lenses (Varilux, etc.)
  - Select or ultra-progressive lenses
  - Photochromic glass lenses
  - Polarized lenses
- Anti-reflective coating (standard/premium/ultra)
- High-index lenses
- Single vision, conventional bifocal, conventional trifocal, and lenticular; glass, plastic, or polycarbonate, all lens powers, fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses
- Scratch-resistant coating
  - Contact lenses, in lieu of eyeglasses, when they will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression
  - Contact lenses used in the treatment of certain eye conditions such keratoconus, pathological myopia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism

This benefit will cover either prescription lenses for eyeglass frames or a full year supply of prescription contact lenses, but not both.

**Adult 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.

**Aniridia**

*Eligible health services* include coverage for treatment of aniridia including related eye exams and contact lenses.
9. Outpatient prescription drugs

What you need to know about your outpatient prescription drug benefits

Read this section carefully so that you know:

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

All medically necessary outpatient prescriptions drugs (including non-formulary prescription drugs and disposable devices for administration) are covered under this plan but some may be subject to precertification or step therapy to determine medical necessity and may require a medical exception as explained later in this certificate of coverage.

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:

- 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.

Pharmacies include in-network retail 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 four requirements:
- They are medically necessary
- 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 has general rules to follow:
- You need a prescription from your prescriber
- Your drug needs to be medically necessary for your illness or injury. See the Medical necessity and precertification requirements section
- You need to show your ID card to the pharmacy when you get a prescription filled

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, or denial of coverage.

What outpatient prescription drugs are covered

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

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

Types of pharmacies

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

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

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

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

**Other services**

**Preventive contraceptives**
For females, your outpatient prescription drug plan covers all 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.

**Contraceptives for non-contraceptive purposes**
Eligible health services include female contraceptives prescribed by a **prescriber** for reasons other than contraceptive purposes.

**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
- Pen delivery systems for the administration of insulin
- 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:
- Your **school health services** for pharmacies
- **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 is prescribed for the treatment of a life-threatening condition
- The drug is prescribed and necessary for the treatment of a chronic and seriously debilitating condition and the drug is on the preferred drug guide. If the drug is not on the preferred drug guide then your prescriber may request a medical exception and submit the exception to us.
- The drug must be accepted as safe and effective to treat your condition(s) in one of the following standard compendia:
  - American Hospital Formulary Service’s 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
- Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

A life-threatening condition means:

- Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted
- Any disease or condition with a likely fatal outcome where the clinical intervention is needed to survive

Chronic and seriously debilitating means diseases or conditions that require ongoing treatment to maintain remission or prevent decline and cause significant long-term sickness.

Health care services related to off-label use of these drugs may be subject to precertification, step therapy or other requirements or limitations. Eligible health services also include services related to the administration of the drug.

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.

Pain management for the terminally ill

Eligible health services include pain management prescription drugs for a terminally ill covered person.

Pediatric asthma services and supplies

Eligible health services include outpatient self-management training, education and the following supplies for a child:

- Nebulizers, including face masks and tubing
- Inhaler spacers
- Peak flow meters

Additional or replacement inhaler spacers, nebulizers and peak flow meters are covered under this plan.
Preventive care drugs and supplements

**Eligible health services** include preventive care drugs and supplements (including over-the-counter drugs and supplements) as outlined in the USPSTF A&B recommendations and ACA guidelines when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. These drug and supplements are covered at no cost share.

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

These prescriptions are covered at no cost share.

Sexual dysfunction/enhancement

**Eligible health services** include **prescription drugs** for the treatment of sexual dysfunction/enhancement. For the most up-to-date information on dosing, call Member Services at the toll-free number on your ID card.

Preventive care tobacco cessation prescription and over-the-counter drugs

**Eligible health services** include preventive care **prescription drugs** and over-the-counter (OTC) drugs that have been FDA-approved to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. These prescription and over-the-counter drugs are covered at no cost share.

Obesity drugs

**Eligible Health Services** include charges made by a **pharmacy** for **prescription drugs** prescribed by a **prescriber** for the sole purpose of weight loss (anti-obesity agents).

