



Student Health Insurance

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

Schedule of Benefits

Prepared exclusively for:

Policyholder:	Angelo State
Policyholder number:	686176
Student policy effective date:	08/15/2018
Plan effective date:	08/15/2018
Plan issue date:	10/23/2018
Actuarial value and metallic level:	82.39% - Gold

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

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

Schedule of benefits

This schedule of benefits lists the **policy year deductibles**, **copayments** and **coinsurance** that apply to the services you receive under this plan. You should review this schedule of benefits to become familiar with your **policy year deductibles**, **copayments** and **coinsurance** and any limits that apply to the services and supplies.

How to read your schedule of benefits

- When we say:
 - “In-network coverage”, we mean you get care from our **in-network providers**.
 - “Out-of-network coverage”, we mean you can get care from **out-of-network providers**.
- The **policy year deductibles**, **copayments** and **coinsurance** listed in the schedule of benefits below reflects the **policy year deductibles**, **copayment** and **coinsurance** amounts under your plan.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount that the plan pays. You are responsible for paying any remaining **coinsurance**.
- You are responsible for paying any **policy year deductibles**, **copayments**, and **coinsurance**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums. They are combined maximums for **in-network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule of benefits you will find detailed explanations about your:
 - **Policy year deductibles**
 - **Copayment**
 - **Maximums**
 - **Coinsurance**
 - **Maximum out-of-pocket limits**

Important note:

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

How to contact us for help

We are here to answer your questions.

- Log onto your Aetna Navigator® secure website at www.aetnastudenthealth.com.
- Call Member Services at the toll-free number on your ID card 1-877-480-4161.

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

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

Important note about your cost sharing:

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

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

Here's an example of how cost sharing works:

You pay your policy year deductible	Your physician charges	Your physician collects the copayment from you	The plan pays 80% coinsurance	You pay 20% coinsurance
\$250	\$120	\$20	\$80	\$20

Plan features	In-network coverage*	Out-of-network coverage*
Policy year deductible		
You have to meet your policy year deductible before this plan pays for benefits.		
Student	\$500 per policy year	\$1,000 per policy year
Spouse	\$500 per policy year	\$1,000 per policy year
Each Child	\$500 per policy year	\$1,000 per policy year
Family	\$1,500 per policy year	\$3,000 per policy year
Policy year deductible waiver		
<p>The policy year deductible is waived for all of the following eligible health services:</p> <ul style="list-style-type: none"> In-network care for <i>Preventive care and wellness, physician and specialist office visit, consultant office visit, Walk-in clinic visit, outpatient mental health office visit, outpatient substance abuse office visit, urgent care, and Pediatric dental care services.</i> In-network and out-of-network care for <i>Preventive Immunizations up to age 6, Hospital emergency room visit, and Outpatient prescription drugs.</i> 		

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Maximum out-of-pocket limits		
Maximum out-of-pocket limit per policy year		
	In-network coverage*	Out-of-network coverage*
Student	\$6,850 per policy year	\$13,700 per policy year
Spouse	\$6,850 per policy year	\$13,700 per policy year
Each child	\$6,850 per policy year	\$13,700 per policy year
Family	\$13,700 per policy year	\$27,400 per policy year
Preauthorization covered benefit penalty		
<p>This only applies to out-of-network coverage: The certificate of coverage contains a complete description of the preauthorization program. You will find details on preauthorization requirements in the <i>Medical necessity and preauthorization requirements</i> section.</p> <p>Failure to preauthorize your eligible health services when required will result in the following benefit penalty:</p> <ul style="list-style-type: none"> • A \$500 benefit penalty will be applied separately to each type of eligible health service <p>The additional percentage or dollar amount of the recognized charge which you may pay as a penalty for failure to obtain preauthorization is not a covered benefit, and will not be applied to the out-of-network policy year deductible amount or the maximum out-of-pocket limit, if any.</p>		

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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**.

Eligible health services	In-network coverage*	Out-of-network coverage*
1. Preventive care and wellness		
Routine physical exams		
Performed at a physician’s office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Routine physical exams for covered persons age 18 or more Maximum age and visit limits per policy year		
Screening for abdominal aortic aneurysm	1 time for adults aged 65-75 who have ever smoked	
Screening for cholesterol at increased risk for coronary heart disease	Men age 35 and older Men under age 35 who have heart disease or risk factors for heart disease Women who have heart disease or risk factors for heart disease	
Colorectal cancer screening	For adults over 50	
Screening for aspirin use for the primary prevention of cardiovascular disease and colorectal cancer as recommended by their physician	For adults age 50-59 years of age who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years	
Routine physical exams for covered persons from birth to age 18: Maximum age and visits per policy year		
Autism screening	At intervals of 18 and 24 months	
Developmental screening	Under age 3 and surveillance throughout childhood	
Blood pressure screenings at certain intervals	0-11 months 1-4 years 5-10 years 11-14 years 15-17 years	

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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 onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Covered persons age 22 & over: Maximum visits per policy year	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office No policy year deductible, copayment or coinsurance applies for children from birth through age 6	100% (of the negotiated charge) per visit No policy year deductible, copayment or coinsurance applies for children from birth through age 6	60% (of the recognized charge) per visit
Limited to:		
Routine physical exams for adults age 18 or more	As shown in the certificate of coverage	
Routine physical exams for children from birth to age 18	As shown in the certificate of coverage	
Additional maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Well woman preventive visits Routine gynecological exams (including Pap smears)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Pap smear or screening using liquid based cytology methods	1 Pap smear every 12 months for women age 18 and older	

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Gynecological exam that includes a rectovaginal pelvic exam	1 exam every 12 months for women over age 25 who are at risk for ovarian cancer	
Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test	1 exam every 12 months for women age 18 and older	
Screening for osteoporosis	For women over age 60 depending on risk factors	
Additional maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Additional Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration Women’s Preventive Services Guidelines.	
Additional Maximum visits per policy year	1 visit	
Preventive screening and counseling services		
Obesity and/or healthy diet counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year (This maximum applies only to covered persons age 22 and older)	26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Misuse of alcohol and/or drugs counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	5 visits*	
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		

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Use of tobacco products counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	8 visits*	
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Depression screening counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Sexually transmitted infection counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	2 visits*	
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.		
Genetic risk counseling for breast and ovarian cancer office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Age limitations	Not subject to any age limitations	

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Routine cancer screenings Performed at a physician’s office, specialist’s office or facility		
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Mammogram maximums	1 low-dose mammogram every 12 months for covered persons age 35 or older For covered persons of any age, subject to any age, family history and frequency guidelines as set forth in the most current: <ul style="list-style-type: none">Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task ForceThe comprehensive guidelines supported by the Health Resources and Services Administration	
Prostate specific antigen (PSA) tests maximums	1 PSA test every 12 months for covered persons age 50 and older 1 PSA test every 12 months for covered persons age 40 and older with a family history of prostate cancer, or other risk factor	
Fecal occult blood tests maximums	1 occult test every 12 months for covered persons age 50 or older	
Sigmoidoscopies maximums	1 flexible sigmoidoscopy every 5 years for covered persons age 50 or older	
Colonoscopies maximums	1 colonoscopy every 10 years for covered persons age 50 or older	
Lung cancer screening maximums	1 screening every 12 months*	
*Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.		

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Additional maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none">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; andThe comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure member website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Prenatal care Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
Preventive care services only	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Important note: You should review the <i>Maternity care</i> and <i>Well newborn nursery care</i> sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services - facility or office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits*	
*Important note: Any visits that exceed the lactation counseling services maximum are covered under the <i>Physicians and other health professionals</i> section.		

