

Student Health Insurance

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

Schedule of benefits

Prepared exclusively for:

Policyholder:	Rockhurst University
Policyholder number:	232088
Student policy effective date:	08/01/2026
Plan effective date:	08/01/2026
Plan issue date:	04/24/2026
Actuarial value and metallic level:	81.55% - Gold

Underwritten by Aetna Life Insurance Company in the State of Missouri

Important notices:

If you would prefer to have your care coordinated by your **physician** or **school health services**, you should contact your **physician** or **school health services** who will coordinate your care and direct you to an **in-network provider**, or **out-of-network provider** for **medically necessary** services or supplies. If you receive **eligible health services** without contacting your **physician** or **school health services**, you will not be subject to any penalties and the claims for those **eligible health service**s will be processed according to their applicable **in-network provider**, or **out-of-network provider** benefit level. Note that you have full freedom of choice in the selection of any duly licensed health care professional. Coordination of care is not needed for **emergency services**, or to receive obstetrical and gynecological care and **mental health treatment** and **substance related disorders** services from an **in-network provider**.

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**, **copayments** and **coinsurance** listed in the schedule of benefits below reflect the **policy year deductibles**, **copayments** 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 received that are not **covered services**.
- This plan has maximums for specific **covered services** . For example, these could be visit, day or dollar maximums. They are separate maximums for **in-network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule of benefits you will find detailed explanations about your:
  - **Policy year deductibles**
  - **Copayments**
  - Maximums
  - **Coinsurance**
  - **Maximum out-of-pocket limits**

Important note:
All **covered services** are subject to the **policy year deductible**, **copayment** and **coinsurance** unless otherwise noted in the schedule of benefits below. The *Surprise bill* section in the certificate of coverage explains your protections from a surprise bill.

How to contact us for help

We are here to answer your questions.

- Log in to your **Aetna®** website at https://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.

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 **covered services** are paid under the plan, and then you pay your **copayment** and **coinsurance**.

Here's an example of how cost sharing works:

- You pay your **policy year deductible** of $1,000
- Your **physician** charges $120
- Your **physician** collects the **copayment** from you – $20
- The plan pays 80% **coinsurance** – $80
- You pay 20% **coinsurance** – $20

Plan features

Policy year deductibles

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

Deductible type	In-network coverage	Out-of-network coverage
Student	$500 per **policy year**	$1,000 per **policy year**

Policy year deductible waiver

The **policy year deductible** is waived for all of the following **covered services**:

- In-network care for:
  - *Preventive care and wellness*
  - *Pediatric Dental Type A services*
  - *Pediatric Vision Care Services*
- In-network care and out-of-network care for:
  - *Well newborn nursery care*
  - *Outpatient prescription drugs*

Maximum out-of-pocket limits

Maximum out-of-pocket limit per **policy year**

Maximum out-of-pocket type	In-network coverage	Out-of-network coverage
Student	$7,500 per **policy year**	$15,000 per **policy year**

Precertification covered service penalty

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

Failure to **precertify** your **covered services** when required will result in the following benefit penalty:

- A $500 benefit penalty will be applied separately to each type of **covered service**

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

Covered services

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**.

1. Preventive care and wellness

Routine physical exams

Performed at a **physician's** office

Description	In-network coverage	Out-of-network coverage
Routine physical exam	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Routine physical exam limits for **covered persons** through age 21: maximum age and visit limits per **policy year**	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 in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	
Routine physical exam limits for **covered persons** age 22 and over: maximum visits per **policy year**	1 visit	

Preventive care immunizations

Performed in a facility or at a **physician's** office

Preventive care immunizations for **covered persons** from birth to age 5 are not subject to any deductible or **copayment** limits.

Description	In-network coverage	Out-of-network coverage
Preventive care immunizations	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Preventive care immunization maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention or by the Missouri Department of Health and Senior Services. For details, contact your **physician** or Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	

Well woman preventive visits

Routine gynecological exams (including Pap smears)

Description	In-network coverage	Out-of-network coverage
Performed at a **physician**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Well woman routine gynecological exam maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration and the American Cancer Society.	
Maximum visits per **policy year**	1 visit	

Preventive screening and counseling services

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

Description	In-network coverage	Out-of-network coverage
Obesity and/or healthy diet counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Obesity and/or healthy diet counseling maximum visits	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	
Misuse of alcohol and/or drugs counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Misuse of alcohol and/or drugs counseling maximum visits per **policy year**	5 visits	
Use of tobacco products counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Use of tobacco products counseling maximum visits per **policy year**	8 visits	

Description	In-network coverage	Out-of-network coverage
Sexually transmitted infection counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Sexually transmitted infection counseling maximum visits per **policy year**	2 visits	
Genetic risk counseling for breast and ovarian cancer office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Genetic risk counseling for breast and ovarian cancer age and frequency limitations	Not subject to any age or frequency limitations	

Routine cancer screenings

Performed at a **physician** office, **specialist** office or facility
No additional expense such as deductible, coinsurance, or copayment limits will be imposed for breast cancer screening including diagnostic imaging or ultrasound screening for a covered person at risk for breast cancer, or to evaluate an abnormality.

Description	In-network coverage	Out-of-network coverage
Routine cancer screenings	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Routine cancer screening maximums	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF Comprehensive guidelines supported by the Health Resources and Services Administration The American Cancer Society guidelines For details, contact your **physician** or Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	

Description	In-network coverage	Out-of-network coverage
Mammogram maximums	1 baseline mammogram age 35 through 39 1 mammogram annually age 40 and over; or as recommended by a **physician** for those at above average risk due to personal or family history	
Lung cancer screening maximums	1 screening every 12 months	

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

Prenatal care

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

Description	In-network coverage	Out-of-network coverage
Preventive care services only	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit

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

Comprehensive lactation support and counseling services

Facility or office visits

Description	In-network coverage	Out-of-network coverage
Lactation counseling services	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit

Breast feeding durable medical equipment

Description	In-network coverage	Out-of-network coverage
Breast pump supplies and accessories	100% (of the **negotiated charge**) per item No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per item

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

Family planning services –contraceptives

Counseling services

Description	In-network coverage	Out-of-network coverage
Female contraceptive counseling services office visit	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Contraceptive counseling services maximum visits per **policy year** either in a group or individual setting	2 visits	

Important note:
Any visits that exceed the contraceptive counseling services maximum are covered under *Physician services* office visits.

Contraceptives (prescription drugs and devices)

Description	In-network coverage	Out-of-network coverage
Female contraceptive **prescription drugs** and devices provided, administered, or removed, by a **provider** during an office visit	100% (of the **negotiated charge**) per item No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per item

Voluntary sterilization

Description	In-network coverage	Out-of-network coverage
Inpatient **provider** services	100% (of the **negotiated charge**) No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**)
Outpatient **provider** services	100% (of the **negotiated charge**) No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit

2. Physicians and other health professionals

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

Description	In-network coverage	Out-of-network coverage
Office hours visits (non-surgical and non-preventive care by a **physician** or **specialist**, includes **telemedicine** consultations)	$25 **copayment** then the plan pays 80% (of the balance of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Allergy testing and treatment

Description	In-network coverage	Out-of-network coverage
Allergy testing performed at a **physician** or **specialist** office	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.
Allergy injections treatment performed at a **physician** or **specialist** office	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Physician and specialist – inpatient surgical services

Description	In-network coverage	Out-of-network coverage
Inpatient **surgery** performed during your **stay** in a **hospital** or birthing center by a surgeon (Includes anesthetist and surgical assistant expenses)	80% (of the **negotiated charge**)	60% (of the **recognized charge**)

Physician and specialist – outpatient surgical services

Description	In-network coverage	Out-of-network coverage
Outpatient **surgery** performed at a **physician** or **specialist** office or outpatient department of a **hospital** or **surgery center** by a surgeon (Includes anesthetist and surgical assistant expenses)	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

In-hospital non-surgical physician services

Description	In-network coverage	Out-of-network coverage
In-**hospital** non-surgical **physician** services	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Consultant services (non-surgical and non-preventive)

Description	In-network coverage	Out-of-network coverage
Office hours visits (non-surgical and non-preventive care by a consultant, includes **telemedicine** consultations)	$25 **copayment** then the plan pays 80% (of the balance of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Second surgical opinion

Description	In-network coverage	Out-of-network coverage
Second surgical opinion	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Alternatives to physician office visits

Walk-in clinic visits (non-emergency visit)

Description	In-network coverage	Out-of-network coverage
Walk-in clinic (non-emergency visit)	$25 **copayment** then the plan pays 80% (of the balance of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

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

3. Hospital and other facility care

Hospital care (facility charges)

Description	In-network coverage	Out-of-network coverage
Inpatient **hospital** (**room and board**) and other miscellaneous services and supplies) Subject to **semi-private room rate** unless **intensive care unit** is required **Room and board** includes intensive care For **physician** charges, refer to the *Physician and specialist – inpatient surgical services* benefit	$200 **copayment** then the plan pays 80% (of the balance of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

Preadmission testing

Description	In-network coverage	Out-of-network coverage
Preadmission testing	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.

Anesthesia and related facility charges for a dental procedure

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

Description	In-network coverage	Out-of-network coverage
Anesthesia and related facility charges for a dental procedure	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Alternatives to hospital stays

Outpatient surgery (facility charges)

Description	In-network coverage	Out-of-network coverage
Facility charges for **surgery** performed in the outpatient department of a **hospital** or **surgery center** For **physician** charges, refer to the *Physician and specialist – outpatient surgical services* benefit	80% (of the **negotiated charge**)	60% (of the **recognized charge**)

Home health care

Description	In-network coverage	Out-of-network coverage
Home health care	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Hospice care

Description	In-network coverage	Out-of-network coverage
Inpatient facility (**room and board** and other miscellaneous services and supplies)	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Hospice care important note:
This includes part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day. It also includes part-time or intermittent **home health aide** services to care for you up to 8 hours a day.

Outpatient private duty nursing

Description	In-network coverage	Out-of-network coverage
Outpatient private duty nursing	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Skilled nursing facility

Description	In-network coverage	Out-of-network coverage
Inpatient facility (**room and board** and miscellaneous inpatient care services and supplies) Subject to **semi-private room rate** unless **intensive care unit** is required **Room and board** includes intensive care	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

4. Emergency services and urgent care

Emergency services

Description	In-network coverage	Out-of-network coverage
Emergency room	$200 **copayment** then the plan pays 80% (of the balance of the **negotiated charge**) per visit	Paid the same as in-network coverage
Non-emergency care in an emergency room	Not covered	Not covered

Emergency services important note:

- **Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the 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, or call Member Services for an address at 1-877-626-2308 and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.
- A separate emergency room **copayment** will apply for each visit to an emergency room. If you are admitted to a **hospital** as an inpatient right after a visit to an emergency room, your emergency room **copayment** will be waived and your inpatient **copayment** will apply.
- **Covered services** that are applied to the emergency room **copayment** cannot be applied to any other **copayment** under the plan. Likewise, a **copayment** that applies to other **covered services** under the plan cannot be applied to the emergency room **copayment**.
- Separate **copayment** amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These **copayment** amounts may be different from the emergency room **copayment**. They are based on the specific service given to you.
- Services given to you in the emergency room that are not part of the emergency room benefit may be subject to **copayment** amounts that are different from the emergency room **copayment** amounts.

Urgent care

Description	In-network coverage	Out-of-network coverage
Urgent medical care provided by an urgent care **provider**	$25 **copayment** then the plan pays 80% (of the balance of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Non-urgent use of urgent care **provider**	Not covered	Not covered

5. Pediatric dental carePediatric dental care

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

Description	In-network coverage	Out-of-network coverage
Type A services	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Type B services	70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Type C services	50% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Orthodontic services	50% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Dental emergency services	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.

Benefit Group	Benefit Description	Frequency/Limitation
Diagnostic and Preventive Care (Type A Expenses):		
Visits and Images		
	Periodic oral evaluation-established patient	limited to 2 visits per year
	Problem-focused examination	limited to 2 visits per year
	Oral evaluation-child under 3	limited to 2 visits per year
	Comprehensive oral evaluation	limited to 2 visits per year
	Detailed and extensive oral evaluation - problem focused, by report	limited to 2 visits per year
	Comprehensive periodontal evaluation - new or established patient	limited to 2 visits per year
	Intraoral comprehensive image series, including bitewings	limited to 1 set every 3 years
	Periapical 1st radiographic image	
	Periapical each additional radiographic image	
	Intra-oral, occlusal radiographic image	
	Bitewing image - one image	limited to 2 sets per year
	Bitewing images - two images	limited to 2 sets per year
	Bitewing image - three images	limited to 2 sets per year
	Bitewing images - four images	limited to 2 sets per year
	Vertical bitewing images	limited to 2 sets per year
	Panoramic radiographic image	limited to 1 set every 3 years
	2D Cephalometric image	
	2D oral/facial photographic images	
	Intraoral tomosynthesis-comprehensive series of radiographic images	limited to 1 set every 3 years
	Intraoral tomosynthesis – bitewing radiographic image	limited to 2 sets per year
	Intraoral tomosynthesis – periapical radiographic image	
	Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	limited to 1 set every 3 years
	Intraoral tomosynthesis – bitewing radiographic image – image capture only	limited to 2 sets per year
	Intraoral tomosynthesis – periapical radiographic image – image capture only	
	Interpretation of diagnostic image	
	Testing for cracked tooth	
	Diagnostic models	
	Panoramic radiographic image – image capture only	
	2-D cephalometric radiographic image – image capture only	

	Intraoral – occlusal radiographic image – image capture only	
	Intraoral – periapical radiographic image – image capture only	
	Intraoral – bitewing radiographic image – image capture only	
	Intraoral – comprehensive series of radiographic images – image capture only	limited to 1 set every 3 years
	Prophylaxis (cleaning) - Adult	limited to 2 treatments per year
	Prophylaxis (cleaning) - Child	limited to 2 treatments per year
	Topical fluoride varnish	limited to 2 courses of treatment every 12 months
	Topical application of fluoride	limited to 2 courses of treatment every 12 months
	Sealants, per tooth	limited to 1 application every 3 years for permanent molars
	Sealant repair, per tooth	
	Resin infiltration of lesion	limited to 1 per tooth every 3 years
	Application of hydroxyapatite regeneration medicament – per tooth	limited to 1 per tooth every 3 years
	Palliative treatment of dental pain - per visit	
Space Maintainers		
	Space maintainers (Includes all adjustments within 6 months after installation)	
	Space Maintainer - Fixed - unilateral, per quadrant	
	Space Maintainer - Fixed Bilateral, Maxillary	
	Space Maintainer - Fixed Bilateral, Mandibular	
	Space Maintainer - Removable, Unilateral, per quadrant	
	Space Maintainer - Removable Bilateral, Maxillary	
	Space Maintainer - Removable Bilateral, Mandibular	
	Re-cement or re-bond bilateral space maintainer - maxillary	
	Re-cement or re-bond bilateral space maintainer - mandibular	
	Re-cement or re-bond unilateral space maintainer - per quadrant	
	Removal of fixed unilateral space maintainer - per quadrant	

	Removal of fixed bilateral space maintainer - maxillary	
	Removal of fixed bilateral space maintainer - mandibular	
Basic Restorative Care (Type B Expenses):		
Visits and Images		
	Consultation (by other than the treating provider)	
	Office visit after regularly scheduled hours	
	Treatment of complications (post surgical) unusual circumstances, by report	
Images, Pathology, Drugs		
	Extra-oral first 2D projection radiographic image	
	Extra-oral posterior dental radiographic image	
	Extra-oral posterior dental radiographic image – image capture only	
	Photo biomodulation therapy - first 15 minute increment, or any portion thereof	
	Therapeutic drug injection, by report	
	Infiltration of a sustained release therapeutic drug - per quadrant	
Oral Surgery		
	Extraction - coronal remnants - primary tooth	
	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth	
	Removal of impacted tooth - soft tissue	
	Removal of impacted tooth - partially bony	
	Removal of impacted tooth - completely bony	
	Removal of impacted tooth - completely bony with unusual surgical complications	
	Removal of residual tooth roots (cutting procedure)	
	Coronectomy – intentional partial tooth removal, impacted teeth only	
	Oroantral fistula closure	
	Tooth re-implantation and/or stabilization	
	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	
	Exposure of an unerupted tooth	