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 <strong>prescription</strong>. Then you fill out and send a <strong>prescription drug</strong> refund form to us, including all itemized pharmacy receipts.  &lt;br&gt; • Submission of a claim doesn’t guarantee payment. If your claim is approved, you will be reimbursed the cost of your <strong>prescription</strong> 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.

Medical exceptions
Sometimes you or your prescriber may ask for a medical exception to get health care services 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 notify you (or your designee) or your prescriber of our decision 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 notify you (or your designee) or your prescriber of our decision 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.
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

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.

Breasts
- Services and supplies given by a provider for breast reduction or gynecomastia, except as medically necessary.

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

Refer to the When you disagree - claim decisions and appeals procedures section for information on how to request an independent medical review from the California Department of Insurance for experimental or investigational treatment.

Clinical trial therapies (routine patient costs)
- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna’s claim policies)
Cornea or cartilage transplants
- Cornea (corneal graft with amniotic membrane)
- Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

This exclusion does not apply to medically necessary cornea or cartilage transplants.

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

This exclusion does not apply to:
- Surgery after an accidental injury when performed as soon as medically feasible or as described in the Eligible health services under your plan – Reconstructive surgery and supplies section.
- Coverage that may be provided under the Eligible health services under your plan - Gender reassignment (sex change) treatment section.
- Any medically necessary treatment due to complications from cosmetic procedures.

Counseling
- Religious, career, pastoral, or financial counseling

Custodial care
Except for services provided under hospice care, skilled nursing care, or inpatient hospital benefits, assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

Dermatological treatment
- Acne treatment
- Cosmetic treatment and procedures

Dental care for adults
- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolecotomy
  - 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.

This exclusion does not apply to the covered benefits provided in the Eligible health services under your plan – Adult dental care for cancer treatments and dental injuries benefit.
Durable medical equipment (DME)
- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems
- Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician

Early intensive behavioral interventions
- Certain early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, and similar programs) and other intensive educational interventions

Educational services
- 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 that are not medically necessary and 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.

Refer to the When you disagree - claim decisions and appeals procedures section for information on how to request an independent medical review from the California Department of Insurance for experimental or investigational treatment.
Emergency services and urgent care
- Non-emergency services in a hospital emergency room facility
- Non-emergency care in an urgent care facility (at a non-hospital freestanding facility)

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

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

This exclusion does not apply to diabetic shoes and inserts covered in the Eligible health services under your plan – Prosthetics and orthotic devices benefit.

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

Any services that would be otherwise available to a covered person will be covered for those undergoing gender reassignment treatment.
Genetic care
- Any treatment, device, drug, service or supply to alter the body’s genes, genetic make-up, or the expression of the body’s genes except for the correction of congenital birth defects

Growth/Height care
- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

This exclusion does not apply to medically necessary growth/height care.

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
- 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

The maintenance therapy exclusion above does not apply to habilitative services that maintain or prevent deterioration or regression of function.

Hospice care
- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling which includes estate planning and the drafting of a will
- Homemaker or caretaker services that are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house
Incidental surgeries
• Charges made by a physician for incidental surgeries. These are non-medically necessary surgeries performed during the same procedure as a medically necessary surgery.

Maternity and related newborn care
• Any services and supplies related to planned home births or in any other place not licensed to perform deliveries unless the birth occurs in an emergency situation and the mother is unable to reach a place 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

This exclusion does not apply to any disposable supplies that are covered benefits in the Eligible health services under your plan – Durable medical equipment, Home health care, Hospice care, Diabetic services and supplies (including equipment and training) and Outpatient prescription drug benefits.

Motor vehicle accidents
• Services and supplies given by a provider for injuries sustained from a motor vehicle accident but only when benefits have been paid under other automobile medical payment insurance.