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Breast feeding durable medical equipment		
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item
Important note: See the <i>Breast feeding durable medical equipment</i> section of the certificate of coverage for limitations on breast pump and supplies.		
Family planning services – contraceptives		
Contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Counseling services		
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 <i>Physician services</i> office visits.		
Contraceptives (prescription drugs and devices)		
Contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item
Voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) per admission No copayment or policy year deductible applies	60% (of the recognized charge) per admission
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit

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Eligible health services	In-network coverage*	Out-of-network coverage*
2. Physicians and other health professionals		
Physician and specialist services (non-surgical and non-preventive)		
Office hours visits (non-surgical and non-preventive care by a physician and specialist, includes telemedicine or telehealth consultations)	\$30 copayment per visit then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's 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's or specialist's 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.
Physician and specialist – inpatient surgical services		
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) per admission	60% (of the recognized charge) per admission
Physician and specialist –outpatient surgical services		
Outpatient surgery performed at a physician's or specialist's 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		
In-hospital non-surgical physician services	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission

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Consultant services (non-surgical and non-preventive)		
Consultant office visits		
Office hours visits (non-surgical and non-preventive care), includes telemedicine or telehealth consultations	\$30 copayment per visit then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) per visit
Second surgical opinion		
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)		
Walk-in clinic (non-emergency visit)	\$30 copayment per visit then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) per visit
<p>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. <i>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.</i></p>		

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Eligible health services	In-network coverage*	Out-of-network coverage*
3. Hospital and other facility care		
Hospital care		
<p>Inpatient hospital (room and board) and other miscellaneous services and supplies</p> <p>Subject to semi-private room rate unless intensive care unit required</p> <p>Room and board intensive care</p> <p>For physician charges, refer to the <i>Physician and specialist- inpatient surgical services</i> benefit</p>	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Preadmission testing		
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 <i>Coverage is subject to certain conditions. See the benefit description in the certificate of coverage for details.</i>		
Anesthesia and related facility charges for a dental procedure	80% (of the negotiated charge)	60% (of the recognized charge)
Alternatives to hospital stays		
Outpatient surgery (facility charges)		
<p>Facility charges for surgery performed in the outpatient department of a hospital or surgery center</p> <p>For physician charges, refer to the <i>Physician and specialist - outpatient surgical services</i> benefit</p>	80% (of the negotiated charge)	60% (of the recognized charge)
Home health care		
Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	60 visits	

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Hospice care		
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
Maximum visits per policy year	Unlimited	
Skilled nursing facility		
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
Maximum days of confinement per policy year	25 days	

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Eligible health services	In-network coverage*	Out-of-network coverage*
4. Emergency services and urgent care		
Emergency services		
Hospital emergency room Includes complex imaging services, lab work and radiological services needed to stabilize you and performed during a hospital emergency room visit, and any surgery which results from the hospital emergency room visit	\$200 copayment per visit (waived if admitted) then the plan pays 80% (of the balance of the negotiated charge) No policy year deductible applies	Paid the same as in-network coverage
Important note: <ul style="list-style-type: none"> As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment and coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. A separate hospital emergency room copayment will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment will be waived and your inpatient copayment will apply. Covered benefits that are applied to the hospital emergency room copayment cannot be applied to any other copayment under the plan. Likewise, a copayment that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment. Separate copayment amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment amounts may be different from the hospital emergency room copayment. They are based on the specific service given to you. 		
Non-emergency care in a hospital emergency room	Not covered	Not covered

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Urgent care		
Urgent medical care provided by an urgent care provider **Does not include complex imaging services, lab work and radiological services performed during an urgent medical care visit	\$50 copayment per visit then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) per visit
**See the cost-sharing that applies to these covered benefits in this schedule of benefits		
Non-urgent use of urgent care provider	Not Covered	Not Covered

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Eligible health services	In-network coverage*	Out-of-network coverage*
5. Pediatric dental care		
Limited to covered persons through the end of the month in which the person turns age 19		
Type A services The payment or reimbursement for services rendered by a dentist of a non-contracting dental provider shall be reimbursed the same as a contracting dental provider.	100% (of the negotiated charge) per visit No copayment or deductible applies	100% (of the recognized charge) per visit No policy year deductible applies
Type B services The payment or reimbursement for services rendered by a dentist of a non-contracting dental provider shall be reimbursed the same as a contracting dental provider.	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit No policy year deductible applies	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.
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. The payment or reimbursement for services rendered by a dentist of a non-contracting dental provider shall be reimbursed the same as a contracting dental provider.		

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Type A services: diagnostic and preventive care

Visits and images

- D0120-Office visit during regular office hours, for oral examination (limited to 2 visits every 12 months)
- D0150-Comprehensive oral evaluation
- D0180-Comprehensive periodontal evaluation (limited to 2 visits every 12 months)
- D0140-Problem-focused examination (limited to 2 visits every 12 months)
- D0145-Oral evaluation-child under 3 (limited to 2 visits every 12 months)
- D0150-Comprehensive oral evaluation (limited to 2 visits every 12 months)
- D0160-Detailed and extensive oral evaluation – problem focused
- D1120-Prophylaxis (cleaning) (limited to 2 treatments per year)
- D1208-Topical application of fluoride (limited to 2 courses every 12 months)
- D1206-Topical fluoride varnish (limited to 2 courses every 12 months)
- D1351-Sealants, per tooth (limited to: one application every 3 years for permanent molars)
- D1352-Preventive resin restorations (limited to one application every 3 years for permanent molars only)
- D1353-Sealant repair, per tooth (limited to one application every 3 years for permanent molars)
- D0270-Bitewing images-one image (limited to 2 sets per 12 months)
- D0272-Bitewing images-two images (limited to 2 sets per 12 months)
- D0273-Bitewing images-three images (limited to 2 sets per 12 months)
- D0274-Bitewing images-four images (limited to 2 sets per 12 months)
- D0210-Complete image series, including bitewings, if medically necessary, (limited to 1 set every 3 years)
- D0330-Panoramic images (limited to 1 set every 3 years)
- D0277-Vertical bitewing images, 7 to 8 radiographic images (limited to 2 sets per year)
- D0220-Periapical images
- D0240-Intra-oral, occlusal radiographic image
- D0340-Cephalometric radiographic image
- D0350-2D oral/facial photographic images
- D0391-Interpretation of diagnostic image
- D0240-Intra-oral, occlusal view, maxillary or mandibular
- D0470-Diagnostic models
- D9110-Emergency palliative treatment (per visit)
- D2990-Resin infiltration of lesion (limited to one per tooth every 3 years)
- D4346-Scaling in presence of generalized moderate or severe gingival inflammation-full mouth, after oral evaluation

Space maintainers

- D1510 or D1515-Fixed (unilateral or bilateral)
- D1520 or D1525-Removable (unilateral or bilateral)
- D1550-Re-cementation of space maintainer
- D1555-Removal of space maintainer performed by dentist or practice that did not originally place the appliance
- D1575-Distal shoe space maintainer-fixed (unilateral)

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Type B services: basic restorative care

Visits and images

- D9311-Consultation with a medical health care professional
- D9440-Professional visit after hours (payment will be made on the basis of services rendered or the charge for the after-hours visit, whichever is greater)
- D9310-Consultation (by other than the treating provider)
- D9930-Treatment of complications (post surgical) unusual circumstances, by report

Images, pathology and drugs

- D0250-Upper or lower jaw, extra-oral
- D0251-Extra-oral posterior dental radiographic image
- D9610-Therapeutic drug injection, by report