	Placement of device to facilitate eruption of impacted tooth	
	Excisional biopsy of minor salivary glands	
	Incision and drainage of abscess - intraoral soft tissue	
	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	
	Incision and drainage of abscess - extraoral soft tissue	
	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	
	Alveoplasty, in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	
	Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces, per quadrant	
	Alveoplasty, not in conjunction with extraction - four or more teeth or tooth spaces, per quadrant	
	Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces, per quadrant	
	Removal of lateral exostosis (maxilla or mandible)	
	Removal of torus palatinus	
	Removal of torus mandibularis	
	Suture of small wounds up to 5 cm	
	Bone replacement graft for ridge preservation - per site	
	Buccal / labial frenectomy (frenulectomy)	
	Lingual frenectomy (frenulectomy)	
	Excision of hyperplastic tissue - per arch	
	Excision of pericoronal gingiva	
Periodontics		
	Periodontal scaling and root planing, four or more teeth per quadrant	limited to 4 separate quadrants every 2 years
	Periodontal scaling and root planing, one to three teeth per quadrant	limited to once per quadrant every 2 years
	Periodontal maintenance procedures following active therapy	limited to 4 in 12 months, combined with prophylaxis after completion of active periodontal therapy
	Collection and application of autologous blood concentrate product	limited to 1 in 36 months
	Occlusal adjustment limited - non ortho related	

	Occlusal adjustment full mouth	
Endodontics		
	Pulp cap - direct (excluding final restoration)	
	Pulp cap - indirect (excluding final restoration)	
	Therapeutic pulpotomy (excluding final restoration)	
	Partial pulpotomy for apexogenesis	
	Pulpal therapy (resorbable filling) - anterior, primary tooth	
	Pulpal therapy (resorbable filling) - posterior, primary tooth	
	Pulpal regeneration - initial visit	
	Pulpal regeneration - interim medication replacement	
	Pulpal regeneration - completion of treatment	
	Retrograde filling - per root	
Restorative Dentistry		
	Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)	
	Amalgam - one surface, primary or permanent	
	Amalgam - two surfaces, primary or permanent	
	Amalgam - three surfaces, primary or permanent	
	Amalgam - four or more surfaces, primary or permanent	
	Resin-based composite - one surface, anterior	
	Resin-based composite - two surfaces, anterior	
	Resin-based composite - three surfaces, anterior	
	Resin-based composite - four or more surfaces, anterior	
	Resin-based composite crown - anterior	
	Resin-based composite - one surface, posterior	
	Resin-based composite - two surfaces, posterior	
	Resin-based composite - three surfaces, posterior	
	Resin-based composite - four or more surfaces, posterior	

	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	
	Pins:	
	Pin retention—per tooth, in addition to restoration	
	Crowns (when tooth cannot be restored with a filling material):	
	Prefabricated stainless steel crown - primary teeth	
	Prefabricated stainless steel crown - permanent teeth	
	Prefabricated resin crown	
	Placement of interim direct restoration	
	Prefabricated porcelain/ceramic crown - primary tooth	
	Recementation or Re-bond:	
	Recement or re-bond Inlay, onlay, veneer or partial coverage restoration	
	Recement or re-bond indirectly fabricated or prefabricated post and core	
	Recement or re-bond crown	
	Excavation of a tooth resulting in the determination of non-restorability	
	Recement implant/abutment supported crown	
	Recement implant/abutment supported fixed partial denture	
	Recement fixed partial denture retainers	
Prosthodontics		
	Dentures and Partials	
	Adjustment to complete denture - maxillary	(Adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture)
	Adjustment to complete denture - mandibular	(Adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture)
	Adjustment to partial denture - maxillary	(Adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture)

	Adjustment to partial denture - mandibular	(Adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture)
	Repairs:	
	Repair broken complete denture base, mandibular	
	Repair broken complete denture base, maxillary	
	Replace missing or broken tooth - complete denture - per tooth	
	Repair resin partial denture base, mandibular	
	Repair resin partial denture base, maxillary	
	Repair cast partial framework, mandibular	
	Repair cast partial framework, maxillary	
	Repair or replace broken retentive/clasping materials - per tooth	
	Replace missing or broken teeth – partial denture- per tooth	
	Add tooth to existing partial denture - per tooth	
	Add clasp to existing partial denture – per tooth	
	Replace all teeth and acrylic on cast metal framework - maxillary	
	Replace all teeth and acrylic on cast metal framework - mandibular	
	Tissue conditioning, per denture - maxillary	
	Tissue conditioning, per denture - mandibular	
	Add metal substructure to acrylic full denture, per arch	
	Rebase, complete maxillary denture	
	Rebase, complete mandibular denture	
	Rebase partial maxillary denture	
	Rebase partial mandibular denture	
	Rebase hybrid prosthesis	
	Reline complete maxillary denture - direct	
	Reline complete mandibular denture - direct	
	Reline maxillary partial denture - direct	
	Reline mandibular partial denture - direct	
	Reline complete maxillary denture - indirect	
	Reline complete mandibular denture - indirect	

	Reline maxillary partial denture - indirect	
	Reline mandibular partial denture - indirect	
	Soft liner for complete or partial removable denture – indirect	
	Fixed partial denture repair necessitated by restorative material failure	
General Anesthesia and Intravenous Sedation		
	Evaluation for deep sedation or general anesthesia	
	Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof	
	Administration of deep sedation/general anesthesia - each subsequent 15 minute increment, or any portion thereof	
	Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	
	Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	
	Intravenous moderate (conscious) sedation/anesthesia – first 15 minutes	
	Administration of moderate sedation-intravenous - each subsequent 15 minute increment, or any portion thereof	
	Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof	
	Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof	
Major Restorative Care (Type C Expenses):		
Periodontics		
	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bound spaces, per quadrant	limited to 1 per quadrant every 3 years
	Gingivectomy or gingivoplasty - one to three teeth per quadrant	limited to 1 per quadrant every 3 years
	Gingivectomy or gingivoplasty, to allow access for restorative procedure, per tooth	limited to 1 per quadrant every 3 years
	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	limited to 1 per quadrant every 3 years

	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	limited to 1 per quadrant every 3 years
	Crown lengthening clinical - hard tissue	
	Osseous surgery (including flap and closure) - four or more contiguous teeth	limited to 1 per quadrant every 3 years
	Osseous surgery (including flap and closure) - one to three teeth per quadrant	limited to 1 per site every 3 years
	Bone replacement graft - retained natural tooth - first site in quadrant	Limited to 1 every 3 years
	Pedicle soft tissue graft procedures	
	Autogenous connective tissue graft procedure	
	Non-autogenous connective soft tissue graft	
	Free soft tissue graft procedure (including donor surgical sites)	
	Free soft tissue graft procedure (including donor surgical sites) each additional tooth, each additional contiguous tooth, implant or edentulous tooth position in same graft site	
	Autogenous connective tissue graft procedure (including donor and recipient surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site	
	Non-autogenous connective tissue graft procedure (including donor and recipient surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site	
	Debridement, full mouth to enable a comprehensive periodontal evaluation and diagnosis	limited to 1
Endodontics		
	Root canal therapy, including images:	
	Endodontic therapy, anterior tooth (excluding final restoration)	
	Endodontic therapy, premolar tooth (excluding final restoration)	
	Endodontic therapy, molar tooth (excluding final restoration)	
	Retreatment of previous root canal therapy, including images:	
	Retreatment of previous root canal therapy - anterior tooth	
	Retreatment of previous root canal therapy - premolar tooth	
	Retreatment of previous root canal therapy - molar tooth	

	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
	Apexification/recalcification - interim medication replacement	
	Apexification/recalcification - final visit (includes completed root canal - apical closure/calcific repair of perforations, root resorption, etc.)	
	Pulpal regeneration - initial visit	
	Pulpal regeneration - interim medications replacement	
	Pulpal regeneration - completion of treatment	
	Apicoectomy - anterior	
	Apicoectomy - premolar (first root)	
	Apicoectomy - molar (first root)	
	Apicoectomy - each additional root	
	Root amputation - per root	
	Surgical repair of root resorption - anterior	
	Surgical repair of root resorption – premolar	
	Surgical repair of root resorption – molar	
	Hemisection (including any root removal), not including root canal therapy	
Restorative		
	Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. (limited to 1 per tooth every 5 years)	
	Inlay - metallic - one surface	limited to 1 tooth every 5 years
	Inlay - metallic - two surfaces	limited to 1 tooth every 5 years
	Inlay - metallic - three or more surfaces	limited to 1 tooth every 5 years
	Onlay - metallic - two surfaces	limited to 1 tooth every 5 years
	Onlay - metallic - three surfaces	limited to 1 tooth every 5 years
	Onlay - metallic - four or more surfaces	limited to 1 tooth every 5 years
	Inlay - porcelain/ceramic - one surface	limited to 1 tooth every 5 years
	Inlay - porcelain/ceramic - two surfaces	limited to 1 tooth every 5 years

	Inlay - porcelain/ceramic - three or more surfaces	limited to 1 tooth every 5 years
	Onlay - porcelain/ceramic - two surfaces	limited to 1 tooth every 5 years
	Onlay - porcelain/ceramic - three surfaces	limited to 1 tooth every 5 years
	Onlay - porcelain/ceramic - four or more surfaces	limited to 1 tooth every 5 years
	Inlay - composite/resin - one surface	limited to 1 tooth every 5 years
	Inlay - composite/resin - two surfaces	limited to 1 tooth every 5 years
	Inlay - composite/resin - three surfaces	limited to 1 tooth every 5 years
	Onlay - composite/resin - two surfaces	limited to 1 tooth every 5 years
	Onlay - composite/resin - three surfaces	limited to 1 tooth every 5 years
	Onlay - composite/resin - four or more surfaces	limited to 1 tooth every 5 years
	Crowns (limited to 1 tooth every 5 years)	limited to 1 tooth every 5 years
	Crown - resin-based composite (indirect)	limited to 1 tooth every 5 years
	Crown - resin with high noble metal	limited to 1 tooth every 5 years
	Crown - resin with predominantly base metal	limited to 1 tooth every 5 years
	Crown - resin with noble metal	limited to 1 tooth every 5 years
	Crown - porcelain/ceramic	limited to 1 tooth every 5 years
	Crown - porcelain fused to high noble metal	limited to 1 tooth every 5 years
	Crown - porcelain fused to predominantly base metal	limited to 1 tooth every 5 years
	Crown - porcelain fused to noble metal	limited to 1 tooth every 5 years
	Crown - porcelain fused to titanium and titanium alloys	limited to 1 tooth every 5 years
	Crown - 3/4 cast high noble metal	limited to 1 tooth every 5 years
	Crown - 3/4 cast predominantly base metal	limited to 1 tooth every 5 years
	Crown - 3/4 cast noble metal	limited to 1 tooth every 5 years
	Crown - 3/4 porcelain/ceramic	limited to 1 tooth every 5 years
	Crown - full cast high noble metal	limited to 1 tooth every 5 years

	Crown - full cast predominantly base metal	limited to 1 tooth every 5 years
	Crown - full cast noble metal	limited to 1 tooth every 5 years
	Crown - titanium and titanium alloys	limited to 1 tooth every 5 years
	Core build-up, including any pins when required	
	Post and core in addition to crown, indirectly fabricated	
	Each additional cast indirectly fabricated post same tooth	
	Prefabricated post and core in addition to crown	
	Each additional prefabricated post - same tooth	
	Labial veneer (resin laminate) - direct	
	Labial veneer (resin laminate) - indirect	limited to 1 tooth every 5 years
	Labial veneer (porcelain laminate)	limited to 1 tooth every 5 years
	Repairs:	
	Crown repair necessitated by restorative material failure	
	Inlay repair necessitated by restorative material failure	
	Onlay repair necessitated by restorative material failure	
	Veneer repair necessitated by restorative material failure	
Prosthodontics		
	Dentures and partial dentures: (Replacement of existing dentures or partial dentures / bridges) (limited to 1 every 5 years)	
	Complete upper denture	limited to 1 every 5 years
	Complete lower denture	limited to 1 every 5 years
	Immediate upper denture	limited to 1 every 5 years
	Immediate lower denture	limited to 1 every 5 years
	Upper partial denture - resin base, including retentive/clasping materials, rests, and teeth)	limited to 1 every 5 years
	Lower partial denture - resin base, including retentive/clasping materials, rests, and teeth)	limited to 1 every 5 years
	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	limited to 1 every 5 years

	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	limited to 1 every 5 years
	Immediate maxillary partial denture – resin base (including any retentive/clasping materials, rests and teeth)	limited to 1 every 5 years
	Immediate mandibular partial denture – resin base (including any retentive/clasping materials, rests and teeth)	limited to 1 every 5 years
	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	limited to 1 every 5 years
	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	limited to 1 every 5 years
	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	limited to 1 every 5 years
	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	limited to 1 every 5 years
	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	limited to 1 every 5 years
	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	limited to 1 every 5 years
	Interim partial denture (including retentive/clasping materials, rests and teeth), maxillary	
	Interim partial denture (including retentive/clasping materials, rests and teeth), mandibular	
	Removable unilateral partial denture one piece cast metal (including retentive/clasping material, rest and teeth), maxillary	limited to 1 every 5 years
	Removable unilateral partial denture one piece cast metal (including retentive/clasping material, rest and teeth), mandibular	limited to 1 every 5 years
	Removable unilateral partial denture - one piece flexible base (including retentive/clasping material, rest and teeth) - per quadrant	limited to 1 every 5 years
	Removable unilateral partial denture - one piece resin (including retentive/clasping material, rests and teeth) - per quadrant	limited to 1 every 5 years

	Implant Services:	
	Endosteal implant - surgical placement	1 every 5 years
	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 every 5 years
	Subperiosteal implant	1 every 5 years
	Transosseous mandibular implant	1 every 5 years
	Implant connecting bar	1 every 5 years
	Modification of a prefabricated abutment may be necessary	1 every 5 years
	Created by a laboratory process, specific for an individual application	1 every 5 years
	Abutment supported porcelain/ceramic crown	1 every 5 years
	Abutment supported porcelain fused to metal crown (high noble metal)	1 every 5 years
	Abutment supported porcelain fused to metal crown (predominately base metal)	1 every 5 years
	Abutment supported porcelain fused to metal crown (noble metal)	1 every 5 years
	Abutment supported cast metal crown (high noble metal)	1 every 5 years
	Abutment supported cast metal crown (predominately base metal)	1 every 5 years
	Abutment supported cast noble metal crown (noble metal)	1 every 5 years
	Implant supported porcelain/ceramic crown	1 every 5 years
	Implant supported crown - porcelain fused to high noble alloys	1 every 5 years
	Implant supported crown high noble alloys	1 every 5 years
	Abutment supported retainer - for porcelain/ceramic fixed partial denture (FPD)	1 every 5 years
	Abutment supported retainer - porcelain fused to high noble metal fixed partial denture (FPD)	1 every 5 years
	Abutment supported retainer - for porcelain fused to predominately base metal fixed partial denture (FPD)	1 every 5 years
	Abutment supported retainer - for porcelain fused to noble metal fixed partial denture (FPD)	1 every 5 years
	Abutment supported retainer - for cast high noble metal fixed partial denture (FPD)	1 every 5 years

	Abutment supported retainer - for cast predominately base metal fixed partial denture (FPD)	1 every 5 years
	Abutment supported retainer - for cast noble metal fixed partial denture (FPD)	1 every 5 years
	Implant supported - for ceramic fixed partial dental retainer (FPD)	1 every 5 years
	Implant supported retainer for FPD - porcelain fused to high noble alloys	1 every 5 years
	Implant supported retainer for metal fixed partial denture (FPD) - high noble alloys	1 every 5 years
	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	1 every 5 years
	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths: includes cleaning of the implant surfaces, without flap entry and closure	
	Implant supported crown - porcelain fused to predominantly base alloys	1 every 5 years
	Implant supported crown - porcelain fused to predominantly noble alloys	1 every 5 years
	Implant supported crown - porcelain fused to titanium and titanium alloys	1 every 5 years
	Implant supported crown - predominately base alloys	1 every 5 years
	Implant supported crown - noble alloys	1 every 5 years
	Implant supported crown - titanium and titanium alloys	1 every 5 years
	Accessing and retorquing loose implant screw - per screw	1 every 5 years
	Repair of implant/abutment supported prosthesis	1 every 5 years
	Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	1 every 5 years
	Abutment supported crown - titanium and titanium alloys	1 every 5 years
	Remove broken implant retaining screw	1 every 5 years
	Abutment supported crown - porcelain fused to titanium and titanium alloys	1 every 5 years
	Implant supported retainer - porcelain fused to predominately base alloys	1 every 5 years
	Implant supported retainer for FPD - porcelain fused to noble alloys	1 every 5 years
	Implant removal, by report	1 every 5 years