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, except as covered in the Eligible health services under your plan – Emergency services and urgent care section.
Obesity

- 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:
  - 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 selling the organ

Other primary payer

- Payment for a portion of the charge that has been paid by Medicare or another party as the primary payer

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions

Outpatient prescription or non-prescription drugs and medicines

- Outpatient prescription drugs or non-prescription drugs and medicines provided free of charge to you by the policyholder

Pediatric dental care

- Braces (orthodontics), mouth guards, and other devices to protect, replace or reposition teeth that are not medically necessary
- Cosmetic services and supplies including:
  - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance
  - Augmentation and other substances to protect, clean, whiten bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the Eligible health services under your plan section
  - Veneers on molar crowns and pontics will always be considered cosmetic
- Procedures, appliances, or restorations (other than those for replacement of structure loss from caries) which alter, restore or maintain occlusion
- Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes
- TMJ dysfunction procedures solely for the treatment of bruxism. Eligible health services are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation. General anesthesia and intravenous sedation, unless medically necessary and only when done in connection with another eligible health service
• Orthodontic treatment, except as covered in the Eligible health services under your plan – Pediatric dental care section, such as:
  o Lingually placed direct bonded appliances and arch wires (invisible braces)
  o Removable acrylic aligners (invisible aligners)
• Pontics, crowns, cast or processed restorations made with high noble metals (gold foil)
• Replacement of third molars (wisdom teeth) and teeth beyond the normal complement of 32
• Services and supplies:
  – Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  – Provided for your personal comfort or convenience or the convenience of another person, including a provider
  – Provided in connection with treatment or care that is not covered under your policy
  – Rendered before the effective date or after the termination of coverage
• Surgical removal of impacted third molars (wisdom teeth) only for orthodontic reasons, except as medically necessary and unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests
• Treatment by other than a dental provider

Personal care, comfort or convenience items
• Any service or supply primarily for your convenience and personal comfort or that of a third party

Preventive care and wellness
• Services for diagnosis or treatment of a suspected or identified illness or injury
• Non-preventive care 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
• Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
• Male contraceptive methods or devices, except as covered in the Eligible health services under your plan – Family planning services - other section
• The reversal of voluntary sterilization procedures, including any related follow-up care

Private duty nursing (outpatient only)

Prosthetic devices
• Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless covered under the Eligible health services under your plan – Prosthetic and orthotic devices, 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 or misuse

School health services
• Services and supplies normally provided without charge 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

This exclusion does not apply to prescription drugs prescribed for the treatment of sexual dysfunction/enhancement as covered under the Outpatient prescription drugs – Other services section.

Sinus surgery
- Any services or supplies given by providers for non-medically necessary sinus surgery except for acute purulent sinusitis

Strength and performance
- Services, devices and supplies that are not medically necessary, such as drugs or preparations designed primarily for enhancing your:
  – Strength
  – Physical condition
  – Endurance
  – Physical performance

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

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

Transplant services
- 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 without intending to use them for transplantation within 12 months from harvesting, for an existing illness
- Travel and lodging expenses for transplants that are not obtained at an IOE facility
Treatment in a federal, state, or governmental entity
- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Treatment of infertility
All charges associated with the treatment of infertility, except as described under the Eligible health services under your plan – Treatment of infertility – Basic infertility section. This includes:
- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate except for otherwise covered benefits provided to a covered person who is a 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, 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
Exceptions and exclusions that apply to outpatient prescription drugs

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

Cosmetic drugs
- Medications or preparations used for cosmetic purposes

Devices, products and appliances, unless medically necessary for the administration of a covered outpatient prescription drug.

Dietary supplements including medical foods. This does not apply to enteral and parenteral nutrition or FDA approved OTC drugs required by the USPSTF A and B recommendations list (e.g. aspirin, vitamin D, folic acid, and iron supplements) when prescribed by a physician

Drugs or medications
- Which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), unless recommended by the United States Preventive Services Task Force. This exception does not apply to FDA approved OTC female contraceptive methods prescribed by a provider
- That is therapeutically equivalent or therapeutically alternative to a covered prescription drug including biosimilar (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). Even if one drug or medication becomes available OTC, the prescription strengths of these drugs are still covered. The entire class of the prescription drugs will not be excluded in this case
- Not approved by the FDA
- For which the cost is covered by a federal, state, or government agency (for example: Medical or Veterans Administration)
- That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications

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

Immunizations related to travel or work
- Immunizations related to travel or work unless recommended by the United States Preventive Services Task Force (USPSTF)

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

Prescription drugs:
- Filled prior to the effective date or after the termination date of coverage under this plan.
- 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

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. See www.aetna.com/docfind or call 1-866-529-2517 for a list of in-network providers. 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 (unless your provider stops being in our network due to imminent harm to patients, a determination of fraud, or a final state disciplinary action by a licensing board). This is called continuity of care.