Oral surgery

- Extractions
 - D7140-Erupted tooth or exposed root
 - D7111-Coronal remnants, primary tooth
 - D7250-Removal of residual tooth roots
 - D7210-Surgical removal of erupted tooth/root tip
 - D7251-Coronectomy
- Impacted teeth
 - D7220-Removal of tooth (soft tissue)
- Surgical removal of impacted teeth
 - D7230-Removal of tooth (partially bony)
 - D7240-Removal of tooth (completely bony)
 - D7241-Removal of tooth (completely bony with unusual surgical complications)
- Other surgical procedures
 - D7310-Alveoplasty, in conjunction with extractions – four or more teeth, per quadrant
 - D7311-Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
 - D7320-Alveoplasty, not in conjunction with extraction - per quadrant
 - D7321-Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
 - D7970-Excision of hyperplastic tissue
 - D7971-Excision of periocoronal gingiva
 - D7471-Removal of exostosis
 - D7472-Removal of torus palatinus
 - D7473-Removal of torus mandibularis
 - D7270-Tooth reimplantation
 - D7272-Transplantation of tooth or tooth bud
 - D7260-Closure of oral fistula of maxillary sinus
 - D7280-Exposure of an unerupted tooth
 - D7283-Crown exposure to aid eruption
 - D7960-Frenectomy

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- D7910-Suture of small wound less than 5cm
- D7510-Incision and drainage of abscess
- D7485-Reduction of osseous tuberosity
- D7953-Bone replacement graft for ridge preservation-per site
- D7921-Collection and application of autologous blood (limited to 1 every 36 months)

Periodontics

- D9951 or D9952-Occlusal adjustment-limited or complete (other than with an appliance or by restoration)
- D4341-Root planing and scaling –per quadrant-4 or more teeth (limited to 4 separate quadrants every 2 years)
- D4342-Root planning and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
- D4910-Periodontal maintenance procedures following active therapy (limited to 4 in 12 months combined with adult prophylaxis after completion of active periodontal therapy)

Endodontics

- Pulp capping, D3110-direct or D3120-indirect
- Pulpotomy, D3220-theraputec or D3222-apexogenesis-partial
- Pulpal therapy, D3230-anterior or D3240-posterior (primary tooth)
- D3357-Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp, does not include final restoration)
- D335-Pulpal regeneration, initial visit
- D3356-Pulpal regeneration, interim medication replacement
- D3430-Retrograde filing

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 restorations, D2140-1 surface; D2150-2 surface; D3160-3 surface and D2161-4 or more surface
- D2930-Resin-based composite crown, anterior
- Resin-based composite restorations (other than for molars), D2330-1 surface anterior; D2331-2 surface anterior; D2332-3 surface anterior or D2335-4 or more surfaces or involving incisal angle (anterior)
- Resin-based composite restorations, D2391-1 surface posterior; D2392-2 surface posterior; D2393-3 surface posterior or D2394-4 or more surfaces posterior
- D2940-Protective resin
- D2941-Interim therapeutic restoration-primary teeth
- Pins
- D2951-Pin retention—per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
- Prefabricated stainless steel, D2930-primary teeth or D2931-permanent teeth

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- D2932-Prefabricated resin crown (excluding temporary crowns)
- Re-cementation
 - D2910-Inlay
 - D2915-Fabricated-prefabricated post and core
 - D2920-Crown
 - D6930-Fixed partial denture retainers
 - D6092-Implant/abutment supported crown
 - D6093-Implant/abutment supported fixed partial denture

Prosthodontics

- Dentures and partials
 - Office reline, D5730-complete upper denture; D5731-complete lower denture; D5740-upper partial denture or D5741-lower partial denture
 - Laboratory relines, D5750-complete upper denture; D5751-complete lower denture, D5760-upper partial denture or D5761-lower partial denture
 - Special tissue conditioning, per denture, D5850-upper or D5851-lower
 - Rebase, per denture, D5710-complete upper denture; D5711-complete lower denture; D5720-upper partial denture or D5721-lower partial denture
 - Adjustment to denture (more than 6 months after installation), D5420-complete upper; D5411-complete lower; D5421-partial upper or D5422-partial lower
- Full and partial denture repairs
 - Broken dentures, no teeth involved, D5511-complete mandibular base or D5512-complete maxillary base
 - Repair cast framework (partial), D5621-mandibular or D5622-maxillary
 - D5520-Replacing missing or broken teeth, each tooth (complete denture)
 - Repair resin, D5611-partial mandibular base or D5612-partial maxillary base
 - D5630-Broken clasp, per tooth (partial denture)
 - D5640-Replace broken tooth-per tooth (partial denture)
 - D5670-Replace all teeth and acrylic on cast metal framework-upper partial denture
 - D5671-Replace all teeth and acrylic on cast metal framework-lower partial denture
 - Adding teeth to existing partial denture
 - D5650-Each tooth
 - D5660-Each clasp
- Repairs: bridges; partial dentures, D6980-fixed and necessitated by material failure

General anesthesia and intravenous sedation

- D9219-Evaluation-general anesthesia/deep sedation
- D9222-Deep sedation/general anesthesia-first 15 minutes
- D9223-General anesthesia/deep sedation-each subsequent 15 minute increment
- D9239-Intravenous moderate (conscious) sedation/anesthesia-first 15 minutes
- D2943-Intravenous conscious sedation-each subsequent 15 minute increment

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Type C services: major restorative care

Periodontics

- D4261-Osseous surgery, including flap and closure, 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- D4260-Osseous surgery, four or more contiguous teeth, per quadrant (limited to 1 per quadrant every 3 years)
- Soft tissue graft procedures
- Bone replacement graft – first site in quadrant (limited to 1 per quadrant every 3 years)
- D4210-Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)
- D4211-Gingivectomy, 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- D4212-Gingivectomy or gingivoplasty, to allow access for restorative procedure, per tooth (limited to 1 per quadrant every 3 years)
- D4240-Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
- D4241-Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- D4249-Clinical crown lengthening
- D4263-Bone replacement graft – retained natural tooth – first site in quadrant site (limited to 1 every 3 years)
- D4270-Pedical soft tissue graft procedure
- D4275-Non-autogenous connective soft tissue allograft
- D4277-Free soft tissue graft procedure 1st tooth, implant, or edentulous tooth position in graft
- D4278-Free soft tissue graft procedure each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4283-Autogenous connective tissue graft procedure – each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4285-Non-autogenous connective tissue graft procedure – each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4273-Subepithelial connective tissue graft procedures including donor site surgery
- D4355-Full mouth debridement (limited to 1 treatment per lifetime)

Endodontics

- Apexification/recalcification, D3351-initial visit; D3352-interim medication replacement or D3353-final visit
- Apicoectomy, D3410-anterior; D3421-premolar; D3425-molar or D3426-each additional tooth
- Root canal therapy including images:
 - D3310-Anterior
 - D3320-Premolar
 - D3330-Molar
- Retreatment of previous root canal therapy:
 - D3346-Anterior
 - D3347-Premolar
 - D3348-Molar
- D3450-Root amputation
- D3920-Hemisection (including any root removal)
- Pulpal regeneration, D3355-initial visit; D3356-interim medications replacement or D3357-completion of treatment

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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.