	Debridement of peri-implant defect	1 every 5 years
	Debridement and osseous contouring of peri-implant defect	1 every 5 years
	Bone graft for repair of peri-implant defect	1 every 5 years
	Bone graft at time of implant placement	1 every 5 years
	Removal of implant body not requiring bone removal or flap elevation	1 every 5 years
	Implant/abutment supported removable denture for completely endentulous arch - maxillary	1 every 5 years
	Implant/abutment supported removable denture for completely endentulous arch - mandibular	1 every 5 years
	Implant/abutment supported removable denture for partially edentulous arch - maxillary	1 every 5 years
	Implant/abutment supported removable denture for partially edentulous arch - mandibular	1 every 5 years
	Implant/abutment supported fixed denture for completely edentulous arch – maxillary	1 every 5 years
	Implant/abutment supported fixed denture for completely edentulous arch – mandibular	1 every 5 years
	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	1 every 5 years
	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	1 every 5 years
	Implant/abutment supported interim fixed denture for edentulous arch – mandibular	
	Implant/abutment supported interim fixed denture for edentulous arch – maxillary	
	Implant supported retainer - porcelain fused to titanium and titanium alloys	1 every 5 years
	Implant supported retainer for metal full partial denture (FPD) - predominantly base alloys	1 every 5 years
	Implanted supported retainer for metal full partial denture (FPD) - noble alloys	1 every 5 years
	Implant supported retainer for metal full partial denture (FPD) - titanium and titanium alloys	1 every 5 years

	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	1 every 5 years
	Radiographic/Surgical Implant Index, By Report	1 every 5 years
	Replacement of an implant screw	1 every 5 years
	Abutment support retainer crown for FPD titanium and titanium alloys	1 every 5 years
	Abutment supported retainer - porcelain fused to titanium and titanium alloys	1 every 5 years
	Pontics - Fixed partial denture:	
	Pontic - cast high noble metal	1 every 5 years
	Pontic - cast predominantly base metal	1 every 5 years
	Pontic - cast noble metal	1 every 5 years
	Pontic - titanium	1 every 5 years
	Pontic - porcelain fused to high noble metal	1 every 5 years
	Pontic - porcelain fused to predominantly base metal	1 every 5 years
	Pontic - porcelain fused to noble metal	1 every 5 years
	Pontic - porcelain fused to titanium and titanium alloys	1 every 5 years
	Pontic - porcelain/ceramic	1 every 5 years
	Pontic - resin with high noble metal	1 every 5 years
	Pontic - resin with predominantly base metal	1 every 5 years
	Pontic - resin with noble metal	1 every 5 years
	Inlays/Onlays-Fixed partial denture:	
	Retainer - cast metal for resin bonded fixed prosthesis	1 every 5 years
	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	1 every 5 years
	Inlay - porcelain/ceramic, two surfaces	1 every 5 years
	Inlay - cast high noble metal, two surfaces	1 every 5 years
	Inlay - cast high noble metal, three or more surfaces	1 every 5 years
	Inlay - cast predominately base metal, two surfaces	1 every 5 years
	Inlay - cast predominately base metal, three or more surfaces	1 every 5 years
	Inlay - cast noble metal, two surfaces	1 every 5 years
	Inlay - cast noble metal, three or more surfaces	1 every 5 years
	Onlay - porcelain/ceramic, two surfaces	1 every 5 years
	Onlay - cast high noble metal, three or more surfaces	1 every 5 years
	Onlay - cast predominately base metal, three or more surfaces	1 every 5 years

	Onlay - cast noble metal, three or more surfaces	1 every 5 years
	Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)	
	Crowns-Fixed partial dentures:	
	Retainer crown - porcelain/ceramic	limited to 1 every 5 years
	Retainer crown - porcelain fused to high noble metal	limited to 1 every 5 years
	Retainer crown - porcelain fused to predominantly base metal	limited to 1 every 5 years
	Retainer crown - porcelain fused to noble metal	limited to 1 every 5 years
	Retainer crown - porcelain fused to titanium and titanium alloys	limited to 1 every 5 years
	Retainer crown - high noble metal (3/4 cast)	limited to 1 every 5 years
	Retainer crown - predominantly base metal (3/4 cast)	limited to 1 every 5 years
	Retainer crown - noble metal (3/4 cast)	limited to 1 every 5 years
	Retainer crown - porcelain/ceramic (3/4 cast)	limited to 1 every 5 years
	Retainer crown - 3/4 titanium and titanium alloys	limited to 1 every 5 years
	Retainer crown - high noble metal (full cast)	limited to 1 every 5 years
	Retainer crown - predominantly base metal (full cast)	limited to 1 every 5 years
	Retainer crown - noble metal (full cast)	limited to 1 every 5 years
	Stress breaker	
	Pediatric partial denture, fixed	limited to 1 every 5 years
	Removable appliance therapy	
	Fixed appliance therapy	
	Cleaning and inspection of removable complete denture, maxillary	
	Cleaning and inspection of removable complete partial denture, mandibular	
	Cleaning and inspection of removable complete partial denture, maxillary	
	Cleaning and inspection of removable complete denture, mandibular	
	Occlusal guard adjustment	Not eligible within first 6 months after placement of appliance
	Occlusal guard - hard appliance, full arch	
	Occlusal guard - soft appliance, full arch	
	Occlusal guard - hard appliance, partial arch	

	Cleaning and inspection of occlusal guard – per appliance	
Orthodontic Care		
	Limited orthodontic treatment of the primary dentition	
	Limited orthodontic treatment of the transitional dentition	
	Limited orthodontic treatment of the adolescent dentition	
	Comprehensive orthodontic treatment of the transitional dentition	
	Comprehensive orthodontic treatment of the adolescent dentition	
	Comprehensive treatment of the adult dentition	
	Comprehensive orthodontic treatment with orthognathic surgery	
	Pre-orthodontic treatment examination	
	Periodic orthodontic treatment visit	
	Periodic orthodontic treatment visit associated with orthognathic surgery	
	Orthodontic retention (removal of appliances, construction and placement of retainer)	
	Repair of orthodontic appliance - maxillary	
	Repair of orthodontic appliance - mandibular	
	Re-cement or re-bond fixed retainer - maxillary	
	Re-cement or re-bond fixed retainer - mandibular	
	Repair of fixed retainer, includes reattachment - maxillary	
	Repair of fixed retainer, includes reattachment - mandibular	
	3D printing of a 3D dental surface scan	
	3D intraoral surface scan – direct	

6. Specific conditions

Birthing center (facility charges)

Description	In-network coverage	Out-of-network coverage
Inpatient (**room and board**) and other miscellaneous services and supplies)	Paid at the same cost-sharing as **hospital** care.	Paid at the same cost-sharing as **hospital** care.

Diabetic services and supplies (including equipment and training)

Description	In-network coverage	Out-of-network coverage
Diabetic services and supplies (including equipment and training)	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.

Temporomandibular joint dysfunction (TMJ) and Craniomandibular joint dysfunction (CMJ) treatment

Description	In-network coverage	Out-of-network coverage
TMJ and **CMJ** 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.

Accidental injury to sound natural teeth

Description	In-network coverage	Out-of-network coverage
Accidental injury to **sound natural teeth**	80% (of the **negotiated charge**)	80% (of the **recognized charge**)

Dermatological treatment

Description	In-network coverage	Out-of-network coverage
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Maternity care

Description	In-network coverage	Out-of-network coverage
Maternity care (includes delivery and postpartum care services in a **hospital** or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Well newborn nursery care

Description	In-network coverage	Out-of-network coverage
Well newborn nursery care in a **hospital** or birthing center	80% (of the **negotiated charge**) No **policy year deductible** applies	60% (of the **recognized charge**) No **policy year deductible** applies

Important 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**.

Gender affirming treatment

Description	In-network coverage	Out-of-network coverage
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Autism spectrum disorder

The cost share for physical and occupational therapy services will be no greater than the cost share for a **physician's** office visit.

Description	In-network coverage	Out-of-network coverage
Autism spectrum disorder diagnosis and testing	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.
Autism spectrum disorder treatment (includes **physician** and **specialist** office visits)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Applied behavior analysis	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.

Behavioral health

Mental health treatment – inpatient

Description	In-network coverage	Out-of-network coverage
Inpatient **hospital mental health disorders** treatment (**room and board** and other miscellaneous **hospital** services and supplies) Inpatient **residential treatment facility mental health disorders** treatment (**room and board** and other miscellaneous **residential treatment facility** services and supplies) Subject to **semi-private room rate** unless **intensive care unit** is required **Mental health disorder room and board** intensive care	$200 **copayment** then the plan pays 80% (of the balance of the **negotiated charge**) per admission Coverage is provided under the same terms, conditions as any other **illness**.	60% (of the **recognized charge**) per admission Coverage is provided under the same terms, conditions as any other **illness**.

Mental health treatment – outpatient

Description	In-network coverage	Out-of-network coverage
Outpatient **mental health disorders** office visits to a **physician** or **behavioral health provider** (Includes **telemedicine** consultations)	$25 **copayment** then the plan pays 80% (of the balance of the **negotiated charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**.	60% (of the **recognized charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**.
Other outpatient **mental health disorders** treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive outpatient program	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Substance related disorders treatment – inpatient

Description	In-network coverage	Out-of-network coverage
Inpatient **hospital substance related disorders detoxification** (**room and board** and other miscellaneous **hospital** services and supplies) Inpatient **hospital substance related disorders** rehabilitation (**room and board** and other miscellaneous **hospital** services and supplies) Inpatient **residential treatment facility substance related disorders** (**room and board** and other miscellaneous **residential treatment facility** services and supplies) Subject to **semi-private room rate** unless **intensive care unit** is required **Substance related disorders room and board** intensive care	$200 **copayment** then the plan pays 80% (of the balance of the **negotiated charge**) per admission Coverage is provided under the same terms, conditions as any other **illness**.	60% (of the **recognized charge**) per admission Coverage is provided under the same terms, conditions as any other **illness**.

Substance related disorders treatment – outpatient

Detoxification and rehabilitation

Description	In-network coverage	Out-of-network coverage
Outpatient **substance related disorders** office visits to a **physician** or **behavioral health provider** (Includes **telemedicine** consultations)	$25 **copayment** then the plan pays 80% (of the balance of the **negotiated charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**.	60% (of the **recognized charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**.
Other outpatient **substance related disorder** services Partial hospitalization treatment Non-residential treatment Intensive outpatient program	80% (of the **negotiated charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**.	60% (of the **recognized charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**.

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network coverage	Out-of-network coverage
Treatment of mouth, jaws and teeth	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.

Reconstructive surgery and supplies

Description	In-network coverage	Out-of-network coverage
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.

Transplant services

Description	In-network coverage (IOE facility)	Out-of-network coverage (Includes **providers** who are otherwise part of **Aetna's** network but are non-IOE **providers**)
Inpatient and outpatient transplant facility services	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.
Inpatient and outpatient transplant **physician** and **specialist** services	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.

Transplant services – travel and lodging

Description	In-network coverage (IOE facility)	Out-of-network coverage (Includes **providers** who are otherwise part of **Aetna's** network but are non-IOE **providers**)
Transplant services – travel and lodging	Covered	Covered
Lifetime maximum payable for travel and lodging expenses for any one transplant, including tandem transplants	$10,000	
Maximum payable for lodging expenses per **IOE** patient	$50 per night	
Maximum payable for lodging expenses per companion	$50 per night	

Transplant travel and lodging important note:
Detailed receipts for transportation and lodging expenses must be submitted when claims are sent to us. For lodging and ground transportation benefits, we will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code 213 (d)(2)(B). Contact Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.

Infertility Services

Basic infertility

Description	In-network coverage	Out-of-network coverage
Treatment of basic **infertility**	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.

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Description	In-network coverage	Out-of-network coverage
Diagnostic complex imaging services performed in the outpatient department of a **hospital** or other facility	80% (of the **negotiated charge**)	60% (of the **recognized charge**)

Diagnostic lab work and radiological services

Description	In-network coverage	Out-of-network coverage
Diagnostic lab work performed in a **physician's** office, the outpatient department of a **hospital** or other facility	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Diagnostic radiological services performed in a **physician's** office, the outpatient department of a **hospital** or other facility	80% (of the **negotiated charge**)	60% (of the **recognized charge**)

Chemotherapy

Description	In-network coverage	Out-of-network coverage
Chemotherapy	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Outpatient infusion therapy

Description	In-network coverage	Out-of-network coverage
Outpatient infusion therapy performed in a **covered person's** home, **physician's** office, outpatient department of a **hospital** or other facility	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.

Outpatient radiation therapy

Description	In-network coverage	Out-of-network coverage
Outpatient radiation therapy	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Specialty prescription drugs

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

Description	In-network coverage	Out-of-network coverage
Specialty prescription drugs	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.

Outpatient respiratory therapy

Description	In-network coverage	Out-of-network coverage
Respiratory therapy	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Transfusion or kidney dialysis of blood

Description	In-network coverage	Out-of-network coverage
Transfusion or kidney dialysis of blood	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.

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

Description	In-network coverage	Out-of-network coverage
Cardiac rehabilitation	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Pulmonary rehabilitation

Description	In-network coverage	Out-of-network coverage
Pulmonary rehabilitation	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Short-term rehabilitation and habilitation therapy services

The cost share will be no greater than the cost share of a **physician's** office visit.

Description	In-network coverage	Out-of-network coverage
Outpatient physical, occupational, speech, and cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	Unlimited	

Chiropractic services

The cost share for a single chiropractic service will not be more than 50% of the **negotiated charge** or **recognized charge**, as applicable, for that service.

Description	In-network coverage	Out-of-network coverage
Chiropractic services	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Important note:
We may require prior authorization or notification before any follow-up diagnostic tests are ordered by a chiropractor or for any office visits for treatment in excess of twenty-six per **policy year**.

Diagnostic testing for learning disabilities

Description	In-network coverage	Out-of-network coverage
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.

8. Other services

Ambulance service

Description	In-network coverage	Out-of-network coverage
Emergency ground, air, and water **ambulance** (Includes non-emergency **ambulance**)	80% (of the **negotiated charge**) per trip	Paid the same as in-network coverage

Clinical trials

Description	In-network coverage	Out-of-network coverage
Experimental or investigational	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.
Routine patient costs	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Durable medical equipment (DME)

Description	In-network coverage	Out-of-network coverage
Durable medical equipment	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item

Nutritional support

Description	In-network coverage	Out-of-network coverage
Nutritional support	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.

Orthotic devices

Description	In-network coverage	Out-of-network coverage
Orthotic devices	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item

Osteoporosis (non-preventive care)

Description	In-network coverage	Out-of-network coverage
Physician or **specialist** office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Prosthetic devices

Description	In-network coverage	Out-of-network coverage
Cochlear implants Coverage is limited to **covered persons** age 18 and over	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Cranial prosthetics (Medical wigs)	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Prosthetic devices	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item

Hearing aids

Description	In-network coverage	Out-of-network coverage
Hearing aids	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Hearing aids maximum per ear: **Covered persons** through age 17	One per ear every 4 years	

Podiatric (foot care) treatment

Description	In-network coverage	Out-of-network coverage
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)

Description	In-network coverage	Out-of-network coverage
Performed by a legally qualified ophthalmologist or optometrist	100% (of the **negotiated charge**) per visit	70% (of the **recognized charge**) per visit
Maximum visits per **policy year**	1 visit	

Pediatric comprehensive low vision evaluations

Description	In-network coverage	Out-of-network coverage
Performed by a legally qualified ophthalmologist or optometrist	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.
Maximum	One comprehensive low vision evaluation every **policy year**	

Pediatric vision care services and supplies

Description	In-network coverage	Out-of-network coverage
Office visit for fitting of contact lenses	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	70% (of the **recognized charge**) per visit
Maximum contact lens fitting visits per **policy year**	1 visit	
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	100% (of the **negotiated charge**) per item No **policy year deductible** applies	70% (of the **recognized charge**) per item
Maximum number of eyeglass frames per **policy year**	One set of eyeglass frames	
Maximum number of **prescription** lenses per **policy year**	One pair of **prescription** lenses	
Maximum number of **prescription** contact lenses per **policy year** (includes non-conventional **prescription** contact lenses and aphakic lenses prescribed after cataract **surgery**)	Daily disposable: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable: one set	
Optical devices	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.
Maximum number of optical devices per **policy year**	One optical device	

Pediatric vision care 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.