Care will continue during a transitional period that will vary based on your condition.
<table>
<thead>
<tr>
<th>If you have this condition</th>
<th>The length of transitional period is</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute condition</td>
<td>As long as the condition lasts</td>
</tr>
<tr>
<td>Serious chronic condition</td>
<td>No more than 12 months. Usually until you complete a period of treatment and your physician can safely transfer your care to another physician.</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>All three trimesters of pregnancy and the immediate post-partum period</td>
</tr>
<tr>
<td>Terminal illness</td>
<td>As long as the person lives</td>
</tr>
<tr>
<td>Care of a child under 3 years</td>
<td>Up to 12 months</td>
</tr>
<tr>
<td>An already scheduled surgery or other procedure</td>
<td>Within 180 days of you joining the Aetna plan or your provider leaving the network</td>
</tr>
</tbody>
</table>

Acute condition means:
- A medical condition that appears suddenly, or
- A medical problem that requires immediate medical care and does not last long

Serious chronic condition means:
- A medical condition due to a disease or other medical problem, or
- A medical disorder that is serious and:
  - Continues without full cure
  - Worsens over time
  - Requires ongoing treatment to maintain remission or prevent deterioration

You or your provider should call us for approval to continue any care. You can also call Member Services at the number on the back of your ID card to get a copy of our policy on continuity of care.

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

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

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

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

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

The general rule
When you get eligible health services:

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

  And then

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

  And then

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

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

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

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

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

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

In all these cases, the provider may require you to pay the entire charge. Any amount you pay will not count towards your policy year deductible or towards your maximum out-of-pocket limit.
Important exception - surprise bills
A surprise bill is a bill you receive for eligible health services performed by an out-of-network physician or health professional at a network facility. This happens when:

- A network physician or health professional is unavailable at the time the eligible health services are performed
- An out-of-network physician or health professional performs services without your knowledge
- Unforeseen medical issues or services arise at the time the eligible health services are performed

A surprise bill does not include a bill for health care services when a network physician or health professional is available and you choose to receive services from an out-of-network physician or health professional. In this case, you will have to pay the out-of-network cost share.

In the case of a surprise bill, you will pay the same cost share you would if the eligible health services were received from a network health professional (the in-network cost share). Any cost share you pay related to the surprise bill will count toward:

- Your in-network deductible, if any
- Your copayments/coinsurance
- Your in-network 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 within 20 days of the loss or as soon thereafter as is reasonably possible. We will send you a claim form within 15 days of your request.</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>- You can provide notice to Aetna at: Aetna Life Insurance Company Claim Division 151 Farmington Avenue Hartford, CT 061561, or - To any authorized agent of Aetna</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 the notice and proof of loss within 90 days of the loss or as soon as reasonably possible (but in no event later than 1 year except in the absence of legal capacity).</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 will not be longer than 30 days after the support is received.</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.

**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>5 business days</td>
<td>30 calendar days</td>
<td>24 hours for urgent request* or 72 hours if clinical information is required and received more than 24 hours after request.* 5 business days for non-urgent request.</td>
</tr>
<tr>
<td>Extensions</td>
<td>None</td>
<td>15 calendar days**</td>
<td>15 calendar 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.  
**We must notify you of the extension request within the first 5 business day period.  
*** We must notify you of the extension request within the first 30 calendar day period.

**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.

You may also complain directly to the California Department of Insurance. You can contact them by:

- Calling them at 1-800-927-HELP (4357); TDD: 1-800-482-4TDD (4833)
- Writing them at California Department of Insurance, Consumer Services Division, 300 Spring Street, South Tower, Los Angeles, CA 90013
- Accessing their website at [www.insurance.ca.gov](http://www.insurance.ca.gov)
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 each adverse benefit determination 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>5 business days</td>
<td>30 calendar 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></td>
</tr>
</tbody>
</table>