- Inlays/Onlays (limited to 1 per tooth every 5 years)
 - Inlays:
 - D2510-metallic 1 surface
 - D2520-metallic 2 surface
 - D2530-metallic 3 or more surface
 - D2610-porcelain/ceramic 1 surface
 - D2620-porcelain/ceramic 2 surface
 - D2630-porcelain/ceramic 3 or more surface
 - D2650-composite/resin 1 surface
 - D2651-composite/resin 2 surface
 - D2652-composite/resin 3 surface
 - Onlays:
 - D2542-metallic 2 surface
 - D2543-metallic 3 surface
 - D2544-metallic 4 or more surface
 - D2642-porcelain/ceramic 2 surface
 - D2643-porcelain/ceramic 3 surface
 - D2644-porcelain/ceramic in addition to inlay
 - D2662-composite/resin 2 surface
 - D2663-composite/resin 3 surface
 - D2664-composite/resin 4 or more surface
- Veneers (non-cosmetic), D2960-Labial veneer resin in office (no limit); D2961-Labial veneer resin laminate or D2963-Labial veneer porcelain (limited to 1 per tooth every 5 years)
- Crowns (limited to 1 per tooth every 5 years)
 - D2710-Resin (limited to 1 per tooth every 5 years)
 - D2722-Resin with noble metal (limited to 1 per tooth every 5 years)
 - D2721-Resin with base metal (limited to 1 per tooth every 5 years)
 - D2720-Resin with high noble metal (limited to 1 per tooth every 5 years)
 - D2740-Porcelain/ceramic (limited to 1 per tooth every 5 years)
 - D2752-Porcelain with noble metal (limited to 1 per tooth every 5 years)
 - D2751-Porcelain with base metal (limited to 1 per tooth every 5 years)
 - D2750-porcelain with high noble metal (limited to 1 per tooth every 5 years)
 - D2791-Base metal (full cast) (limited to 1 per tooth every 5 years)
 - D2792-Noble metal (full cast) (limited to 1 per tooth every 5 years)
 - D2790-High noble metal (full cast) (limited to 1 per tooth every 5 years)
 - D2794-Titanium (limited to 1 per tooth every 5 years)
 - 3/4 cast metallic: D2780-High noble; D2781-predominantly base or D2782-noble or D2783-porcelain/ceramic (limited to 1 per tooth every 5 years)
- D2952-Post and core
- D2953-each additional post
- D2954-prefabricated

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- D2957-each additional prefabricated post
- D2050-Core build-up
- Repair: D2980-crowns, D2981-inlays, D2982-onlays, D2983-veneers

Prosthodontics

- Replacement of existing bridges or dentures (limited to 1 every 5 years)
- Bridge abutments (See Inlays/Onlays and Crowns) (limited to 1 per tooth every 5 years)
- Pontics (limited to 1 per tooth every 5 years)
 - D6211-Base metal (full cast) (limited to 1 per tooth every 5 years)
 - D6212-Noble metal (full cast) (limited to 1 per tooth every 5 years)
 - D6210-High noble metal (full cast) (limited to 1 per tooth every 5 years)
 - D6242-Porcelain with noble metal (limited to 1 per tooth every 5 years)
 - D6241-Porcelain with base metal (limited to 1 per tooth every 5 years)
 - D6240-Porcelain with high noble metal (limited to 1 per tooth every 5 years)
 - D6245-Porcelain/ceramic
 - D6252-Resin with noble metal (limited to 1 per tooth every 5 years)
 - D6251-Resin with base metal (limited to 1 per tooth every 5 years)
 - D6250-Resin with high noble metal (limited to 1 per tooth every 5 years)
 - D6214-Titanium (limited to 1 per tooth every 5 years)
- D5281-Removable partial denture (unilateral) (limited to 1 every 5 years)
- One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics (limited to 1 every 5 years)
- D6545-Retainer – cast metal for resin bonded fixed prosthesis (limited to 1 every 5 years)
- D6548-Retainer – porcelain/ceramic for resin bonded fixed prosthesis (limited to 1 every 5 years)
- Dentures and partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
- D5110-Complete upper denture (limited to 1 every 5 years)
- D5120-Complete lower denture (limited to 1 every 5 years)
- D5130-Immediate upper denture (limited to 1 every 5 years)
- D5140-Immediate lower denture (limited to 1 every 5 years)
- Partial D5211-upper or D5212-lower, resin base (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- Partial D5213-upper or D5214-lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- Immediate partial denture, D5221-maxillary or D5222-mandibular, resin base (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- Immediate partial denture, D5223-maxillary or D5224-mandibular, cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- Interim partial denture, D5820-upper or D5821-lower
- Implants (only if determined as a dental necessity and limited to 1 per tooth every 5 years)
- Implant supported complete denture, partial denture (limited to 1 every 5 years)
- D6012-Surgical placement of interim implant body (limited to 1 every 5 years)
- D6010-Surgical placement of endosteal implant (limited to 1 every 5 years)
- D6040-Surgical placement of eposteal implant (limited to 1 every 5 years)

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- D6050-Implant transosteal, including hardware (limited to 1 every 5 years)
- D6080-Implant maintenance procedures (limited to 1 every 5 years)
- Implant supported complete denture, partial denture (limited to 1 every 5 years)
- D6056-Prefabricated abutment (limited to 1 every 5 years)
- D6057-Custom fabricated abutment (limited to 1 every 5 years)
- Abutment supported crown, (limited to 1 every 5 years)
 - D6058-porcelain/ceramic
 - D6059-porcelain fused to high noble metal
 - D6060-porcelain fused to predominately base metal
 - D6061-porcelain fused to noble metal
 - D6062-cast high noble metal
 - D6063-case predominately base metal
 - D6064-cast noble metal
- Implant supported crown, D6065-porcelain/ceramic; D6066-porcelain fused to high noble metal (titanium) or D6067-metal (titanium) (limited to 1 every 5 years)
- Implant supported retainer fixed partial denture, D6075-ceramic; D6076-porcelain fused to high noble metal or D6077-cast metal (limited to 1 every 5 years)
- Abutment supported retainer fixed partial denture, (limited to 1 every 5 years)
 - D6068-porcelain/ceramic
 - D6069-porcelain fused to high noble metal
 - D6070-porcelain fused to predominately base metal
 - D6071-porcelain fused to noble metal
 - D6072-cast high noble metal
 - D6073-predominately base metal
- D6104-Bone graft at time of implant placement (limited to 1 every 5 years)
- D6103-Bone graft for repair of peri-implant defect (limited to 1 every 5 years)
- Implant/abutment supported removable denture, D6110-upper or lower; D6112-partially edentulous arch upper or D6113-partially edentulous arch lower (limited to 1 every 5 years)
- Implant/abutment supported for fixed denture, D6114-completely edentulous arch upper; D6115-completely edentulous arch lower; D6116-partially edentulous arch upper or D6117-partially edentulous arch lower (limited to 1 every 5 years)
- D6090-Repair implant prosthesis (limited to 1 every 5 years)
- D6094-abutment supported crown titanium (limited to 1 every 5 years)
- D6095-Repair implant abutment (limited to 1 every 5 years)
- D6096-Remove broken implant retaining screw
- D6091-Replacement of semi-precision or precision attachment (limited to 1 every 5 years)
- D6101-Debridement of a peri-implant defect or defects surrounding a single implant (limited to 1 every 5 years)
- D6102-Debridement/osseous contouring of a peri-implant defect (limited to 1 every 5 years)
- D6100-Implant removal, by report (limited to 1 every 5 years)
- D6190-Implant index (limited to 1 every 5 years)
- D6055-Connecting bar
- D6081-Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure (limited to per tooth every 2 rolling years)