9. Outpatient prescription drugs

Plan features

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

Policy year deductible and copayment waiver for risk reducing breast cancer

The outpatient **prescription drug policy year deductible** and the **prescription drug copayment** will not apply to risk reducing breast cancer **prescription drugs** filled at a **retail in-network pharmacy**. This means that such risk reducing breast cancer **prescription drugs** are paid at 100%.

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

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

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

Policy year deductible and copayment waiver for contraceptives

The **policy year deductible** and the **prescription drug copayment** will not apply to female contraceptive methods when obtained at an **in-network pharmacy**.

This means that such contraceptive methods are paid at 100% for:

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

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

Preferred generic prescription drugs

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	$25 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$25 **copayment** per supply then the plan pays 70% (of the balance of the **recognized charge**) No **policy year deductible** applies

Non-preferred generic prescription drugs

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	$100 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$100 **copayment** per supply then the plan pays 70% (of the balance of the **recognized charge**) No **policy year deductible** applies

Preferred brand-name prescription drugs

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	$65 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$65 **copayment** per supply then the plan pays 70% (of the balance of the **recognized charge**) No **policy year deductible** applies

Non-preferred brand-name prescription drugs

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	$100 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$100 **copayment** per supply then the plan pays 70% (of the balance of the **recognized charge**) No **policy year deductible** applies

Diabetic supplies, drugs and insulin

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above

Diabetic insulin important note:
Your cost share will not exceed $25 per 30 day supply of a covered preferred **prescription** insulin drug filled at an **in-network pharmacy**. No **policy year deductible** applies for preferred insulin.

Specialty drugs

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **specialty pharmacy** or a **retail pharmacy**	**Copayment** per supply of 20% of the **negotiated charge** then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	**Copayment** per supply of 20% of the **recognized charge** then the plan pays 100% (of the balance of the **recognized charge**) No **policy year deductible** applies

Anti-cancer drugs taken by mouth

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply	100% (of the **negotiated charge**) No **policy year deductible** applies	100% (of the **recognized charge**) No **policy year deductible** applies

Contraceptives (birth control)

Brand-name prescription drugs and devices are covered at 100% at an **in-network pharmacy** when a generic is not available

Description	In-network coverage	Out-of-network coverage
For each fill up to a or up to 12 month supply of generic and OTC drugs and devices filled at a **retail pharmacy**	100% (of the **negotiated charge**) No **policy year deductible** applies	100% (of the **recognized charge**) No **policy year deductible** applies
For each fill up to a or up to 12 month supply of **brand-name prescription drugs** and devices filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above

Preventive care drugs and supplements

Description	In-network coverage	Out-of-network coverage
Preventive care drugs and supplements filled at a **retail pharmacy** For each 30 day supply	100% (of the **negotiated charge**) per **prescription** or refill No **copayment** or **policy year deductible** applies	Paid according to the type of drug per the schedule of benefits, above
Preventive care drugs and supplements maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	

Risk reducing breast cancer prescription drugs

Description	In-network coverage	Out-of-network coverage
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy** For each 30 day supply	100% (of the **negotiated charge**) per **prescription** or refill No **copayment** or **policy year deductible** applies	Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer **prescription drugs** maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered risk reducing breast cancer **prescription drugs**, contact Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	

Tobacco cessation prescription and over-the-counter drugs

Description	In-network coverage	Out-of-network coverage
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** For each 30 day supply	100% (of the **negotiated charge**) per **prescription** or refill No **copayment** or **policy year deductible** applies	Paid according to the type of drug per the schedule of benefits, above
Tobacco cessation **prescription drugs** and OTC drugs maximums	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	

Outpatient prescription drugs important note:
Dispense As Written (DAW)
If a **provider** prescribes a covered **brand-name prescription drug** when a **generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost share for the brand-name drug. If a **provider** does not specify DAW and you request a covered **brand-name prescription drug**, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug. The cost difference related to a **prescription** not specified as DAW does not apply toward your **policy year deductible** or **maximum out-of-pocket limit**.

General coverage provisions

This section provides detailed explanations about these features:

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

Policy year deductible provisions

Covered services that are subject to the **policy year deductible** include those provided under the medical plan and outpatient **prescription drug** benefits provided under the **prescription drug** benefit.

Covered services applied to the out-of-network **policy year deductibles** will not be applied to satisfy the in-network **policy year deductibles**. **Covered services** applied to the in-network **policy year deductibles** will not be applied to satisfy the out-of-network **policy year deductibles**.

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

Individual

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

Copayments

In-network coverage

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

Out-of-network coverage

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

Coinsurance

Coinsurance is both the percentage of **covered services** that the plan pays and what you pay. The specific percentage that we have to pay for **covered services** is listed earlier in the schedule of benefits. **Coinsurance** is not a **copayment**.

Maximum out-of-pocket limits provisions

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

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

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments**, **coinsurance** and **policy year deductibles** for **covered services** during the **policy year**. This plan has an individual **maximum out-of-pocket limit**.

Individual

Once the amount of the **copayments**, **coinsurance** and **policy year deductibles** you have paid for **covered services** during the **policy year** meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the **policy year** for that person.

Medical

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

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
- **Precertification** penalties because you did not get a service or supply **precertified**

Calculations; determination of recognized charge; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one **policy year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the certificate of coverage.

Student Health Insurance

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

Certificate of Coverage

Prepared exclusively for:

Policyholder:	Rockhurst University
Policyholder number:	232088
Student policy effective date:	08/01/26
Plan effective date:	08/01/26
Plan issue date:	04/24/26

Underwritten by Aetna Life Insurance Company

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

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.

This certificate of coverage will tell you about your **covered services** – 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 **covered services** and tells you about limits – like when your plan covers only a certain number of visits.

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

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

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

Welcome to your **Aetna** plan.

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Let's get started!

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

Some notes on how we use words in the certificate of coverage and schedule of benefits

- When we say "you" and "your", we mean the **covered student**
- When we say "us", "we", and "our", we mean **Aetna**
- Some words appear in **bold** type and we define them in the *Glossary* section

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

What your plan does – providing covered services

Your plan provides **covered services** for which your plan has the obligation to pay.

This plan provides **covered services** for medical and **pharmacy** services.

Aetna will not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on you because you are diagnosed with autism spectrum disorder or developmental or physical disabilities.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after the eligibility and enrollment process is completed. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you are no longer a student. To learn more see the *When coverage ends* section.

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

Covered 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 **covered services**? They are health care services that meet these requirements:

- They are listed in the ***Covered services*** *and exclusions* section.
- They are not carved out in the *What your plan doesn't cover – general exclusions* section.
- They are not beyond any limits in the schedule of benefits.
- They are **medically necessary**. See the *Medical necessity and precertification requirements* and the *Glossary* for more information.
- They are not prohibited by law. See *Services not permitted by law* in the *What your plan doesn't cover – general exclusions* section for more information.

Paying for covered services – the general requirements

There are several general requirements for the plan to pay any part of the expense for a service. They are:

- The expense is for a **covered service**
- You get the care from an **in-network provider** or **out-of-network provider**
- You or your **provider precertifies** the service when required

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

Paying for covered services – sharing the expense

Generally your plan and you will share the expense of your **covered 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 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 "independent review organization" or IRO for short, will make the final decision for us.

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

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

Your in-network coverage helps you:

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

Generally your in-network coverage will pay only when you get care from an **in-network provider**.

You may go directly to **in-network providers** for **covered services**.

For more information about **in-network providers**, see the *Who provides the care* section.

Aetna's network of providers

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

If you can't find an **in-network provider** for a service or supply that you need, call Member Services at the toll-free number in the *How to contact us for help* section. 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 services** 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 **covered 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 grievances procedures* section.

Surprise bill

There may be times when you unknowingly receive services or don't consent to receive services from an **out-of-network provider**, even when you try to stay in the network for your **covered services**. You may get a bill at the out-of-network rate that you didn't expect. This is called a surprise bill.

An **out-of-network provider** can't balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirements, such as **deductibles**, **copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider** and ancillary services initiated from your **emergency service**
- Non-emergency services provided by an **out-of-network provider** at an in-network facility, except when the **out-of-network provider** has given you the following:
  - The out-of-network notice for your signature
  - The estimated charges for the items and services
  - Notice that the **provider** is an **out-of-network provider**
- Out-of-network air ambulance services

The **out-of-network provider** must get your consent to be treated and balance billed by them.

Ancillary services mean any professional services including:

- Anesthesiology
- Hospitalist services
- Items and services related to emergency medicine
- Laboratory services
- Neonatology
- Pathology
- Radiology
- Services provided by an **out-of-network provider** because there was no **in-network provider** available to perform the service

A facility in this instance means an institution providing health care related services, or a health care setting. This includes the following:

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory, and imaging centers
- Rehabilitation facilities
- Other therapeutic health settings

A surprise bill claim is paid based on the median contracted rate for all plans offered by us in the same insurance market for the same or similar item or service that is all of the following:

- Provided by a **provider** in the same or similar specialty or facility of the same or similar facility type
- Provided in the geographic region in which the item or service is furnished

The median contracted rate is subject to additional adjustments as specified in federal regulations.

Any cost share paid with respect to the items and services will apply toward your in-network **deductible** and **maximum out-of-pocket limit** if you have one.

It is not a surprise bill when you knowingly choose to go out-of-network and have signed a consent notice for these services. In this case, you are responsible for all charges.

If you receive a surprise bill or have any questions about what a surprise bill is, contact us.

How to contact us for help

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

- Calling our Member Services at the toll-free number 1-877-626-2308
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156
- Visiting https://www.aetnastudenthealth.com to register and access your **Aetna** website

Aetna's 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.

Your ID card

We issued to you a digital ID card which you can view or print by going to the website at https://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 student identification number. The **provider** office can use that information to verify your eligibility and benefits.

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

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

Who the plan covers

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

You will find information in this section about:

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

Who is eligible?

- All Full Time Undergraduates (12hrs) and Full Time Graduates (9hrs) are automatically enrolled in the plan unless proof of comparable coverage is provided.
- All part-time students can enroll on a voluntary basis

Medicare eligibility

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

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

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

When you can join the plan

As a student you can enroll yourself:

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

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

Notification of change in status

It is important that you notify us and the **policyholder** of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us and the **policyholder** as soon as possible of status changes such as:

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

Special times you can join the plan

You can enroll in these situations:

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

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

Effective date of coverage

Enrollment

Student coverage

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

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

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

Late enrollment

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

- We agree to enroll you, or
- You enroll because you lost coverage for any reason under another health plan with similar health coverage

Medical necessity and precertification requirements

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

- The **covered service** is **medically necessary**
- You or your **provider precertifies** the service when required

Medically necessary; medical necessity

Covered services under the plan must be **medically necessary**. The **medical necessity** requirements are stated in the *Glossary* section, where we define "**medically necessary, medical necessity**". That is where we also explain what our medical directors or their **physician** designees consider when determining if a service is **medically necessary**.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

Precertification

You need **precertification** from us for some **covered services**.

Precertification for medical services and supplies

In-network care

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

Out-of-network care

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

Precertification call

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call Member Services at the toll-free number in the *How to contact us for help* section. You, your **physician** or the facility must call us within these timelines:

Type of care	Timeframe
Non-emergency admission	Call at least 14 days before the date you are scheduled to be admitted
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted
Urgent admission	Call before you are scheduled to be admitted
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment is scheduled

An **urgent admission** is a **hospital** admission by a **physician** due to the onset of or change in an **illness**, the diagnosis of an **illness**, or an **injury**.

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

Aetna will not retroactively reduce or terminate a previously approved service or supply unless:

- Such authorization is based on a material misrepresentation or omission about the treated or cause of the health condition; or
- The plan terminated before services are provided; or
- Coverage terminated before the services were provided

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 services**, the notification will explain why and how you can appeal our decision. You or your **provider** may request a review of the **precertification** decision. See the *When you disagree - claim decisions and grievance procedures* section.

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

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

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

Inpatient –

- Gender affirming treatment
- **Stays** in a **hospice facility**
- **Stays** in a **hospital**
- **Stays** in a rehabilitation facility
- **Stays** in a **residential treatment facility** for treatment of **mental health disorders** and **substance related disorders**
- **Stays** in a **skilled nursing facility**

Outpatient –

- Certain **prescription drugs** and devices
- Complex imaging
- **Cosmetic** and reconstructive **surgery**
- Gender affirming treatment
- Home health care
- **Hospice care**
- Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
- Kidney dialysis
- Knee **surgery**
- Non-emergency transportation by airplane
- Outpatient back **surgery** not performed in a **physician's** office
- Partial hospitalization treatment – **mental health disorders** and **substance related disorders** treatment
- Private duty nursing services
- Sleep studies
- Transcranial magnetic stimulation (TMS)
- Wrist **surgery**

Contact us to get a complete list of the services that require **precertification**. The list may change from time to time.

Sometimes you or your **provider** may want us to review a service that doesn't require **precertification** before you get care. This is called a predetermination, and it is different from **precertification**. Predetermination means that you or your **provider** requests the pre-service clinical review of a service that does not require **precertification**.

See *Medically Necessary, Medical Necessity* above and the "**medically necessary, medical necessity**" definition in the *Glossary* section for more information on what we consider when making a **precertification** decision.

For certain drugs covered under your medical plan or **prescription drug** plan, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs. The **medical necessity** requirements are in the *Glossary* section, where we define "**medically necessary, medical necessity**".

Step therapy is a type of **precertification** where you must try one or more prerequisite drugs before a **step therapy** drug is covered. A 'prerequisite' is something that is required before something else. Prerequisite drugs are FDA-approved, may cost less and treat the same condition. If you don't try the prerequisite drugs first, the **step therapy** drug may not be covered.

Contact us or go online to get the most up-to-date **precertification** requirements and list of **step therapy prescription drugs**.

Requesting a medical exception
Sometimes you or your **provider** may ask for a medical exception for **prescription drugs** that are not covered or for which coverage was denied. You, someone who represents you, or your **provider** can contact us. You will need to provide us with clinical documentation. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other **covered persons**. For directions on how you can submit a request for a review:

- Contact Member Services at the toll-free number 1-877-626-2308
- Log in to your **Aetna** website at https://www.aetnastudenthealth.com
- Submit the request in writing to CVS Health, ATTN: **Aetna** PA, 1300 E Campbell Road, Richardson, TX 75081

You, someone who represents you, or your **provider** may seek a quicker medical exception when the situation is urgent. It's an urgent situation when you have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug.

Covered services and exclusions

The information in this section is the first step to understanding your plan's **covered services**. These services are:

- Described in this section.
- Not listed as exclusions in this section or the *General exclusions* section.
- Not beyond any limitations in the schedule of benefits.
- Not prohibited by law. See *Services not permitted by law* in the *General exclusions* section for more information.

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 exclusion.
- Home health care is generally covered but may only be covered up to a set number of visits per year. This is a limitation. You can find out about limitations for **covered services** in the schedule of benefits.
- Your **provider** may recommend services that are considered **experimental, investigational, or unproven** services. But an **experimental, investigational, or unproven** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a life-threatening disease or condition . See *Clinical trials* in the list of **covered services** below.

We explain **covered services** and exclusions in this section. You can find out about general exclusions in the *General exclusions* section.

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

Important note:

- We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **medically necessary, experimental, investigational, or unproven**. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact us. See the *How to contact us for help* section for how.
- We cover **medically necessary**, sex-specific **covered services**, regardless of identified gender.

1. Preventive care and wellness

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

You will see references to the following recommendations and guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- United States Preventive Services Task Force
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

- Missouri Department of Health and Senior Services
- American Cancer Society
- American College of Radiology for breast cancer screening

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.

- 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 **covered services** for diagnostic testing and treatment.

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

- 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 in to your **Aetna** website at https://www.aetnastudenthealth.com or by calling the toll-free number in the *How to contact us for help* section. This information can also be found at the https://www.healthcare.gov website.

Routine physical exams

Covered services include office visits to your **physician** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents
- Immunization guidelines as recommended by Missouri Department of Health and Senior Services
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
  - Screening for gestational diabetes for women
  - High-risk Human Papillomavirus (HPV) DNA testing for women age 30 and older
- Radiological services, lab and other tests given in connection with the exam
- Testing for lead poisoning, including pregnant women
- For covered newborns, an initial **hospital** checkup, hearing screenings, necessary re-screenings, audiology assessment and follow-up

Preventive care immunizations

Covered services include immunizations provided by your **physician** or other **health professional** for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and Missouri Department of Health and Senior Services.