If we do not respond to your appeal within 30 days, or 3 days for an urgent care claim, you can request an independent medical review (IMR) from the California Department of Insurance within 6 months of either date. The commissioner may extend the time you have to request an IMR beyond the 6 months if circumstances require it.
Independent medical review from the California Department of Insurance
You have a right to request an independent medical review (IMR) from the California Department of Insurance only if:

- Our claim decision involved medical judgment
- We decided the service or supply is not medicinally necessary or not appropriate
- We decided the service or supply is experimental or investigational
- You have received urgent or emergency care denials

Independent medical review for experimental or investigational therapies
You have a right to request an independent medical review (IMR) for denial of experimental or investigational therapies if:

- You have a life-threatening or seriously debilitating condition that standard therapies are neither effective, appropriate, or covered for your condition, and
- Your physician has recommended a drug, device, procedure, or therapy that may be more beneficial in treatment of your condition but has been denied coverage by us

If we decide to deny coverage then we will notify you in writing of the opportunity to request an IMR within five business days of our decision.

You must submit the request for IMR Within six months of the date you received the decision from us

- The IMR system will assign a neutral, independent physician with the proper expertise to review your case

How long will it take to get an IMR decision?
The IMR decision generally takes 30 calendar days after you provide all the information you need to send in.

Sometimes you can get a faster IMR decision. Your provider must certify that a delay in your receiving health care services would jeopardize your health. Once the review is complete, we will abide by the decision of the independent reviewer.

You can contact the California Department of Insurance at:

  California Department of Insurance
  Consumer Services Division
  300 Spring Street
  South Tower
  Los Angeles, CA 90013
  1-800-927-HELP (4357)
  TDD: 1-800-482-4TDD (4833)
  www.insurance.ca.gov

You can also request IMR online by accessing California’s website: https://www.insurance.ca.gov/01-consumers/110-health/60-resources/01-imr/index.cfm

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

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

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Plan</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>
</tbody>
</table>

**Benefit reserve**
- Each family member has a separate benefit reserve for each policy year
- The benefit reserve:
  - Is made up of the amount that the secondary plan saved due to COB
  - Is used to cover any unpaid allowable expenses
  - Balance is erased at the end of each policy year

### How COB works with Medicare

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

You have Medicare when you are entitled to premium-free Medicare Part A or enrolled in Medicare Part B or Premium Part A, or both, by reason of:
- Age
- Disability
- ALS / Lou Gehrig’s disease or
- End stage renal disease

When you have Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. 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>
<th>Medicare is primary</th>
</tr>
</thead>
<tbody>
<tr>
<td></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>
<td></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.aetnostudenthealth.com](http://www.aetnostudenthealth.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:

- We discontinue the plan for the reasons stated in the student policy
- The policyholder ends the student policy
- You are no longer eligible for coverage
- The last day for which any required premium contribution has been paid in accordance with the grace period provision
- The date you are no longer in an eligible class
- We end your coverage in accordance with the Why would we end your coverage? Provision below
- You become covered under another medical plan offered by the policyholder
- The date you are no longer in an eligible class
- We end your coverage in accordance with the Why would we end your coverage? Provision below
- You become covered under another medical plan offered by the policyholder
- The date you withdraw from the school because of entering the armed forces of any country

If your coverage ends because you 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.

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

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

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

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

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

See the Continuation of coverage for other reasons section to learn how you can extend your coverage.
When will coverage end for any dependents?
Coverage for your dependent will end if:

- For a dependent child, on the first premium due date following the child’s 26th birthday.
- Your dependent is no longer eligible for coverage.
- The date dependents are no longer an eligible class.
- You do not make the required premium contribution toward the cost of dependents’ coverage.
- Your coverage ends for any of the reasons listed above.
- For your spouse, the date the marriage ends in divorce or annulment.
- For your domestic partner or civil union partner, the date the domestic partnership or civil union ends.

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

Why would we suspend paying claims or end your and your dependents’ coverage?
We will give you 30 days advance written notice if we suspend paying your claims because:

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

We may immediately end your and your dependents coverage if:

- You commit fraud or intentionally misrepresent a material fact regarding yourself when you applied for or obtained coverage. You can refer to the General provisions – other things you should know- Honest mistakes and intentional misrepresentation section for more information on rescissions.