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- Retainer porcelain/ceramic, D6600-inlay or D6608-onlay (limited to 1 tooth every 5 years)
- Retainer inlay cast high noble metal, DD6602-two surfaces or D6603-three or more surfaces (limited to 1 tooth every 5 years)
- Retainer inlay cast predominantly base metal, DD6604-two surfaces or D6605-three or more surfaces (limited to 1 tooth every 5 years)
- Retainer inlay cast noble metal, DD6606-two surfaces or D6607-three or more surfaces (limited to 1 tooth every 5 years)
- Retainer onlay, D6611-cast high noble metal; D6613-cast predominately base metal or D6615-cast noble metal, three or more surfaces (limited to 1 tooth every 5 years)
- Retainer crown, D6740-procelain/ceramic; D6750-porcelain fused to high noble metal; D6751-porcelain fused to predominantly base metal or D6752-porcelain fused to noble metal (limited to 1 every 5 years)
- Retainer crown $\frac{3}{4}$ cast, D6780-high noble metal; D6781-predominantly base metal; D6782-noble metal or D6783-porcelain/ceramic (limited to 1 every 5 years)
- Retainer crown full cast, D6790-high noble metal; D6791-predominantly base metal or D6792-noble metal (limited to 1 every 5 years)
- D6940-Stress breakers
- D8210-Removable appliance therapy
- D8220-Fixed or cemented appliance therapy
- D9940-Occlusal guard, patients age 13 older
- D9943-Occlusal guard adjustment (Not eligible within first 6 months after placement of appliance)
- D6985-Pediatric partial denture
- Cleaning and inspection of removable complete denture, D9932-upper or D9935-lower
- Cleaning and inspection of removable partial denture, D9933-lower or D9934-upper

Orthodontic services

Medically necessary orthodontic treatment (includes removal of appliances, construction of retainer)

- D8010; D8020 or D8030-Limited orthodontic treatment of the primary, transitional and adolescent dentition
- D8050 or D8060-Interceptive orthodontic treatment of the primary, transitional dentition
- D8070 or D8080-Comprehensive orthodontic treatment of the transitional and adolescent dentition
- D8670-Periodic orthodontic treatment visit (as part of contract)
- D8660-Pre-orthodontic treatment visit to monitor growth or development
- D8680-Orthodontic retention (removal of appliances, construction and placement of retainers(s))
- D8691-Repair of orthodontic appliance
- D8693-Rebonding or recementing; and/or repair, as required of fixed retainers

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Eligible health services	In-network coverage*	Out-of-network coverage*
6. Specific conditions		
Birth center		
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)		
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.
Family planning services – other		
Voluntary sterilization for males		
Inpatient physician or specialist surgical 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
Outpatient physician or specialist surgical 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
Abortion		
Inpatient physician or specialist surgical services	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Outpatient physician or specialist surgical services	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment		
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.
Impacted wisdom teeth		
Impacted wisdom teeth	80% (of the negotiated charge)	80% (of the recognized charge)

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Accidental injury to sound natural teeth		
Accidental injury to sound natural teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Blood and body fluid exposure		
Blood and body fluid exposure	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.
Dermatological treatment		
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		
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		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	80% (of the recognized charge) No policy year deductible applies
<i>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.</i>		
Pregnancy complications		
Inpatient (room and board and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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Gender reassignment (sex change) treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Autism spectrum disorder		
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, 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.
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.
Services for children with developmental delays		
Services for children with developmental delays	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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Mental health treatment		
Mental health treatment – inpatient		
<p>Inpatient hospital mental disorders treatment (room and board and other hospital services and supplies)</p> <p>Inpatient residential treatment facility mental disorders treatment (room and board and other residential treatment facility services and supplies)</p> <p>Subject to semi-private room rate unless intensive care unit is required</p> <p>Mental disorder room and board intensive care</p> <p>Coverage is provided under the same terms and conditions as any other illness.</p>	<p>80% (of the negotiated charge) per admission</p>	<p>60% (of the recognized charge) per admission</p>
Mental health treatment – outpatient		
<p>Outpatient mental disorder treatment office visits to a physician or behavioral health provider (includes telemedicine or telehealth cognitive behavioral therapy consultations)</p> <p>Coverage is provided under the same terms and conditions as any other illness.</p>	<p>\$30 copayment per visit then the plan pays 100% (of the balance of the negotiated charge)</p> <p>No policy year deductible applies</p>	<p>60% (of the recognized charge) per visit</p>

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<p>Other outpatient mental disorders treatment (includes skilled behavioral health services in the home)</p> <p>Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment)</p> <p>Intensive outpatient program (at least 2 hours per day and at least 6 hours per week of clinical treatment)</p> <p>Coverage is provided under the same terms and conditions as any other illness.</p>	<p>80% (of the negotiated charge) per visit</p>	<p>60% (of the recognized charge) per visit</p>
Substance abuse related disorders treatment-inpatient		
<p>Inpatient hospital substance abuse detoxification (room and board and other hospital services and supplies)</p> <p>Inpatient hospital substance abuse rehabilitation (room and board and other hospital services and supplies)</p> <p>Inpatient residential treatment facility substance abuse (room and board and other residential treatment facility services and supplies)</p> <p>Subject to semi-private room rate unless intensive care unit is required</p> <p>Substance abuse room and board intensive care</p> <p>Coverage is provided under the same terms, conditions as any other illness.</p>	<p>80% (of the negotiated charge) per admission</p>	<p>60% (of the recognized charge) per admission</p>

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Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation		
Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine or telehealth cognitive behavioral therapy consultations) Coverage is provided under the same terms, conditions as any other illness.	\$30 copayment per visit then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) per visit
Outpatient substance abuse telemedicine or telehealth cognitive behavioral therapy consultations	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
Other outpatient substance abuse services (includes skilled behavioral health services in the home) Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment)* Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment) Coverage is provided under the same terms, conditions as any other illness.	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Oral and maxillofacial treatment (mouth, jaws, and teeth)		
Oral and maxillofacial treatment (mouth, jaws, and teeth)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Reconstructive surgery and supplies		
Reconstructive surgery and supplies	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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Eligible health services	In-network coverage* (IOE facility)	In-network coverage* (Non-IOE facility)	Out-of-network coverage*
Transplant services			
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.	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.	Covered according to the type of benefit and the place where the service is received.
Transplant services-travel and lodging			
Lifetime Maximum Benefit payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	\$10,000		
Maximum Benefit payable for Lodging Expenses per IOE patient	\$50 per night		
Maximum Benefit payable for Lodging Expenses per companion	\$50 per night		

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Eligible health services	In-network coverage*	Out-of-network coverage*
Treatment of infertility		
Basic infertility services		
Inpatient and outpatient care - 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.

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Eligible health services	In-network coverage*	Out-of-network coverage*
7. Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Diagnostic lab work and radiological services		
Diagnostic lab work and radiological services performed in the physician’s office, outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Cardiovascular disease testing		
Cardiovascular disease testing	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	1 screening every 5 years Limited to: Men age 45 and over but less than 76 and women age 55 and over but less than 76	
Chemotherapy		
Chemotherapy	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 infusion therapy		
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 or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Outpatient radiation therapy		
Outpatient radiation therapy	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.

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

Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Outpatient respiratory therapy		
Respiratory therapy	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Transfusion or kidney dialysis of blood		
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		
Cardiac rehabilitation	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
Pulmonary rehabilitation		
Pulmonary rehabilitation	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 rehabilitation and habilitation therapy services		
Outpatient physical, occupational, speech, and cognitive therapies	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Combined for short-term rehabilitation services and habilitation therapy services		
Acquired brain injury		
Acquired brain injury	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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

Chiropractic services		
Chiropractic services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	35 visits	
Evaluation and therapy for learning and developmental disabilities		
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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

Eligible health services	In-network coverage*	Out-of-network coverage*
8. Other services and supplies		
Acupuncture in lieu of anesthesia		
Acupuncture in lieu of anesthesia	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.
Alzheimer's disease		
Alzheimer's disease	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.
Ambulance service		
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 trial therapies (experimental or investigational)		
Clinical trial therapies	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.
Clinical trials (routine patient costs)		
Clinical trial (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)		
Durable medical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Enteral formulas and nutritional supplements		
Enteral formulas and nutritional supplements	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
Osteoporosis (non-preventive care)		
Physician's or specialist's 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.