The following is not covered under this benefit:

- Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment

Well woman preventive visits

Covered services include your routine:

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

Preventive screening and counseling services

Covered 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**
  Covered 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**
  Covered 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**
  Covered services include the following screening and counseling services to help you to stop the use of tobacco products:
  - Preventive counseling visits
  - Treatment visits
  - Class visits

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

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

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

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Breast cancer screenings including initial screening mammograms, including digital mammography and breast tomosynthesis. If necessary to complete the screening process, additional imaging (e.g., MRI, ultrasound, mammography) and pathology evaluation as provided for in the American College of Radiology guidelines for breast cancer screening.
- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

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

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

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height
- Preeclampsia screening

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

Important note:
You should review the benefit under *Covered services and exclusions – Maternity care* and *Well newborn nursery care* section of this certificate of coverage for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services

Covered 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

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

Breast pump

Covered services include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**
- The buying of:
  - An electric breast pump (non-**hospital** grade, cost is covered by your plan once every 12 months) or
  - A manual breast pump (cost is covered by your plan once per pregnancy)

If an electric breast pump was purchased within the previous 12 month period, the purchase of another electric breast pump will not be covered until a 12 month period has elapsed since the last purchase.

Breast pump supplies and accessories

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

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

Family planning services – contraceptives

Covered services include family planning services such as:

Counseling services

Covered services include counseling services provided by a **provider** on contraceptive methods. These will be covered when you get them in either a group or individual setting.

Contraceptives

Covered services include contraceptive **prescription drugs** and devices (including any related services or supplies) when they are provided by, administered, or removed by a **provider**. This includes male condoms.

Voluntary sterilization

Covered services include charges billed separately by the **provider** for voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

Important note:
See the following sections for more information:

- *Maternity care*
- *Well newborn nursery care*
- *Infertility services*
- *Outpatient prescription drugs*

The following are not preventive **covered services**:

- Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA

2. Physicians and other health professionals

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

Covered 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 services** are also covered if you use **telemedicine** instead.

Allergy testing and treatment

Covered services include the services and supplies that your **physician** or **specialist** may provide for:

- Allergy testing
- Allergy injections treatment

The following are not covered under this benefit:

- Allergy sera and extracts administered via injection

Physician and specialist – inpatient surgical services

Covered 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**

Coverage includes **covered services** provided by a licensed mid-wife.

Anesthetist
Covered services 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 services 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**.

The following are not covered under this benefit:

- A **stay** in a **hospital** (**Hospital stays** are covered in the *Covered services and exclusions – Hospital and other facility care* section)
- Services of another **physician** for the administration of a local anesthetic

Physician and specialist – outpatient surgical services

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

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

Surgical assistant
Covered services 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**.

The following are not covered under this benefit:

- A **stay** in a **hospital** (**Hospital stays** are covered in the *Covered services and exclusions – Hospital and other facility care* section)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

In-hospital non-surgical physician services

During your **stay** in a **hospita**l for **surgery**, **covered 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)

Covered 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 services include treatment by the consultant.

The consultation by a **physician** or **specialist** may happen by way of **telemedicine.**

Important note:
Your **student policy** covers **telemedicine**. All in-person consultant office visits provided by a **physician** or **specialist** that are **covered services** are also covered if you use **telemedicine** instead.

Second surgical opinion

Covered services include a second surgical opinion by a s**pecialist** to confirm your need for a **surgery**. The **specialist** must be board-certified in the medical field for the **surgery** that is being proposed by your **physician**.

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

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

Alternatives to physician and specialist office visits

Walk-in clinic (non-emergency visit)

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

- Scheduled and unscheduled visits for **illnesses** and **injuries** that are not **emergency medical conditions**
- Preventive care immunizations administered within the scope of the clinic's license
- Preventive screening and counseling services that will help you:
  - With obesity or healthy diet
  - To stop using tobacco products

3. Hospital and other facility care

Hospital care (facility charges)

Covered services include inpatient and outpatient **hospital** care. This includes:

- Semi-private **room and board**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge.
- Services of **physicians** employed by the **hospital**.
- Administration of blood and blood products.

The following are not **covered services** :

- All services and supplies provided in:
  - Rest homes
  - Any place considered a person's main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

Preadmission testing

Covered services include pre-admission testing on an outpatient basis before a scheduled **surgery**.

For your preadmission testing to be eligible for coverage, the following conditions must be met:

- The testing is related to the scheduled **surgery**
- The testing is done within the 7 days before the scheduled **surgery** and
- The testing is not repeated in, or by, the **hospital** or **surgery center** where the **surgery** is done

Anesthesia and related facility charges for a dental procedure

Covered services include:

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

for your dental procedure.

The following conditions must be met:

- Your **dental provider** cannot safely perform the oral **surgery** in a dental office setting, and
- You are a child age 5 or under, or
- You are severely disabled
- A person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental services are provided

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

Alternatives to hospital stays

Outpatient surgery (facility charges)

Covered 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.

The following are not covered under this benefit:

- A **stay** in a **hospital** (See the *Hospital care – facility charges* benefit in this section)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Home health care

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

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

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

Home health care services do not include **custodial care**.

The following are not covered under this benefit:

- 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
- Homemaker or housekeeper services
- Food or home delivered services
- Maintenance therapy

Hospice care

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

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

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

Hospice care services provided by the **providers** below may be covered, even if the **providers** are not an employee of the **hospice care agency** responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient **prescription drugs**
  - Psychological counseling
  - Dietary counseling

The following are not covered under this benefit:

- 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

Outpatient private duty nursing

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

Skilled nursing facility

Covered services include inpatient **skilled nursing facility** care.

The types of **skilled nursing facility** care services that are eligible for coverage include:

- **Room and board**, up to the **semi-private room rate**
- Services and supplies that are provided during your **stay** in a **skilled nursing facility**

4. Emergency services and urgent care

Covered services include services and supplies for the treatment of an **emergency medical condition** or an **urgent condition**.

Emergency services

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

- An ambulance
- A **hospital** emergency room or an independent freestanding emergency department facility, along with their:
  - Staff **physician** services
  - Nursing staff services
  - Staff radiologist and pathologist services

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

Your coverage for **emergency services** will continue until the following conditions are met:

- You are evaluated and your condition is stabilized
- Your attending **physician** determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another **provider** if you need more care

For follow-up care, you are covered when:

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

In case of a medical emergency

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

Non-emergency condition

If you go to an emergency room for what is not an **emergency medical condition**, the plan will not cover your expenses. See the schedule of benefits for specific plan details.

The following are not covered under this benefit:

- Non-emergency services in a **hospital** emergency room or an independent freestanding emergency department

Urgent care

In case of an urgent condition

Urgent condition

If you need care for an **urgent condition**, you should first seek care through your **physician.** If your **physician** 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 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**

The following is not covered under this benefit:

- Non-urgent care in an **urgent care facility** (at a non-hospital freestanding facility)

5. Pediatric dental care

Covered services include dental services and supplies provided by a **dental provider** as found in the *Pediatric dental care* section of the schedule of benefits.

Dental emergencies

Covered services also include dental services provided for a **dental emergency**. Services and supplies provided for a **dental emergency** will be covered even if services and supplies are provided by an **out-of-network provider**.

If you have a **dental emergency**, you should consider calling your **in-network dental provider** who may be more familiar with your dental needs. If you cannot reach your **in-network dental provider**, you may get treatment from any **dentist**. The care received from an **out-of-network provider** must be for the temporary relief of the **dental emergency** until you can be seen by your **in-network dental provider**. Services given for other than the temporary relief of the **dental emergency** by an **out-of-network provider** can cost you more. To get the maximum level of benefits, services should be provided by your **in-network dental provider**.

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.

Follow-up care will be paid at the cost-sharing level that applies to the type of **provider** that gives you the care.

Orthodontic treatment

Orthodontic treatment is covered for a severe, dysfunctional, disabling condition, such as:

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

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

- Pre-orthodontic treatment visit
- Comprehensive orthodontic treatment
- Orthodontic retention (removal of appliances, construction and placement of retainers)

Replacements

The plan's "replacement rule" applies to:

- Crowns
- Inlays
- Onlays
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

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

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

Missing teeth that are not replaced

The plan covers installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services if:

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

Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Getting an advance claim review

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

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

When to get an advance claim review

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

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

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

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

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

Pediatric dental care exclusions

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- **Cosmetic** services and supplies including:
  - Plastic **surgery**, reconstructive **surgery**, **cosmetic surgery**, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Covered services and exclusions* section
  - Facings on molar crowns and pontics will always be considered **cosmetic**
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Mouth guards, and other devices to protect, replace or reposition teeth
- Dental implants except when part of an approved treatment plan for a **covered service** described in *Covered services and exclusions- Reconstructive surgery and supplies*
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including **temporomandibular joint dysfunction** disorder (**TMJ**) and **craniomandibular joint dysfunction** disorder (**CMJ**) treatment, orthognathic **surgery**, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Covered services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another **covered service**
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits

- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a **provider**
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a **dental provider**

6. Specific conditions

Birthing center (facility charges)

Covered services include prenatal (non-preventive care) and postpartum care, pregnancy complications, 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 *Covered services and exclusions – Maternity care* and *Well newborn nursery care* sections for more information.

Diabetic services and supplies (including equipment and training)

Covered services include:

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

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

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

Temporomandibular joint dysfunction treatment (TMJ) and Craniomandibular joint dysfunction treatment (CMJ)

Covered services include:

- 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**.

The following are not covered under this benefit:

- Dental implants

Accidental injury to sound natural teeth

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

The following are not covered under this benefit:

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

Dermatological treatment

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

The following are not covered under this benefit:

- **Cosmetic** treatment and procedures

Maternity care

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

After your child is born, **covered services** include:

- 48 hours of inpatient care in a **hospital** or birthing center after a vaginal delivery
- 96 hours of inpatient care in a **hospital** or birthing center after a cesarean delivery
- A shorter **stay** if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

If the mother is discharged earlier, the plan will pay for 2 post-discharge visits (at least one of which is in the home) by an **R.N.** with experience in maternal and child health nursing or a **physician**. The location and schedule of the post-discharge visits will be determined by the attending **physician**. Post-discharge care visits by an **R.N.** or **physician** include, but are not limited to:

- Assessing the health of the newborn and mother
- Parent education
- Assistance and training in breast or bottle feeding
- Providing childhood immunization education and services
- Performing any necessary and appropriate clinical tests
- The performance and submission of a metabolic specimen satisfactory to the state laboratory

These visits will not be subject to any home health care maximums.

The following are not covered under this benefit:

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

Well newborn nursery care

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

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

Gender affirming treatment

Covered services include gender affirming treatment. The services must follow a specific treatment plan ordered by your **provider** and include:

- Behavioral health counseling
- Hormone therapy
- **Surgery** such as:
  - Breast removal or augmentation
  - Removal of testicles, uterus, ovaries
  - Genital reconstruction

Autism spectrum disorder

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

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

Covered services include the services and supplies provided by a **physician**, psychologist, or **behavioral health provider** (including, but not limited to, a psychiatrist, autism service provider, or line therapist) for the diagnosis, testing and treatment of autism spectrum disorders or developmental or physical disabilities, including:

- The diagnosis – assessments, evaluations, or tests to diagnose an autism spectrum disorders or developmental or physical disability
- Psychiatric and psychological services – direct or consultative services provided by a licensed psychiatrist or psychologist
- Habilitative or rehabilitative care – professional counseling and guidance services, and treatment programs, including applied behavior analysis therapy, that are necessary to develop the functioning of an individual
- Therapeutic care – physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder or developmental or physical disability
- Medication (covered under your pharmacy benefit) used to address symptoms of autism spectrum disorder or a developmental or physical disability and any health related services to determine the need or effectiveness of the medications
- Equipment related to care

An autism service provider is a person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri, or any person who is licensed under Missouri law as a board-certified behavior analyst by the behavior analyst certification board or licensed under Missouri law as an assistant board-certified behavior analyst.

A line therapist is an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.

A developmental or physical disability is a severe chronic disability that:

- Is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness or autism spectrum disorder which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services
- Manifests before the individual reaches age 19
- Is likely to continue indefinitely
- Results in substantial functional limitations in 3 or more of the following areas of major life activities:
  - Self-care
  - Understanding and use of language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living

We will only cover this treatment if a **physician**, psychologist, or **behavioral health provider** orders it as part of a treatment plan that details the treatment and specifies frequency and duration. At our expense, we have the right to review that treatment plan. We will not review this more than once every 6 months unless the treating **physician** or psychologist agrees a more frequent review is necessary.

We will cover certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions, design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior. This includes the use of:

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

Behavioral health

Mental health treatment

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

- **Inpatient room and board** at the **semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Other services and supplies related to your condition that are provided during your **stay** in a general medical **hospital**, **psychiatric hospital**, or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a general medical **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultations)
  - Individual, group and family therapies for the treatment of mental health

- Other outpatient mental health treatment such as:
  - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
  - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
  - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
    - You are **homebound**
    - Your **physician** orders them
    - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
    - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease
  - Electro-convulsive therapy (ECT)
  - Transcranial magnetic stimulation (TMS)
  - Psychological testing
  - Neuropsychological testing
  - Observation
  - Peer counseling support by a peer support specialist (including **telemedicine** consultation)

Important note:
Covered services include at least two (2) outpatient sessions per year to a **behavioral health provider**. This includes a psychiatrist, psychologist, professional counselor, clinical social worker, or, subject to contractual provisions, a marital and family therapist. These sessions are for the purpose of diagnosis or assessment, but not dependent upon findings. They are not subject to any conditions of **precertification**.

Substance related disorders treatment

Covered services include the treatment of **substance related disorders** provided by a general medical **hospital**, **psychiatric hospital**, **residential treatment facility**, non-residential treatment facility, **physician**, or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Other services and supplies that are provided during your **stay** in a general medical **hospital**, **psychiatric hospital, residential treatment facility,** or non-residential treatment facility.
- Outpatient treatment received while not confined as an inpatient in a general medical **hospital**, **psychiatric hospital** or **residential treatment facility** or non-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 related disorders**
  - Other outpatient **substance related disorders** treatment such as:
    - Outpatient **detoxification**
    - Partial hospitalization treatment provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are **homebound**
      - Your **physician** orders them

        - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
        - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness**, or disease
    - Ambulatory **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Peer counseling support by a peer support specialist (including **telemedicine** consultation)

Telemedicine important note:
Your **student policy** covers **telemedicine** for **mental health disorders** and **substance related disorders**. All in-person **physician** or **behavioral health provider** office visits that are **covered services** are also covered if you use **telemedicine** provided by a **physician** or **behavioral health provider** instead.

Reconstructive surgery and supplies

Covered 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
    - The reconstructive breast surgery and receipt of related prostheses may follow a mastectomy at any time.
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
    - The defect results in severe facial disfigurement or major functional impairment of a body part
    - The purpose of the **surgery** is to improve function, or improve or change the appearance
- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function, or improve or change the appearance.
- Your **surgery** corrects significant deformities caused by earlier treatment and will improve function, or improve or change the appearance.

Transplant services

Covered services include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy for FDA-approved treatments
- Thymus tissue for FDA-approved treatments

Network of transplant facilities

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

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the **IOE facility** we designate to perform the transplant you need. Transplant services received from an **IOE facility** are subject to the in-network **copayment**, **coinsurance**, **policy year deductible**, maximum out-of-pocket and limits, unless stated differently in this certificate and the schedule of benefits. You may also get transplant services at a non-IOE facility, but your cost share will be higher. Transplant services received from a non-IOE facility are subject to the out-of-network **copayment**, **coinsurance**, **policy year deductible**, maximum out-of-pocket and limits, unless stated differently in this certificate and the schedule of benefits.

Important note:
If there are no **IOE facilities** assigned to perform your transplant type in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your transplant services at the facility we designate your cost share will be higher.

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

Travel and lodging expenses

If an **IOE** patient lives 75 or more miles from the **IOE facility, covered 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**. **Covered services** will be reimbursed by the plan and include coach class round-trip air, train, or bus travel and lodging costs.

Other transplants

Covered services include corneal (corneal graft with amniotic membrane) transplants. Corneal cartilage transplants are not available at **IOE facilities**.