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

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

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

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

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

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

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

You are “totally disabled” if you cannot work at your own occupation or any other occupation for pay or profit.

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

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

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

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

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

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

- When you are discharged. Coverage will not end if you are transferred to another hospital or a skilled nursing facility.
- When you no longer need inpatient care.
- When you become covered by another health benefits plan.
- 3 months of coverage.
How can you extend coverage after graduation when you are injured or ill?

If your coverage ends because you are graduating, your coverage may be extended for an injury or illness that started while you were covered under the student policy. Benefits are extended only for the services or supplies to treat that illness or injury.

You may extend coverage but not beyond 4 weeks from:
- The date of the accident or
- The date of the first treatment of the illness

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend coverage for your disabled covered dependent child beyond the plan age limits. If your disabled child:
- Is not able to be self-supporting because of mental or physical disability
- Depends mainly (more than 50% of income) on you for support

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

We may ask you to send us proof of the disability within 31 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won’t ask for this proof more than once a year after 2 years from the date your first send us proof. You must send it to us within 60 days of our request. If you don’t, we can terminate coverage for your dependent child.

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

How can your dependents continue coverage after you die?

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

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

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

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

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

Administrative provisions

How you and we will interpret this certificate of coverage
We prepared this certificate of coverage according to federal laws and state laws that apply. This certificate of coverage will be interpreted according to these laws.

How we administer this plan
We apply policies and procedures 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.

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 at law or in equity until 60 days after we receive written proof of loss.

No legal action can be brought to recover payment under any benefit after 3 years from the time written proof of loss is required.
**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 misrepresentation**

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

All statements made by you or the **policyholder** shall be deemed representations and not warranties.

**Intentional misrepresentation**
If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:
- Loss of coverage, starting on the date the act of fraud or intentional misrepresentation happened.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

**Rescission**
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, via certified mail, at least 30 days prior to the effective date written notice of any rescission of coverage. The notice will explain the reason we are rescinding your 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
- You have the right to appeal to the California Department of Insurance
- We will not rescind your coverage for any reason after it has been in force for 24 months.

**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. Your agreement to repay us applies regardless of whether you are fully compensated or made whole for your losses.
- 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, except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040 where applicable. 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.

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

Covered dependent
A person who is insured under the student policy as a dependent of a covered student.
Covered person
A **covered student** or a **covered dependent** of a **covered student** for whom all of the following applies:
- The person is eligible for coverage as defined in the certificate of coverage
- The person has enrolled for coverage and paid any required premium contribution
- The person’s coverage has not ended

Covered student
A student who is insured under the **student policy**.

Craniomandibular joint dysfunction (CMJ)
This is a disorder of the jaw joint.

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

Dental emergency
Any dental condition that:
- Occurs unexpectedly
- Requires immediate diagnosis and treatment in order to stabilize the condition, which in the absence of immediate attention could reasonably be expected to result in placing your health in serious jeopardy
- Serious impairment to bodily functions including periodontal abscess and acute periodontitis, 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. See [www.aetna.com/docfind](http://www.aetna.com/docfind) or call **1-866-529-2517** for the most up-to-date directory. 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**

**DME** includes the following:
- For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other drugs)
- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pad for a mattress
- Nebulizer and supplies
- Peak flow meters
- IV pole
- Tracheostomy tube and supplies
- Enteral pump and supplies
- Bone stimulator
- Cervical traction (over door)
- Non-segmental home model pneumatic compressor for the lower extremities
- Phototherapy blankets for treatment of jaundice in newborns

**Effective date of coverage**

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

**Elective treatment**

Services and supplies provided to you when there is no evidence of pathology, dysfunction, or **illness** in any part of your body. Examples of elective treatment are:
- Breast reduction
- Sub mucous resection and/or other surgical correction for deviated nasal septum, other than for the treatment of a covered medical condition
Eligible health services
The health care services and supplies and outpatient prescription drugs listed in the Eligible health services under your plan section and not carved out or limited in the Exceptions section of this certificate of coverage or in the schedule of benefits.

Emergency admission
An admission to a hospital or treatment facility ordered by a physician within 24 hours after you receive emergency services.