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

Orthotic devices		
Orthotic devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Prosthetic devices		
Cranial prosthetics (Medical wigs)	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
All other prosthetic devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids and exams		
Hearing aid exams	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hearing aids	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids maximum per ear	One hearing aid per ear every policy year	
Podiatric (foot care) treatment		
Physician and Specialist non-routine foot care (non-surgical office visit)	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)		
Performed by a legally qualified ophthalmologist or optometrist, therapeutic optometrist, or any other providers acting within the scope of their license	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	

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

Pediatric comprehensive low vision evaluations		
Performed by a legally qualified ophthalmologist, optometrist, therapeutic optometrist, or any other providers acting within the scope of their license	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		
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	60% (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 disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received.	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	
<p>*Important note:</p> <p>Refer to the <i>Vision care</i> section in the certificate of coverage for the explanation of these vision care supplies.</p> <p>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.</p> <p>Coverage does not include the office visit for the fitting of prescription contact lenses.</p>		

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

Adult vision care		
Limited to covered persons age 19 and over		
Adult routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist, optometrist, therapeutic optometrist, or any other providers acting within the scope of their license	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum per policy year	1 visit	
Adult routine care services and supplies		
Eyeglass frames, prescription lenses or prescription contact lenses*	80% (of the negotiated charge) per item	60% (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 disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
<p>*Important note:</p> <p>Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.</p> <p>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.</p> <p>Coverage does not include the office visit for the fitting of prescription contact lenses.</p>		

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

Eligible health services	In-network coverage*	Out-of-network coverage*
9. Outpatient prescription drugs		
Plan features		
Outpatient prescription drug benefits are subject to the medical plan’s maximum out-of-pocket limits as explained on the schedule of benefits.		
Policy year deductible waiver		
The policy year deductible is waived for all prescription drugs filled at an in-network and out-of-network retail pharmacy or mail order pharmacy.		
Policy year deductible and copayment waiver for risk reducing breast cancer		
The policy year deductible and the prescription copayment will not apply to risk reducing breast cancer prescription drugs when obtained 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 policy year deductible and the prescription 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 copayment will not apply to contraceptive methods when obtained at an in-network pharmacy.		
This means that such contraceptive methods are paid at 100% for:		
<ul style="list-style-type: none">• Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%.• If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%.		
The policy year deductible and the prescription copayment continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		

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

Preferred generic prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	\$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	\$15 copayment per supply then the plan pays 60% (of the balance of the negotiated charge) No policy year deductible applies
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	\$45 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered
Non-preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	\$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	\$60 copayment per supply then the plan pays 60% (of the balance of the negotiated charge) No policy year deductible applies
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	\$180 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered
Preferred brand-name prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	\$45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	\$45 copayment per supply then the plan pays 60% (of the balance of the negotiated charge) No policy year deductible applies
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	\$135 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered

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

Non-preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	\$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	\$60 copayment per supply then the plan pays 60% (of the balance of the negotiated charge) No policy year deductible applies
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	\$180 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Orally administered anti-cancer prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge) per prescription or refill No policy year deductible applies	100% (of the recognized charge) per prescription or refill No policy year deductible applies
Preventive care drugs and supplements		
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
Maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by calling the toll-free number on your ID card.	

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

Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer prescription drugs 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
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, contact Member Services by calling the toll-free number on your ID card.	
Tobacco cessation prescription and over-the-counter drugs		
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
Maximums	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits above. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs, contact Member Services by calling the toll-free number on your ID card.	
Important note: When you get prescription drugs from a pharmacy, the pharmacy will only require you at that time to pay the lowest amount out of the following:		
<ul style="list-style-type: none">• The applicable copayment• The allowable claim amount for the prescription drug• The amount you would pay for the prescription drug if you bought it without using your plan or any other prescription drug benefits or discounts.		
You may later have to pay additional cost sharing for these prescription drugs. For example, if you have not met your prescription drug deductible (if applicable), you may owe additional cost sharing.		

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

General coverage provisions

This section provides detailed explanations about the:

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

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

Policy year deductible provisions

Eligible health services applied to the out-of-network **policy year deductibles** will be applied to satisfy the in-network **policy year deductibles**. **Eligible health services** applied to the in-network **policy year deductibles** will be applied to satisfy the out-of-network **policy year deductibles**.

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

Individual

This is the amount you owe for in-network and out-of-network **eligible health services** each **policy year** before the plan begins to pay for **eligible health services**. This **policy year deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the **policy year deductible**, this plan will begin to pay for **eligible health services** for the rest of the **policy year**.

Family

This is the amount you and your covered dependents owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. After the amount you and your covered dependents pay for eligible health services reach this family policy year deductible, this plan will begin to pay for eligible health services that you and your covered dependents incur for the rest of the policy year.

To satisfy this family policy year deductible limit for the rest of the policy year, the following must happen:

- The combined eligible health services that you and each of your covered dependents incur towards the individual policy year deductibles must reach this family policy year deductible limit in a policy year.

When this occurs in a policy year, the individual policy year deductibles for you and your covered dependents will be considered to be met for the rest of the policy year.

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

Copayments
<p>In-network coverage</p> <p>This is a specified dollar amount or percentage that must be paid by you when you receive eligible health services from an in-network provider. If Aetna compensates in-network providers on the basis of the negotiated charge amount, your percentage copayment is based on this amount.</p>
<p>Out-of-network coverage</p> <p>This is a specified dollar amount or percentage that must be paid by you when you receive eligible health services from an out-of-network provider. If Aetna compensates out-of-network providers on the basis of the recognized charge amount, your percentage copayment is based on this amount.</p>
Coinsurance
<p>Coinsurance is both the percentage of eligible health services that the plan pays and what you pay. The specific percentage that we have to pay for eligible health services is listed earlier in the schedule of benefits.</p>
Maximum out-of-pocket limits provisions
<p>Eligible health services that are subject to the maximum out-of-pocket limits include covered benefits provided under the medical plan and outpatient prescription drug benefits provided under the prescription drug benefit.</p>
<p>Eligible health services applied to the out-of-network maximum out-of-pocket limit will not be applied to satisfy the in-network maximum out-of-pocket limit and eligible health services applied to the in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.</p>
<p>The maximum out-of-pocket limit is the maximum amount you are responsible to pay for copayments, coinsurance and policy year deductibles for eligible health services during the policy year. This plan has an individual and family maximum-out-of-pocket limit. As to the individual maximum out-of-pocket limit each of you must meet your maximum out-of-pocket limit separately.</p>
<p>Individual</p> <p>Once the amount of the copayments, coinsurance and policy year deductibles you have paid for eligible health services during the policy year meets the individual maximum out-of-pocket limits, this plan will pay:</p> <ul style="list-style-type: none"> • 100% of the negotiated charge for in-network covered benefits • 100% of the recognized charge for out-of-network covered benefits <p>that apply for the rest of the policy year for that person.</p>

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

Family

Once the amount of the **copayments, coinsurance** and **policy year deductibles** you and each of your covered dependents have paid for **eligible health services** during the **policy year** meets the individual **maximum out-of-pocket limits**, this plan will pay:

- 100% of the **negotiated charge** for in-network **covered benefits**
- 100% of the **recognized charge** for out-of-network **covered benefits**

that apply for the rest of the **policy year** for that person.