The following are not covered under this benefit:

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

Infertility services

Basic infertility

Covered services include seeing a **provider**:

- 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.**
- For artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination

See the *Covered services and exclusions-Outpatient prescription drugs* section for information on coverage of infertility **prescription drugs**.

Infertility services exclusions

The following are not covered under the infertility services benefit:

- All infertility services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Infertility medication. See the *Covered services and exclusions-Outpatient prescription drugs* section for information on coverage of infertility **prescription drugs**.
- All infertility services associated with or in support of an Advanced Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, and professional services
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers
  - Gestational carrier cycles
  - Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery).
- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- Infertility medication not injected by your **provider**, including but not limited to menotropins, hCG, and GnRH agonists. See the *Covered services and exclusions-Outpatient prescription drugs* section for information on coverage of infertility **prescription drugs**. All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when either partner has had voluntary sterilization **surgery**, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause).

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Covered services include complex imaging services by a **provider**, including:

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans

Diagnostic lab work and radiological services

Covered services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests.

Chemotherapy

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

Outpatient infusion therapy

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

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

You can access the list of preferred infusion locations by contacting Member Services at the toll-free number in the *How to contact us for help* section or by logging in to your **Aetna** website at https://www.aetnastudenthealth.com.

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

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

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

The following are not covered under this benefit:

- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient **prescription drug** plan
- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Outpatient radiation therapy

Covered services include the following radiology services provided by a **health professional**:

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

Specialty prescription drugs

Covered 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 freestanding outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in the 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 in the *How to contact us for help* section or by logging in to your **Aetna** website at https://www.aetnastudenthealth.com 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 in the *How to contact us for help* section or by logging in to your **Aetna** website at https://www.aetnastudenthealth.com to determine if coverage is under this **specialty prescription drug** or the outpatient **prescription drug** benefit.

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

Outpatient respiratory therapy

Covered 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

Covered services include services and supplies for the transfusion or kidney dialysis of blood. **Covered services** include:

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

Short-term cardiac and pulmonary rehabilitation services

Covered services include the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation

Covered 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

Covered services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if it is part of a treatment plan ordered by your **physician**.

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a **hospital, skilled nursing facility**, or **physician's** office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation and habilitation therapy services

Short-term rehabilitation therapy services

Short-term rehabilitation therapy services are services needed to restore or develop your skills and functioning for daily living.

Covered services include short-term rehabilitation therapy services your **physician** prescribes. The services have to be performed by:

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

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

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

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

  Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

- Cognitive rehabilitation therapy associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Short-term habilitation therapy services

Short-term habilitation therapy services are services needed to keep, learn, or improve your skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).

Covered services include short-term habilitation therapy services your **physician** prescribes. The services have to be performed by:

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

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

Outpatient physical, occupational, and speech habilitation therapy

Covered 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

Covered services include chiropractic services to correct a muscular or skeletal problem.

Diagnostic testing for learning disabilities

Covered services include diagnostic testing for:

- Attention deficit disorder
- Attention deficit hyperactive disorder
- Dyslexia

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

8. Other services

Ambulance services

An ambulance is a vehicle staffed by medical personnel and is equipped to transport an ill or injured person by ground, air, or water.

Emergency

Covered services include emergency transportation when your condition is unstable and requires medical supervision and rapid transport. These emergency ambulance services are limited to transportation by a licensed ambulance:

- To the first facility to provide **emergency services**
- From one facility to another if the first can't provide the **emergency services** you need

Non-emergency

Covered services also include non-emergency transportation when an ambulance is the only safe way to transport you. These non-emergency ambulance services are limited to transportation by a licensed ambulance:

- To the nearest facility able to treat your condition
- From a facility to your home by ground ambulance

The following are not **covered services**:

- Ambulance services for non-emergency transportation
- Ambulance services for routine transportation to receive outpatient or inpatient services

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

Experimental or investigational therapies

Covered services include 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. All of the following conditions must be met:

- Standard therapies have not been effective or appropriate
- We determine you may benefit from the treatment

An approved clinical trial is one that meets all of these requirements:

- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it

- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar organization and:
  - It conforms to standards of the NCI or other applicable federal organization
  - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the protocols of that study

Durable medical equipment (DME)

Covered 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.

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

Your plan only covers the same type of **DME** that **Medicare** covers. But there are some **DME** items **Medicare** covers that your plan does not.

The following are not covered under this benefit:

- 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**

Nutritional support

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

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

The following are not covered under this benefit:

- Any food item, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as described above

Orthotic devices

Covered services include mechanical supportive devices ordered by your **physician** for the treatment of weak or muscle deficient feet.

Osteoporosis (non-preventive care)

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

Prosthetic devices

Covered services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

Prosthetic device means:

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

Coverage includes:

- The prosthetic device
- Wigs needed after cancer treatment (not to exceed one per **policy year**)
- 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

The following are not covered under this benefit:

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

Hearing aids

Covered services include prescribed hearing aids and hearing aid services as described below.

Hearing aid means:

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

Hearing aid services are:

- Audiometric hearing exam and evaluation for a hearing aid **prescription** performed by:
  - A **physician** certified as an otolaryngologist or otologist
  - An audiologist who is legally qualified in audiology, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Replacement parts or repairs for a hearing aid
- Any other related services necessary to access, select and adjust or fit a hearing aid

Hearing aids alternate treatment rule

Sometimes there are several types of hearing aids that can be used to treat a medical condition, all of which provide acceptable results. When alternate hearing aids can be used, the plan's coverage may be limited to the cost of the least expensive device that is:

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

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

The following are not covered under this benefit:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 48 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- Cochlear implants
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist

Podiatric (foot care) treatment

Covered 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 a **covered 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.

The following are not covered under this benefit:

- 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

Telemedicine

Covered services include **telemedicine** consultations when provided by a **physician**, **specialist**, **behavioral health provider telemedicine provider** acting within the scope of their license.

Vision care

Pediatric vision care

Routine vision exams

Covered services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.

Vision care services and supplies

Covered services include:

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

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

The following are not covered under this benefit:

- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for **cosmetic** purposes

9. Outpatient prescription drugs

Prescription drugs

Read this section carefully. This plan does not cover all **prescription drugs** and some coverage may be limited. This doesn't mean you can't get **prescription drugs** that aren't covered; you can, but you have to pay for them yourself. For more information about **prescription drug** benefits, including limits, see the schedule of benefits.

Important note:
A **pharmacy** may refuse to fill or refill a **prescription** when, in the professional judgment of the pharmacist, it should not be filled or refilled.

Your plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication's U.S. Food and Drug Administration (FDA) approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

Covered services are based on the drugs in the **drug guide**. Your cost may be higher if you're prescribed a **prescription drug** that is not listed in the **drug guide**. You can find out if a **prescription drug** is covered; see the *How to contact us for help* section.

Covered services are based on the drugs in the **drug guide**. The **drug guide** contains a formulary exclusions list. This list is subject to change. We exclude **prescription drugs** listed on the formulary exclusions list unless we approve a medical exception. See the *Requesting a medical exception* section for more information on medical exceptions or just contact us.

If you are presently taking a **prescription drug**, we will notify you, electronically or in writing upon your request, at least 31 days prior to any deletions (other than generic substitutions) in the **drug guide** that affect you**.**

Your **provider** can give you a **prescription** in different ways including:

- A written **prescription** that you take to an **in-network pharmacy**
- Calling or e-mailing a **prescription** to an **in-network pharmacy**
- Submitting the **prescription** to an **in-network pharmacy** electronically

The **pharmacy** may substitute a **generic prescription drug** for a **brand-name prescription drug**. Your cost share may be less if you use a generic drug when it is available.

Any **prescription drug** made to work beyond one month shall require the **copayment** amount that equals the expected duration of the medication.

Prescription drug synchronization

If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, your **in-network pharmacy** may be able to coordinate that for you. This is called synchronization. We will apply a prorated daily cost share rate to a partial fill of a maintenance drug, if needed, to synchronize your **prescription drugs**.

How to access in-network pharmacies

An **in-network pharmacy** will submit your claim. You will pay your cost share to the **pharmacy**. You can find an **in-network pharmacy** either online or by phone. See the *How to contact us for help* section. You may go to any of our **in-network pharmacies**.

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 30 day supply of a **prescription drug**.

Mail order pharmacy

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. A **mail order pharmacy** may be used for up to a 90 day supply of a **prescription drug**.

Specialty pharmacy

A **specialty pharmacy** may be used for up to a 30 day supply of a **specialty prescription drug**. You can view the list of **specialty prescription drugs**. See the *How to contact us for help* section.

Prescription drugs covered by this plan are subject to misuse, waste, or abuse utilization review by us, your **provider**, and/or your **in-network pharmacy**. The outcome of this review may include:

- Limiting coverage of a drug to one prescribing **provider** or one **in-network pharmacy**
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

How to access out-of-network pharmacies

You can directly access an **out-of-network pharmacy** to get covered outpatient **prescription drugs**.
When you use an **out-of-network pharmacy**, you pay your in-network **copayment** or **coinsurance** then you pay any remaining **deductible** and then you pay your out-of-network **coinsurance**. 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:

- Paying your in-network outpatient **prescription drug** cost share
- Paying any applicable out-of-network outpatient **prescription drug deductible**
- Your out-of-network **copayment**
- Your out-of-network **coinsurance**
- Any charges over the **recognized charge**
- Submitting your own claims

Other covered services

Anti-cancer drugs taken by mouth

Covered services include any drug prescribed for cancer treatment, including chemotherapy drugs. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

Contraceptives (birth control)

For females who are able to become pregnant, **covered services** include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at an **in-network pharmacy**. At least one form of each FDA-approved contraception method is a **covered service**. You can access a list of covered drugs and devices. See the *How to contact us for help* section.

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the **brand-name prescription drug** or device at no cost share.

Preventive contraceptives important note:
You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review. If the exception is approved, the **brand-name prescription drug** contraceptive will be covered at 100%.

Diabetic supplies
Covered services include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid
- Diabetic syringes, needles and pens
- Continuous glucose monitors
- Insulin infusion disposable pumps
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine

See the *Diabetic services and supplies (including equipment and training)* provision for medical **covered services**.

Eye drop refills
Covered services include early refills of **prescription** eye drops prior to the last day of the prescribed dosage, as long as your **provider** authorizes the early refills and notifies us.

Immunizations
Covered services include preventive immunizations as required by the ACA when given by an **in-network pharmacy**. You can find a participating **in-network pharmacy** by contacting us. Check with the **pharmacy** before you go to make sure the vaccine you need is in stock. Not all **pharmacies** carry all vaccines.

Over-the-counter (OTC) drugs
Covered services include certain OTC medications when you have a **prescription** from your **provider**. You can see a list of covered OTC drugs by logging in to your **Aetna** website.

Preventive care drugs and supplements
Covered services include preventive care drugs and supplements, including OTC ones, as required by the ACA.

Risk reducing breast cancer prescription drugs
Covered services include **prescription drugs** used to treat people who are at:

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

Tobacco cessation prescription and OTC drugs
Covered services include FDA approved **prescription** and OTC drugs to help stop the use of tobacco products. You will need a **prescription** from your **provider** and must fill it at a network **pharmacy**.

Outpatient prescription drug exclusions

The following are not **covered services**:

- Abortion drugs used for elective termination of pregnancy except to prevent the death of the female
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones, unless we have approved a medical exception

- **Cosmetic** drugs including medication and preparations used for **cosmetic** purposes
- Devices, products and appliances unless listed as a **covered service**
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided unless listed in the **drug guide** or we have approved a medical exception
  - Which do not require a **prescription** by law, even if a **prescription** is written, unless listed as a **covered service** or we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered **prescription drug**, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a **covered service**
  - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications unless listed as a **covered service**
  - That are drugs or growth hormones used to stimulate growth and prescribed only to treat idiopathic short stature
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as a **covered service**
- Immunizations related to travel or work
- Immunization or immunological agents unless listed as a **covered service**
- Implantable drugs and associated devices unless listed as a **covered service**
- Infertility:
  - **Prescription drugs** used primarily for the treatment of infertility
- Injectables including:
  - Any charges for the administration or injection of **prescription drugs**
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting , with the exception of Depo Provera and other **injectable drugs** for contraception, unless listed in the **drug guide** or we have approved a medical exception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription drugs**:
  - That are ordered by a **dentist** or prescribed by an oral surgeon in relation to the removal of teeth or **prescription drugs** for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**

- That are used for the purpose of improving visual acuity or field of vision
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card

- **Prescription drugs** indicated for the purpose of weight loss.
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- Tobacco cessation drugs unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

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**

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** fills or refills. You will pay any cost sharing directly to the **in-network pharmacy**.

You will be responsible for only one **copayment** for a covered **prescription** drug if the required single dosage is unavailable and/or a combination of dosage amounts is needed to fill the **prescription** order. Such **copayment** shall not apply to **prescriptions** in excess of any one month supply.

What your plan doesn't cover – general exclusions

General exclusions

The following are not **covered services** under your plan:

Abortion

- Services and supplies provided for an abortion except to prevent the death of the female

Abortion drugs

- Drugs used for elective termination of pregnancy except to prevent the death of the female

Acupuncture

- Acupuncture
- Acupressure

Blood and blood products

- Blood, blood products, and related services that are supplied to your **provider** free of charge

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, including cosmetic drugs, medications, and preparations used for cosmetic purposes, except where described in the *Covered services and exclusions* section

Court-ordered services and supplies

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

Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs.
Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- **Respite care** except in connection with **hospice care**, adult or child day care, or convalescent care
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and **substance related disorder** treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function
    - Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults

- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of **injuries** to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolectomy
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth
  - Prosthetic restoration of dental implants
  - Dental implants except when part of an approved treatment plan for a **covered service** described in the *Covered services and exclusions – Reconstructive surgery and supplies* section.

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

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs, whether or not the program is part of a **residential treatment facility** or otherwise licensed institution
  - Job training
  - Job hardening programs
- Any services that are schooling related or similar programs
- Therapeutic programs within a school, vocational, work, or recreational setting, except for the treatment of autism spectrum disorders.

Examinations

Any health or dental examinations needed:

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

Experimental, investigational, or unproven

- **Experimental, investigational, or unproven** drugs, devices, treatments or procedures unless otherwise covered under clinical trials

Gene-based, cellular and other innovative therapies (GCIT)

All services and supplies associated with GCIT including, but not limited to:

- The cost of the GCIT product.
- Any medical, surgical, professional, and facility charges directly related to GCIT. Examples include:
  - Anesthesia
  - Infusion
  - Lab and radiology
  - Nursing
  - **Physician** or **specialist** services

Growth/Height care

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

Hearing exams

- Hearing exams performed for the evaluation and treatment of **illness**, **injury** or hearing loss.

Jaw joint disorder

- Surgical treatment of **jaw joint disorders**
- Non-surgical treatment of **jaw joint disorders**
- **Jaw joint disorder** treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutic services related to **jaw joint disorders** including associated myofascial pain

This exclusion does not apply to **covered services** for treatment of **TMJ** and **CMJ** as described in the *Covered services and exclusions –Temporomandibular joint dysfunction (TMJ) and Craniomandibular joint dysfunction (CMJ) treatment* section.

Maintenance care

Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services.

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Non-U.S. citizen

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

Obesity surgery and services

- 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 *Covered services and exclusions* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric **surgery**
  - **Surgical procedures**, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis, or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Other primary payer

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

Prescription or non-prescription drugs and medicines

- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones, unless we have approved a medical exception
- Drugs or medications recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
- **Specialty prescription drugs** except as stated in the *Covered services and exclusions* section

Personal care, comfort or convenience items

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

Routine exams and preventive services and supplies

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Covered services and exclusions* section

School health services

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

- Services and supplies provided by **health professionals** who the **policyholder**:
  - Employs
  - Is affiliated with
  - Has an agreement or arrangement with
  - Otherwise designates

Services not permitted by law

- Some laws restrict the range of health care services a **provider** may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

Services provided by a family member

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

Sexual dysfunction and enhancement

- Except where described in the *Covered services and exclusions* section, any treatment, **prescription drug**, 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 of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

Students in mental health field

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

Telemedicine

- Services including:
  - Telephone calls
  - **Telemedicine** kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Tobacco cessation

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

Treatment in a federal, state, or governmental entity

- Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, unless coverage is required by applicable laws

Vision care for adults

- Routine vision exam provided by an ophthalmologist or optometrist, including refraction and glaucoma testing
- Vision care services and supplies

Wilderness treatment programs

Wilderness treatment programs, whether or not the program is part of a **residential treatment facility** or otherwise licensed institution

Work related illness or injuries

- Coverage available to you under workers' compensation or a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment

Important note:
A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered "non-occupational" regardless of cause.

Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are **covered 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 **covered 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 **covered services**. There are some exceptions:

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Covered services and exclusions* section
- Urgent care – refer to the description of **emergency services** and urgent care in the *Covered services and exclusions* section
- Transplants – see the description of transplant services in the *Covered services and exclusions – Specific conditions* section

You may select an **in-network provider** from the **directory** through your **Aetna** website at https://www.aetnastudenthealth.com. You can search our online **directory** for names and locations of **providers** or contact Member Services at the toll-free number in the *How to contact us for help* section.

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 **covered services** from an **out-of-network provider.** If you use an **out-of-network provider** to receive **covered 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

But in some cases, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

If this situation applies to you, contact us for details. If you are undergoing treatment for an acute or chronic condition and your **provider** didn't leave the network based on fraud or lack of quality standards, you'll be able to receive transitional care from your **provider** for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

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

You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.

What the plan pays and what you pay

Who pays for your **covered 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 a **covered service**.

The general rule

When you get **covered 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.

See the schedule of benefits for any exceptions to this general rule.

Important exception – when your plan pays all

Under the in-network level of coverage, your plan pays the entire expense for all **covered services** under the *Preventive care and wellness* benefit.

Important exceptions – when you pay all

You pay the entire expense for a **covered 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 a **covered 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**.

- One more important exception – when you go to the emergency room

When you have to visit an emergency room for **emergency services**, the general rule described earlier doesn't apply.

Instead:

- You pay your initial share, a **copayment**, for each visit. The **copayment** amount is shown in the schedule of benefits.

And then

- If you haven't satisfied your **policy year deductible**, you pay any remaining expense for the visit, up to the amount of your **policy year deductible**.

And then

- Once the **policy year deductible** has been satisfied, the plan and you share the remaining expense up to any **maximum out-of-pocket limit**. The schedule of benefits lists what percentage of this remaining amount your plan pays. Your share is called **coinsurance**.

And then

- The plan pays any remaining expense after you reach your **maximum out-of-pocket limit**.

As with the general rule, when we say "expense" we mean the **negotiated charge** for an **in-network provider**, and **recognized charge** for an **out-of-network provider**.

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 services**
- 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 **covered services** per **policy year** before your plan begins to pay for **covered 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 **covered services** after you have paid your **policy year deductible**. Your schedule of benefits shows you which **copayments** you need to pay for specific **covered 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 services** 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.

Utilization review – claims decisions and procedures

A claim is a request for payment that you or your health care **provider** submits to us when you want or get **covered services**. There are different types of claims. You or your **provider** may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

Adverse benefit determination

Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back. Any time we don't pay even part of the claim, that is an "adverse benefit determination" or "adverse decision". It is also an adverse benefit determination if we deny your request for:

- An admission
- Availability of care
- Concurrent claim extension
- Other health care service or supply

because we determined, based upon the information provided, it does not meet our requirements for **medical necessity**, appropriateness, healthcare setting, level of care or effectiveness, or are **experimental** or **investigational**.

It is important that you carefully read the previous sections within *Let's get started!* When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have to tell you about our decision on a claim depends on the type of claim.

For the purposes of this section, any reference to "you" or "your" also refers to an authorized representative or **provider** designated by you to act on your behalf.

Claim type and timeframes

Emergency care claim

An emergency claim is one that involves emergency services necessary to screen and stabilize you and does not require prior authorization. When you receive an emergency service that requires immediate post evaluation or post stabilization services, we will make a decision within 60 minutes. If we do not make the decision within 60 minutes, the services will be deemed approved.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. We will make a decision within 36 hours (which shall include one working day) of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. "Necessary services" includes the results of any face-to-face clinical evaluation or second opinion that may be required to make our decision.

In the case of a determination to certify an admission, procedure, or service, we will notify the provider rendering the service by telephone or electronically within 24 hours of making the certification. We will also provide written or electronic confirmation to you and the provider within two (2) working days of making the certification.

In the case of an adverse benefit determination, we will notify the provider rendering the service by telephone or electronically within 24 hours of making the adverse benefit determination. We will also provide written or electronic confirmation to you and the provider within one working day of the adverse benefit determination.

Post-service claim
A post service claim is a claim that involves health care services you have already received. We will pay the claim immediately upon receipt of due written loss. We will provide written notice of our decision to you within 10 working days of our determination.

Concurrent care claim extension
A concurrent care claim extension occurs when you need 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**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within one (1) working day of receiving all necessary information.

In the case of a determination to certify an extended stay or additional services, we will notify the **provider** rendering the service, by telephone or electronically, within one working day of making the certification. We will also provide written or electronic confirmation to you and the **provider** within one working day of making our decision. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an adverse determination, we will notify the **provider** rendering the service, by telephone or electronically, within 24 hours of making the adverse determination. We will also provide written or electronic confirmation to you and the **provider** within one working day of making our decision.

Concurrent care claim reduction or termination
A concurrent care claim reduction or termination occur when we decide to reduce or stop payment for an already approved course of treatment. If we deny your request for a concurrent care claim extension, we will notify you of such a determination. You will have enough time to file a grievance of an adverse benefit determination. Your coverage for the service or supply will continue until you receive a final grievance decision from us or an external review by an independent 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.

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

Timely access to review
Contact us if you or your provider need to contact Aetna's review staff.

Filing a claim
When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider** must send us the bill within 12 months of the date you received services, unless you are legally unable to notify us. Failure to send us notice or proof within such time will not invalidate nor reduce any claim. You must send it to us as soon as reasonably possible with a claim form that you can either get online or contact us to provide. If you are unable to complete a claim form, you must send us a description of the services, the bill of charges, and any medical documentation you received from your **provider**.

We will send you a claim form within 15 days after we receive your notice of a claim. If we do not send you a claim form within those 15 days, you will automatically be considered to have met the proof of loss requirements as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, and the character and the extent of the loss for which claim is made. You should always keep your own record of the date, **providers** and cost of your services.

The benefit payment determination is made based on many things, such as your **deductible** or **coinsurance**, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim immediately upon receipt of due written proof of such loss.

We have processes to review claims before and after payment to ensure the services billed meet one or more of the following:

- Our reimbursement policies
- Are free from fraud, waste, and abuse

When we review, we will evaluate submitted claim information and determine the accuracy of the procedure and diagnosis codes for the services billed. Sometimes, this review will change how we pay for the services and what we allow on a claim. This doesn't mean that a service isn't a **covered service**. It may mean that the claim should be submitted differently, or the services billed on the claim don't satisfy one of the items above.

We will tell you and your **provider** of our decision if we find any of the items above are not met.

We will pay the claim within 30 days after we receive your filed claim, or as soon as we receive all the information necessary to support the claim.

We will give you our decision in writing. This will include the main reason(s) for the determination. It will also include instructions for submitting a grievance or reconsideration of the determination, and of requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints and grievance procedures* section for that information.

Complaints and grievance procedures

For the purpose of this section, any reference to "you" or "your" also refers to an authorized representative or **provider** designated by you to act on your behalf.

Another person may submit a complaint or grievance for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else do this for you (even if it is your **provider**). You should fill out an authorized representative form to tell us. You can get this form by contacting us. See *How to contact us* for how. You can use an authorized representative at any time during the internal grievance process.

The difference between a complaint and a grievance

Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. We will review the complaint as quickly as possible. Complaints are resolved on an informal basis.

Grievance

A grievance is a written complaint when you are unhappy about:

- The availability, delivery, or quality of service you received
- An adverse benefit determination
- Claim payment, handling, or reimbursement for services
- The contractual relationship between you and us

You can ask us to re-review your grievance. This is the internal grievance process. You can start the grievance process by contacting us.

Grievance procedure

For any adverse benefit determination, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. If you still don't agree, you can submit a grievance.

There are times you may skip the internal grievance process. But in most situations, you must complete the internal grievance process before you can take any other actions, such as an external review.

Grievance of an adverse benefit determination

First-level grievance

You must file a grievance within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can send your written grievance to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

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

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

We will conduct a complete review of the grievance within 15 calendar days after we receive a pre-service grievance or 20 working days after we receive a post-service grievance unless the review cannot be completed within this time. If more time or information is needed to make the determination, we will notify you in writing on or before the 20th working day and the review will be completed within 30 working days thereafter. The notice will include specific reasons why additional time is needed for the review.

Within 5 working days after the review is complete, the individual not involved in the circumstances that lead to your grievance or its review will decide upon the appropriate resolution and notify you in writing of our decision and your right to file a grievance for a second review. The notice will explain this decision, in terms that are clear and specific, and your right to file a grievance. You will be notified of the decision within 15 working days after the review is completed.

Second-level grievance

You can submit a second grievance under this plan. You must file your second grievance no later than 180 calendar days from the date you receive the notice of the first-level grievance decision.

A grievance advisory panel will review your second-level grievance and consist of other plan members and some of our employees who were not involved with your first-level grievance.

Where the grievance involves an adverse benefit determination, and the grievance advisory panel makes an initial decision that the determination would be upheld, we shall submit the grievance for review to two (2) independent clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstances that led to the grievance or in any subsequent review or determination of the grievance. In the event that both independent reviews agree with the grievance advisory panel's initial decision, the panel's decision shall stand. If both independent reviewers disagree with the grievance advisory panel's initial decision, the initial adverse benefit determination shall be overturned. If one of the two independent reviewers disagree with the grievance advisory panel's initial decision, the panel shall reconvene and make a final decision in its discretion.

The review of your second-level grievance will follow the time frames required for a first-level grievance. We will tell you in writing of the grievance committee's final decision in terms that are clear and specific. You may request access to and copies of documents, records and information relevant to the grievance. This includes the actual benefit provision, guideline, protocol, or other similar criteria on which the grievance decision was based. We will provide you with that information free of charge.

If you are unhappy with our decision, you may at any time contact the Missouri Department of Commerce and Insurance (DCI), at:

Missouri DCI
Division of Consumer Affairs
P.O. Box 690
Jefferson City, Missouri 65102-0690
Consumer Hotline: 800-726-7390
TDD: 573-526-4536

Expedited grievance review

You may request the grievance process be expedited if the time frames of the standard grievance procedures would seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of your **physician**, would cause you severe pain which cannot be managed without the requested services. A request for an expedited grievance review may be submitted orally or in writing.

We will notify you orally within 72 hours after receiving the expedited review request. We will send written confirmation to you within three (3) working days.

External review

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

You may request an external review if:

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

You may also request external review if you want to know if the federal surprise bill law applies to your situation.

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

You do not have to exhaust our internal grievance process before you can request an external review. If you wish to pursue an external review, you may write to the Missouri Department of Commerce and Insurance (DCI) at:

Missouri DCI
Division of Consumer Affairs
P.O. Box 690
Jefferson City, Missouri 65102-0690

Include any information or documentation to support your request. If you have any questions or concerns during the external review process, you can call the DCI's Consumer Affairs Hotline at 800-726-7390.

The Consumer Affairs Division ("Division") will review your grievance as any other consumer complaint. The Division will contact us and request our decision in writing and all supporting documentation. The Division will first review the matter to determine if they can resolve the issue instead of referring to the IRO. However, if the grievance remains unresolved after exhausting the Division's consumer complaint process, then the Director shall refer the unresolved grievance to an IRO to perform an independent review of your claim. Unresolved grievances include a difference in opinion between the treating health care professional and us concerning:

- Appropriateness
- Effectiveness of the health care service
- Health care settings
- Level of care
- **Medical necessity**

If the claim is eligible for external review, the Division will notify you and us. You and we will have 15 working days to provide any additional medical information that you and we wish to have reviewed and considered. All additional information must be received by the Division in writing.

The IRO will:

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

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

How long will it take to get an IRO decision?

After the Director receives the IRO's opinion, the Director will issue a decision which shall be binding on you and us, with limited exceptions for judicial review. The Director's decision will be in writing and provided to you and us within 25 calendar days of receiving the IRO's opinion. At no time will the IRO decision be longer than 45 calendar days of the date the IRO receives your request for an external review, and all the information to be considered, to the date you and we are notified of the Director's decision.

Sometimes you can get a faster IRO decision. You must call us or the Division as soon as possible.

You may be able to get a faster external review for an adverse benefit determination decision if a delay in receiving health care services would:

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

If your situation qualifies for this faster review, you and we will receive a decision from the Director within 72 hours of the IRO getting your request. If the decision is not in writing, the Director will send you and us the written decision within 48 hours after the notification.

Recordkeeping

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

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or grievance.

Coordination of benefits (COB)

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

Key terms

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

Allowable expense means:

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

In this section when we talk about "other plans" through which you may have other coverage for health care expenses, we mean:

- Group, 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, except Medicaid
- 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 your primary plan, we pay your medical claims first as if there is no other coverage
- When this is your secondary plan:
  - We calculate payment as if the primary plan does not exist. Then we reduce our 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.
  - Each family member has a separate benefit reserve for each **policy year**. The benefit reserve balance is:
    - The amount that the secondary plan saved due to COB
    - Used to cover any unpaid allowable expenses
    - Erased at the end of the year

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.

COB rule	Primary plan	Secondary plan
Covered under this plan as a student	Plan covering you as a student	Plan covering you as a dependent

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 (ESRD)

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**.

Who pays first?

- **Medicare** pays first when you have **Medicare** because of:
  - Age
  - Disability
  - ALS / Lou Gehrig's disease
- When you have **Medicare** because of ESRD:
  - We pay first for the first 3 months unless you take a self-dialysis course.
  - If you take a self-dialysis course, there is no **Medicare** waiting period and **Medicare** becomes primary payer on the first of the month of dialysis.
  - 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.

ESRD important note:
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?

Plan status	How we pay
We are primary	We pay your claims as if there is no **Medicare** coverage.
Medicare is primary	We calculate our benefit as if there were no **Medicare** coverage. We reduce our benefit so that when combined with the **Medicare** payment, the total payment is no more than 100% of the allowable expense.

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 in to your **Aetna** member website at https://www.aetnastudenthealth.com. Select Find a Form, then select Your Other Health Plans.
- **By phone:** Call Member Services at the toll-free number in the *How to contact us for help* section.

Right to receive and release needed information

We have the right to release or obtain any information we need for 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 event to occur:

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

Withdrawal from classes – leave of absence

If you withdraw from classes under a school-approved leave of absence, your coverage will remain in force through the end of the period for which **premium** payment has been received. No **premium** will be refunded.

Withdrawal from classes – other than leave of absence

- If you withdraw from classes within 31 days after the policy effective date, you will be considered ineligible for coverage. Your coverage will be terminated retroactively, and any **premium** paid will be refunded.
- If you withdraw from classes more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which **premium** payment has been received. No **premium** will be refunded.
- If you withdraw from classes to enter the armed forces of any country, your coverage will end as of the date of such entry. Upon written notice of entry into such service, the pro rata unearned premiums shall be refunded.

Why would we suspend paying claims or end your coverage?

We will give you 30 days advance written notice if we suspend paying your claims because:

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

We may immediately end your coverage if:

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

On the date your coverage ends, we will refund to the **policyholder**, the spouse or estate for a deceased individual any prepayments for periods after the date your coverage ended.

Special coverage options after your plan coverage ends

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

Continuation of coverage for other reasons

You can request an extension of coverage as we explain below**,** by calling Member Services at the toll-free number in the *How to contact us for help* section.

How can you extend coverage when getting inpatient care when coverage ends?

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

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

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

- When you are discharged. Coverage will not end if you are transferred to another **hospital** or a **skilled nursing facility**.
- When you no longer need inpatient care.
- When you become covered by another health benefits plan.
- 3 months of coverage.

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
- 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

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

Following the law

If, on the policy's effective date, language in the policy is different from a law that applies to it, the policy will follow applicable law.

How we administer this plan

We administer this plan to comply with all applicable laws and regulations. We also apply policies and procedures we've developed 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 and riders too. Under certain circumstances, we, the **policyholder** or the law may change your plan. Changes, however, can only be made through a written authorization signed by an officer of Aetna. No change will be made to this policy unless made by an amendment or a rider that is issued by us. When an emergency or epidemic is declared, we may modify or waive **precertification**, **prescription** quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the **policyholder**, an agent or **provider**, can do this.

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

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

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 a claim for benefits is pending.