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

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

A mental health condition is also an emergency medical condition when either of the following is true:

- You are an immediate danger to yourself or to others
- You are immediately unable to provide for or use food, shelter, or clothing due to the mental disorder

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.

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 (or a friend’s or relative’s home). Reasons for confinement may include, but are not limited to:
- 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 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
Poor health resulting from disease of the body or mind.

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

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

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

Infertile or infertility
A disease defined by the failure to become pregnant:
- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart

Injectable drug(s)
These are prescription drugs when an oral alternative drug is not available.
Injury or injuries
Physical damage done to a person or part of their body.

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

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

Intensive outpatient program (IOP)
An outpatient program that provides clinical treatment services that are medically necessary and delivered by an appropriately licensed or credentialed behavioral health provider. The 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.

Maximum out-of-pocket limit
The maximum out-of-pocket amount for payment of copayments and coinsurance including any policy year deductible, to be paid by you or any covered dependents per policy year for eligible health services.

Medically necessary/Medical necessity
Health care services that we determine a provider exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness or injury, or its symptoms, and that we determine are:
- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness or injury
- Not primarily for the convenience of the patient, physician, or other health care provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness or injury

Generally accepted standards of medical practice means:
- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Consistent with the standards set forth in policy issues involving clinical judgment
Medicare
As used in this plan, Medicare means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

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

*Health coverage*

This is either:

- The amount an *in-network provider* has agreed to accept
- The amount we agree to pay directly to a *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 a *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 a 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 services that are medically necessary and provided by a behavioral health provider with the appropriate license or credentials. The 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</td>
<td>105% of the Medicare allowed rate</td>
</tr>
<tr>
<td>not mentioned below</td>
<td></td>
</tr>
<tr>
<td>Services of hospitals and other facilities</td>
<td>140% of the Medicare allowed rate</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>100% of the average wholesale price (AWP)</td>
</tr>
<tr>
<td>Dental expenses</td>
<td>80% of the prevailing charge rate</td>
</tr>
</tbody>
</table>

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

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

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

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

R.N.
A registered nurse.

Residential treatment facility (mental disorders)

- An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by Aetna or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating mental disorders:

- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)

Residential treatment facility (substance abuse)

An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for substance abuse residential treatment programs. 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 and their covered dependents. School health services will either provide or coordinate the care provided to covered students.

Semi-private room rate
An institution’s room and board charge for most beds in rooms with 2 or more beds. If there are no such rooms, Aetna will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

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

Skilled nursing facility
A facility specifically licensed as a skilled nursing facility by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation hospitals, and portions of a rehabilitation hospital and a hospital designated for skilled or rehabilitation therapy services.

Skilled nursing facility does not include institutions that provide only:
- Minimal care
- Custodial care services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of mental disorders or substance abuse.
Skilled nursing services
Services provided by an R.N. or L.P.N. within the scope of his or her license.

Sound natural teeth
These are natural teeth. If there is a filling in a tooth, the major portion of the tooth must be present. A tooth cannot be decayed, abscessed, or defective. Sound natural teeth are not capped teeth, implants, crowns, bridges, or dentures.

Specialist
A physician who practices in any generally accepted medical or surgical sub-specialty and is board-certified.

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

You can access the list of these specialty prescription drugs by calling Member Services at the toll-free number on your ID card or you can find it on the Aetna website at www.aetna.com/formulary.

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 require that 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

**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
- Telephone calls
- Any other method required by state law

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

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

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

**Urgent condition**
An illness or injury that requires prompt medical attention but is not an emergency medical condition.

**Urgent admission**
This is an admission to the hospital due to an illness or injury that is severe enough to require a stay in a hospital within 2 weeks from the date the need for the stay becomes apparent.

**Walk-in clinic**
A free-standing health care facility. Neither of the following should be considered a walk-in clinic:

- An emergency room
- The outpatient department of a hospital

10,20,30,40,50,60,70,80,95,100,102,110,120,130,140,150,160,170,180,190
**Assistive Technology**

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

**Smartphone or Tablet**

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

**Non-Discrimination**

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

Aetna:

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

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

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

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


**Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.**
Language Assistance

TTY: 711

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

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

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

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

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

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

للمساعدة في اللغة العربية، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

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

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

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

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

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

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

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

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

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