To satisfy this family **maximum out-of-pocket limit** for the rest of the policy year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a **policy year**.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a **covered benefit**, your **copayment, coinsurance** for that **covered benefit** will not count toward satisfying the **maximum out-of-pocket limit** amount.

Medical and Outpatient Prescription Drugs

In-network care

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

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services

Out-of-network care

Costs that you incur that do not apply to your out-of-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
- **Preauthorization** 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.

10,40,50,60,70,100,90,95,100,105

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



Student Health Insurance

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

Certificate of Coverage

Prepared exclusively for:

Policyholder:	Angelo State
Policyholder number:	686176
Student policy effective date:	08/15/18
Plan effective date:	08/15/18
Plan issue date:	10/23/18

Underwritten by Aetna Life Insurance Company

IMPORTANT NOTICES:

- **Notice of Non-Discrimination:**
Aetna Life Insurance Company does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.
- **Sanctioned Countries:**
If coverage provided under this **student policy** violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible health services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Welcome

Thank you for choosing **Aetna**.

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

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

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

Oh, and each of these documents may have amendments or riders attached to them. They change or add to the documents they’re part of. .

Where to next? Flip through the *Table of contents* or try the *Let’s get started!* section right after it. The *Let’s get started!* section gives you a thumbnail sketch 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** and any **covered dependents**
- When we say “us”, “we”, and “our”, we mean **Aetna**
- Some words appear in **bold** type. We define them in the *Glossary* section

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

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible health services** for which your plan has the obligation to pay.

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

How your plan works – starting and stopping coverage

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

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

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

Eligible health services

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

So what are **eligible health services**? They are health care services that meet these three requirements:

- They are listed in the *Eligible health services under your plan* section.
- They are not carved out in the *What your plan doesn't cover –eligible health service exceptions and exclusions* section. We refer to this entire section as the “*Exceptions*” section.
- They are not beyond any limits in the schedule of benefits.

Paying for eligible health services– the general requirements

There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:

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

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

Paying for eligible health services– sharing the expense

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

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

Disagreements

We know that people sometimes see things differently.

The plan tells you how we will work through our differences. And if we still disagree, an independent group of experts called an “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 appeals procedures* section.

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

Your in-network coverage helps you:

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

School health services

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

Aetna's network of providers

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

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

How your plan works while you are covered out-of-network coverage

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

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

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

Your out-of-network coverage:

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

You will find details on:

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

How to contact us for help

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

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

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

You can also contact us by:

- Calling our Member Services at the toll-free number 1-877-480-4161
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

Your ID card

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

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

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

Who the plan covers

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

You will find information in this section about:

- Who is eligible?
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible?

You are eligible if you are a:

- Domestic undergraduate student enrolled in six (6) or more credit hours during the long semester or three (3) or more credit hours during the summer;
- Domestic graduate students enrolled in one (1) or more credit hours;
- Intern, fellow, other student working on their dissertation or thesis

For continuation of coverage plans, you must have been:

- A **covered student** under the **student policy** during this **policy year** or in the previous **policy year** and
- Covered under the **student policy** for at least 1 semester in a row

Medicare eligibility

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

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

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

When you can join the plan

As a student you can enroll yourself and your dependents:

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

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

When you can join the continuation of coverage plan

For continuation of coverage plans, you must:

- Enroll within 31 days of the date you lose coverage under the **student policy**
- Elect a continuation period of up to 6 months
- Give us the all of the **premium** contribution for that period

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

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

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

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

- Your legal spouse that resides with you
- Your domestic partner who meets the rules set by the **policyholder** and requirements under state law
- Your dependent children – your own or those of your spouse or domestic partner
 - The children must be under 26 years of age, and they include:
 - Biological children
 - Stepchildren
 - Legally adopted children
 - A child legally placed with you for adoption (including a foster child)
 - Foster children
 - Children you are responsible for under a qualified medical or dental support order or court-order (whether or not the child resides with you)
 - Grandchildren in your court-ordered custody
 - A grandchild whose parent is already covered as a dependent under this plan
 - Any other child with whom you have a parent-child relationship

A dependent does not include:

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

You may continue coverage for a disabled child past the age limit shown above. See the *How can you extend coverage for your disabled child beyond the plan age limits?* under the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

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

- A **covered dependent** under the **student policy** during this **policy year** or in the previous **policy year** and
- Covered under the **student policy** for at least 6 months in a row

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

Dependents enrolled in the **student policy** because of a court order can be covered under a continuation of coverage plan.

Adding new dependents

You can add the following new dependents at any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
 - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
 - Ask the policyholder when benefits for your spouse will begin. It will be:
 - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
 - Within 31 days of the date of your marriage.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your health plan.
 - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by the policyholder.
 - Ask the policyholder when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
- A newborn child - Your newborn child is covered on your health plan for the first 31 days from the moment of birth.
 - To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31 day period. You can provide verbal or written notice.
 - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
 - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
 - If your coverage ends during this 31 day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.
- An adopted child or a child legally placed with you for adoption - A child that you, or that you and your spouse or domestic partner adopts or is placed with you for adoption is covered on your plan for the first 31 days after you become party in a suit to adopt the child or the adoption or the placement is complete.
 - To keep your child covered, we must receive your completed enrollment information within 31 days after you become party in a suit to adopt the child or the adoption or placement for adoption.
 - You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
 - If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
 - If your coverage ends during this 31 day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31 day period has not ended.
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
 - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
 - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
 - To keep your stepchild covered, we must receive your completed enrollment information within 31 days after the date of your marriage or your Declaration of Domestic Partnership.
 - You must still enroll the stepchild within 31 days after the date of your marriage or your Declaration of Domestic Partnership even when coverage does not require payment of an additional premium contribution for the stepchild.

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

Notification of change in status

It is important that you notify us 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
- Change in marital status
- Enrollment in Medicare
- Change of covered dependent status
- You or your covered dependents enroll in any other health plan

Special times you and your dependents can join the plan

You can enroll in these situations:

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

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

Effective date of coverage

Enrollment

Student coverage

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

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

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

Dependent coverage

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

Continuation of coverage plan

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

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

Late enrollment

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

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

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

Medical necessity and preauthorization requirements

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

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

- The **eligible health service** is **medically necessary**

This section addresses the **medical necessity** and **preauthorization** requirements.

Medically necessary; medical necessity

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

The **medical necessity** requirements are stated in the *Glossary* section, where we define "**medically necessary, medical necessity**". That is where we also explain what our medical directors or their **physician** designees consider when determining if an **eligible health service** is **medically necessary**.

Preauthorization

You need **preauthorization** from us for some **eligible health services**.

Preauthorization for medical services and supplies

In-network care

Your in-network **physician** is responsible for obtaining any necessary **preauthorization** before you get the care. If your in-network **physician** doesn't get a required **preauthorization**, you will only have to pay your applicable **policy year deductible** and/or **copayment/coinsurance**. We may apply a penalty of \$500 of the eligible **medically necessary** charges to your **physician** if they don't get a required **preauthorization**. If your in-network **physician** requests **preauthorization** 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 **preauthorization** from us for any services and supplies on the **preauthorization** list. If you do not **preauthorize**, 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 **preauthorization** appears later in this section. Also, for any **preauthorization** benefit penalty that is applied, see the schedule of benefits *Preauthorization covered benefit penalty* section.