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** and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception
Honest mistakes
You or the **policyholder** may make an honest mistake when you share facts with us. Except for fraud, all statements made by you are considered representations and not warranties. No statement will void this agreement or reduce the benefits after the coverage has been in force for 2 years from its effective date, unless the statement was in a written application or enrollment form signed by you, and you received a copy of the application or enrollment form.

If you or the **policyholder** makes a misstatement about your age, we may make a fair change in **premium** contribution when we learn of the mistake. If we do, we will tell you what the mistake was. We will also change the premium to be equal to the amount that the premium would have been if purchased at the actual age or under the actual condition when the policy was issued.

Intentional deception
If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:
- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage as follows:
- We will give you 31 days advance written notice of any rescission of coverage
- You have the right submit a grievance to **Aetna**
- You have the right to a third-party review conducted by an IRO

Some other money issues
Legal action
You are encouraged to complete the grievance process before you take any legal action against us for any expense or bill. See the *When you disagree - claim decisions and grievances procedures* section. You cannot take any action until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Assignment of benefits

When you see an **in-network provider**, they will usually bill us directly. When you see an **out-of-network provider**, we may choose to pay you or to pay the **provider** directly. To the extent allowed by law, we will not accept an assignment to an **out-of-network provider**.

Financial sanctions exclusions

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 **covered 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). Visit https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx to find out more.

Grace period

You have a grace period of 31 days after the due date for the payment of each premium due after the first premium payment. We will mail a written notice no less than five days prior to the **premium** due date of the intent to **terminate** your **student** policy beyond the timeframe for which **premium** payment has been accepted. The policy will remain in force during the grace period. If premiums are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period.

Payment of premium

The first **premium** payment is due on or before your **effective date of coverage**. **Premium** payments after the first one are due on the 1st of each month. This is the **premium** due date. **Premium** payments are due to us on or before this date.

Recovery of overpayments

We sometimes pay too much for **covered 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.

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 claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just contact us.

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 services** under this plan. **Covered services** will be paid at the applicable level of benefits under the student plan.

Effect of prior coverage - transferred business

Prior coverage means:

- Any plan of student coverage that has been replaced by coverage under part or all of this plan.
- The plan must have been sponsored by the **policyholder** (e.g., transferred business).
- If you are eligible, the replacement can be complete, or in part for your eligible class. Any such plan is prior coverage if provided by another student contract or any benefit section of this plan.

If your coverage under any part of this plan replaces any prior coverage, any benefits provided under such prior coverage may reduce benefits payable under this plan. See the *General coverage provisions* section of the schedule of benefits.

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**.

Behavioral health provider
An individual professional that is licensed or certified to provide diagnostic and/or therapeutic services for **mental health disorders** and **substance related disorders** under the laws of the jurisdiction where the individual practices.

Brand-name prescription drug
An FDA-approved **prescription drug** marketed with a specific name or trademark 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 service**, 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 **covered services** that the plan pays and what you pay. The specific percentage that we have to pay for **covered 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 person
A **covered student** for whom all of the following applies:

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

Covered services
The benefits, subject to varying cost shares, covered under the plan. These are:
- Described in the *Covered services* section
- Not listed as an exclusion in the *Covered services and exclusions* section or *What your plan doesn't cover – general exclusions* section
- Not beyond any limits in the schedule of benefits
- **Medically necessary**. See the *Medical necessity and precertification requirements* and the *Glossary* for more information
- Services that are not prohibited by law

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

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

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

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

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

Dental provider
Any individual legally qualified to provide dental services or supplies. This may be any of the following:
- Any **dentist**
- Group
- Organization
- Dental facility
- Other institution or person

Dentist
A legally qualified **dentist** licensed to do the dental work he or she performs.

Detoxification
The process of getting alcohol or other drugs out of an addicted person's system and getting them physically stable.

Directory
The list of **in-network providers** for your plan. The most up-to-date **directory** for your plan appears at https://www.aetnastudenthealth.com. When searching from our online **provider directory**, 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.

Drug guide
A list of **prescription** and over-the-counter (OTC) drugs and devices established by **Aetna** or an affiliate. It does not include all **prescription** and OTC drugs and devices. This list can be reviewed and changed by **Aetna** or an affiliate. A copy of the **drug guide** is available at your request. You can also find it on the **Aetna** website at https://www.aetnastudenthealth.com.

Durable medical equipment (DME)
Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an **illness** or **injury**
- Suited for use in the home
- Not normally used by people who do not have an **illness** or **injury**
- Not for altering air quality or temperature
- Not for exercise or training

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

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
An acute, sudden and unexpected medical condition, regardless of the final diagnosis that is given, 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 the following, which may include, but shall not be limited to:

- Placing your health in serious danger
- Serious loss to bodily function
- Pain that cannot be controlled
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus
- In the case of a pregnant woman:
  - Serious jeopardy to the health of the fetus
  - One who is having contractions and there is inadequate time to effect a safe transfer to another **hospital** before delivery or
  - A transfer may pose a threat to the health or safety of the woman or unborn child

Emergency services

Treatment given in an ambulance and a **hospital**'s emergency room or an independent freestanding emergency department. This includes evaluation of and treatment to stabilize the **emergency medical condition**. An "independent freestanding emergency department" means a health care facility that is geographically separate, distinct and licensed separately from a **hospital** and provides **emergency services**.

Experimental, investigational, or unproven

A drug, device, procedure, supply, treatment, test, or technology is considered by us to be **experimental, investigational, or unproven** if any of the following apply:

- It hasn't been shown through well-conducted clinical trials or cohort studies published in peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which it's meant.
  - A well-conducted clinical trial means a randomized, controlled trial where the experimental intervention is compared to a control group receiving care according to best practice and study participants are randomly assigned to the experimental or control group.
  - A well-conducted cohort study means a prospective cohort study from more than one institution where the experimental intervention is compared to a group of subjects receiving care according to best practice and where the comparison group is well matched to the experimental intervention group.
- There isn't FDA approval or clearance to market it for the proposed use.
- A national medical society, dental society, or regulatory agency has written that it's **experimental, investigational, or unproven**, or mainly for research purposes.
- It's the subject of a Phase I, Phase II, or the experimental or research arm of a Phase III or Phase IV clinical trial. The FDA and Department of Health and Human Services define these.
- Written procedures or consent form used by a facility **provider** says it's **experimental, investigational, or unproven**.

Important note:
We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **medically necessary**, **experimental, investigational, or unproven**. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact us. See the *How to contact us for help* section for how.

Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product. It is considered to be as effective as the brand-name product and offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance

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 **R.N.**, **L.P.N.**, or **L.V.N**. A **home health aide** primarily aids you in performing the normal activities of daily living while you recover from an **injury** or **illness**.

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

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

Homebound
This means that you are confined to your home because:

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

You are not **homebound** if:

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

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

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

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

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

Hospice facility
An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**.

Hospital
An institution licensed as a **hospital** by applicable law. This is a place that offers medical care under the supervision of a staff of one or more licensed **physicians** and provider 24-hour nursing service by **R.N.s** on duty or call. Patients can stay overnight for care. Or they can be treated and leave the same day. All **hospitals** must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

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**.

Injectable drug(s)
These are **prescription drugs** when an oral alternative drug is not available.

Injury or injuries
Physical damage done to a person or part of their body.

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

Intensive care unit
A **hospital** permanently equipped and staffed to provide care that is more extensive for critically ill or injured patients than available in other **hospital** rooms or wards. Care includes close observation by trained and qualified personnel whose duties are primarily confined to the part of the **hospital** for which an additional charge is made.

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 per **policy year** for **covered services**.

Medically necessary/Medical necessity

Health care services or supplies that prevent, evaluate, diagnose or treat an **illness**, **injury**, disease or its symptoms, and that are all of the following, as determined by us within our discretion:

- In accordance with "generally accepted standards of medical practice"
- Clinically appropriate, in terms of type, frequency, extent, site, place of service, duration, and considered effective for your **illness**, **injury** or disease
- Not primarily for your convenience, the convenience of your **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 your **illness**, **injury** or disease

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 and
- Following the standards set forth in our clinical policies and applying clinical judgment

Important note:
We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **medically necessary, experimental, investigational, or unproven**. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact us. See the *How to contact us for help* section.

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 health disorder

A **mental health disorder** is, in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of **mental health disorder** is in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

Negotiated charge

Health coverage

This is either:

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

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

For surprise billing, calculations will be made based on the median contracted rate.

We may enter into arrangements with **in-network providers** or others related to:

- The coordination of care for **covered persons**
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing

These arrangements will not change the **negotiated charge** under this plan.

Prescription drug coverage from an in-network pharmacy

In-network pharmacy

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

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

Non-preferred drug

A **prescription drug** or device that may have a higher out-of-pocket cost than a **preferred drug**.

Out-of-network dental provider

A **dental provider** who is not an **in-network dental provider** and does not appear in the **directory** for your plan**.**

Out-of-network pharmacy

A **pharmacy** that is not an **in-network pharmacy** or 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.

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.

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 **covered services** per **policy year** before your plan starts to pay as listed in the schedule of benefits.

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**.

Precertification, precertify
A requirement that you or your **physician** contact **Aetna** before you receive coverage for certain services.

A prior authorization review, also called a "Utilization review", is performed before we make a determination. This review is a formal evaluation (pre-service, concurrent or post-service) of the **medical necessity**, effectiveness, efficiency or appropriateness of the requested service, treatment, or setting.

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

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**.

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 **provider**. 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 licensed or certified as a **psychiatric hospital** by applicable laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse or **mental health disorders** (including **substance related 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:

SERVICE OR SUPPLY	RECOGNIZED CHARGE IS BASED ON:
Professional services and other services or supplies not mentioned below	105% of the **Medicare** allowed rate
Services of **hospitals** and other facilities	140% of the **Medicare** allowed rate
Prescription drugs	100% of the average wholesale price (AWP)
Dental expenses	80% of the prevailing charge rate

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

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP **provider**. NAP **providers** are **out-of-network providers** and third-party vendors that have contracts with us but are not **in-network providers**. Claims for services received from a NAP **provider** and paid at the NAP contracted rate are not subject to the federal surprise bill law.

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

- How much work it takes to perform a service
- Other things as needed to decide what rate is reasonable for a particular service or supply

When the **recognized charge** is based on a percentage of the **Medicare** allowed rate, it is not affected by adjustments or incentives given to **providers** under **Medicare** programs.

- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.

Our reimbursement policies

We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the **recognized charge**. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the **provider**

Our reimbursement policies are based on our review of:

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

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

Get the most value out of your benefits
We have online tools to help you decide whether to get care and if so, where. Log in to your **Aetna** website at https://www.aetnastudenthealth.com. The website contains additional information that can help you determine the cost of a service or supply.

R.N.

A registered nurse.

Residential treatment facility

A facility that provides **mental health disorder** services or **substance related disorder** services and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed **physician** for the level of care provided
- Maintains a written treatment plan prepared by a licensed **behavioral health provider** (**R.N.** or master's level) requiring full-time residence and participation
- Has a licensed **behavioral health provider** (**R.N.** or master's level) on-site 24 hours per day 7 days per week

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**.

Room and board
A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

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.

Skilled nursing facility
A facility that provides skilled nursing care and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed **physician** for the level of care provided
- Maintains a written treatment plan prepared by a licensed **provider** (**R.N.** or master's level) requiring full-time residence and participation
- Has a licensed **provider** (**R.N.** or master's level) on-site 24 hours per day 7 days per week
- And is:
  - Credentialed by us, or
  - Certified by **Medicare**, or
  - Accredited by The Joint Commission (TJC) or The Committee on Accreditation of Rehabilitation Facilities (CARF)

Skilled nursing facilities also include rehabilitation **hospitals**, and portions of a rehabilitation **hospital** and a **hospital** designated for skilled or rehabilitation 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 health disorders** or **substance related disorders**.

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 pharmacy
A **pharmacy** that fills **prescriptions** for specialty drugs.

Specialty prescription drug
An FDA-approved **prescription drug** that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:

- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

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

Step therapy
A form of **precertification** where you must try one or more required drug(s) before a **step therapy** drug is covered. The required drugs have FDA approval, may cost less and treat the same condition. If you don't try the appropriate required drug first, you may need to pay full cost for the **step therapy** drug.

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 related disorder
The use of drugs, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association, that directly affect the brain's reward system in an amount or frequency that causes problems with normal activities.

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 **physician**, **specialist**, **behavioral health provider** , or **telemedicine provider** who is performing a clinical medical or behavioral health service by means of electronic communication.

Temporomandibular joint dysfunction (TMJ)

This is a disorder of the jaw joint.

Terminal illness

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

Urgent admission

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

Urgent care facility

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

Urgent condition

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

Walk-in clinic

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near, or within a:

- Drug store
- **Pharmacy**
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- **Hospital**
- Outpatient department of a **hospital**
- **Physician's** office
- **Urgent care facility**

Incentive programs

Wellness and other incentives

Covered students only

We may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services, and to continue your participation in the **Aetna** plan through voluntary incentives. You and your **physician** can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, including but not limited to financial wellness programs, we may provide incentives based on your participation. These are not covered benefits under the plan but are separate components which are not guaranteed and could be discontinued at any time.

Incentives may include but are not limited to:

- Modifications to **copayment**, **coinsurance**, or **policy year deductible** amounts
- **Premium** discounts or rebates
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards or
- Any combination of the above.

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon your health status.

TTY: **711**

English	To access language services at no cost to you, call the number on your ID card.
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	**無料の言語サービスは、IDカードにある番号にお電話ください。**
Karen	လၵ်ၢတၢ်ကမ့ၢ်ကျိၢ်တၢ်မၤစၤအတၢ်ဖံးတၢ်မၤတဖုဉ် လၵ်ၢတအိဉ်ဒီးအပူၤလၵ်ၢနၤကဘဉ်ဟုဉ်အီၤအကျိးကီးဘဉ်လီတဲစိနိဉ်ဂၢ်လၵ်ၢအအိဉ်လၵ်ၢနၤခိဉ်ကီၤ ဗ (၅၅) အလိၣ်ဉ်တက့ၢ်၅၅
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພອືຂ້ໍ້ເຖ ງົ ບ ວ ່ ກ ົ ານພ າ ສ າ ຫ ບ ໍ ່ ເ ສ ຍ ຄ ່ າ, ໃ ຫ ໍ ່ ໂ ທ ຫ າ ເ ບ ໍ ່ ໂ ຫ ຍ ໃ ນ ບ ດ ັ ປ ະ ຈ ໍ າ ຕ ວ ົ ຂ ອ ງ ທ ່ ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដល៏តគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ąh ílínígóó naaltsoos bee atah nílį́įgo nanitinígíí bee nééhoʼdólzinígíí béésh bee hane'í biká'ígíí áajį' hólne'.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਨਿਾਂ ਕਸਿ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਤਿੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܟܕ ܒܥܝܬ ܠܡܬܩܒܠ ܫܘܬܦܐ ܒܠܫܢܐ ܕܠܐ ܡܫܠܡ ܟܬܘܒ ܠܡܣܦܪܐ ܕܟܬܘܒ ܥܠ ܟܪܛܝܣ ܕܗܘܝܘܬܟ
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขทีแสดงอยู่บนบัตรประจำตัวของท่าน

Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.

Aetna Life Insurance Company



Missouri Notice of Protection Provided by Missouri Life and Health Insurance Guaranty Association

This notice provides a *brief summary* of the Missouri Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Missouri law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Missouri law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are as follows:

- Life Insurance

- $300,000 in death benefits but not more than $100,000 in net cash surrender and net cash withdrawal values

- Health Insurance

- $500,000 for health plans
- $300,000 in disability insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

- Annuities

- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

- $300,000 in aggregate for all types of coverage listed above, with the exception of health benefit plans
- $500,000 in aggregate for health benefit plans
- $5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons "Health benefit plan" is defined in section 376.718, RSMo.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Missouri law.

Benefits provided by a long term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the basic life insurance policy or annuity contract to which it relates.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mo-iga.org, or contact:

Missouri Life and Health
Insurance Guaranty Association
2210 Missouri Boulevard
Jefferson City, Missouri 65109
Ph.: 573-634-8455
Ph.: 573-522-6115

Missouri Department of Insurance, Financial
301 West High Street, Room 530
Jefferson City, Missouri 65101
Fax: 573-634-8488
Ph.: 573-522-6115

Insurance companies and agents are not allowed by Missouri law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Missouri law, then Missouri law will control.