Preauthorization call

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

Non- emergency admissions:	You, your physician or the facility will need to call and request preauthorization at least 3 days before the date you are scheduled to be admitted.
An emergency admission :	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission :	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness , the diagnosis of an illness , or an injury .
Outpatient non- emergency services requiring preauthorization :	You or your physician must call at least 3 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Notification calls for certain medical conditions

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

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

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

Inpatient and outpatient preauthorization

When you have an inpatient admission to a facility, we will notify you, your **physician** and the facility about your **preauthorized** length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be **preauthorized**. 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 **preauthorization**, we will notify you, your **physician** and the facility about your **preauthorized** 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 **preauthorized**. 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 **preauthorization** determines that the **stay** or outpatient services and supplies are not **covered benefits**, the notification will explain why and how you can appeal our decision. You or your **provider** may request a review of the **preauthorization** decision. See the *When you disagree - claim decisions and appeals procedures* section.

What if you don't obtain the required preauthorization?

If you don't obtain the required **preauthorization**:

- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits *Preauthorization 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 require preauthorization?

Preauthorization is required for the following types of services and supplies:

Inpatient services and supplies	Outpatient services and supplies
ART services	Applied behavior analysis
Obesity (bariatric) surgery	Certain prescription drugs and devices*
Stays in a hospice facility	Complex imaging
Stays in a hospital	Comprehensive infertility services
Stays in a rehabilitation facility	Cosmetic and reconstructive surgery
Stays in a residential treatment facility for treatment of mental disorders and substance abuse	Emergency transportation by airplane
Stays in a skilled nursing facility	Intensive outpatient program (IOP) – mental disorder and substance abuse diagnoses
	Kidney dialysis
	Knee surgery
	Medical injectable drugs , (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, botox, hepatitis C medications)*
	Outpatient back surgery not performed in a physician's office
	Outpatient detoxification
	Partial hospitalization treatment – mental disorder and substance abuse diagnoses
	Psychological testing/neuropsychological testing
	Sleep studies
	Transcranial magnetic stimulation (TMS)
	Wrist surgery

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

Preauthorization for prescription drugs and devices

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

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

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

Step therapy

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

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

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

Please see the *When you disagree - claim decisions and appeal procedures* section for more information on your appeals rights in these situations.

How can I request a medical exception?

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

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

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

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

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

Eligible health services under your plan

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

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

For example,

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

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

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

Important note:

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

1. Preventive care and wellness

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

Important notes:

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

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

2. Diagnostic testing for the treatment or diagnosis of a medical condition will not be covered under the preventive care and wellness benefit. For those tests, you will pay the cost sharing specific to **eligible health services** for diagnostic testing for the treatment or diagnosis of a medical condition.
3. Gender-specific preventive care and wellness benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

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

Routine physical exams

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

Routine physical exams for covered persons age 18 or more	
<ul style="list-style-type: none"> • Abdominal aortic aneurysm – a one-time screening for men who have ever smoked • Alcohol misuse screening and counseling in a primary care setting • Blood pressure screening • Cholesterol screening for adults at increased risk for coronary heart disease • Colorectal cancer screening for adults over 50 • Depression screening for adults when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up • Prostate specific antigen (PSA) tests 	<ul style="list-style-type: none"> • Diabetes (Type 2) screening for adults with high blood pressure • HIV screening for all adults at higher risk • Obesity screening and counseling for all adults • Tobacco use screening for all adults and cessation interventions for tobacco users • Syphilis screening for all adults at higher risk • Sexually transmitted infection prevention counseling for adults at higher risk • Diet counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease • Aspirin use as recommended by their physician

Routine physical exams for covered persons from birth to age 18	
<ul style="list-style-type: none"> • Autism screening • Behavioral assessments • Cervical dysplasia screening for sexually active females • Congenital hypothyroidism screening for newborns • Developmental screening, and surveillance throughout childhood • Dyslipidemia screening at higher risk of lipid disorders • Hearing screening for all newborns • Hematocrit or hemoglobin screening • Hemoglobinopathies or sickle cell screening for newborns • HIV screening for adolescents at higher risk • Lead screening for covered persons at risk of exposure • Obesity screening and counseling • Phenylketonuria (PKU) screening for this genetic disorder in newborns • Tuberculin testing for covered persons at higher risk of tuberculosis 	<ul style="list-style-type: none"> • Hearing and vision screening to determine the need for hearing and vision correction • Alcohol and drug use assessments for adolescents • Fluoride chemoprevention supplements for children without fluoride in their water source • Gonorrhea preventive medication for the eyes of all newborns • Height, weight and body mass index measurements • Iron supplements for covered persons ages 6 to 12 months at risk for anemia • Medical history throughout development • Oral health risk assessment • Sexually transmitted infection prevention counseling for adolescents at higher risk • Depression screening for adolescents • Blood pressure screening
Routine physical exams for women	
<ul style="list-style-type: none"> • Anemia screening on a routine basis for pregnant women • Bacteriuria urinary tract or other infection screening for pregnant women • BRCA counseling about genetic testing for women at higher risk • Breast cancer mammography screenings • Breast cancer chemoprevention counseling for women at higher risk • Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women • Cervical cancer screening for sexually active women • Pap smear; or screening using liquid-based cytology methods, either alone or in conjunction with a test approved by the United States Food and Drug Administration • A gynecological exam that includes a rectovaginal pelvic exam for women who are at risk of ovarian cancer) • Chlamydia infection screening for younger 	<ul style="list-style-type: none"> • Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes • Gonorrhea screening for all women at higher risk • Hepatitis B screening for pregnant women at their first prenatal visit • Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women • Human Papillomavirus (HPV) DNA test: high risk HPV DNA testing • Osteoporosis screening for women depending on risk factors • Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk • Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users • Sexually transmitted Infections counseling for sexually active women • Syphilis screening for all pregnant women or other women at increased risk

<p>women and other women at higher risk</p> <ul style="list-style-type: none"> • Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs (see the contraception sections, below for more detail) • Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test • Domestic and interpersonal violence screening and counseling for all women • Folic acid supplements for women who may become pregnant 	<ul style="list-style-type: none"> • Well-woman visits to obtain recommended preventive services
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Eligible health services also include:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration.
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial **hospital** checkup

Preventive care immunizations

Eligible health services include immunizations provided by your **physician** for infectious diseases.

Immunizations for adults age 18 or more	Immunizations for children from birth to age 18
<ul style="list-style-type: none">• Hepatitis A• Hepatitis B• Herpes zoster• Human papillomavirus• Influenza• Measles, mumps, rubella• Meningococcal• Pneumococcal• Tetanus, diphtheria, pertussis Varicella	<ul style="list-style-type: none">• Diphtheria, tetanus, pertussis• Haemophilus influenzae type b• Hepatitis A• Hepatitis B• Human papillomavirus• Inactivated poliovirus• Influenza• Measles, mumps, rubella• Meningococcal• Pneumococcal• Rotavirus• Varicella• Any other immunization that is required for the child by law

Eligible health services also include immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment.

Well woman preventive visits

Eligible health services include your routine:

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

Preventive screening and counseling services

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

Here is more detail about those benefits:

- **Obesity and/or healthy diet counseling**

Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:

- Preventive counseling visits and/or risk factor reduction intervention
- Nutritional counseling
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**

Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:

- Preventive counseling visits
- Risk factor reduction intervention
- A structured assessment

- **Use of tobacco products**

Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:

- Preventive counseling visits
- Treatment visits
- Class visits

Tobacco product means a substance containing tobacco or nicotine such as:

- Cigarettes
- Cigars
- Smoking tobacco
- Snuff
- Smokeless tobacco
- Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**

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

- **Genetic risk counseling for breast and ovarian cancer**

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

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms (All forms of low-dose mammography, including digital mammography and breast tomosynthesis)
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies (includes:
 - Bowel preparation medications
 - Anesthesia
 - Removal of polyps performed during a screening procedure
 - Pathology exam on any removed polyps)
- Lung cancer screenings

Unless otherwise stated in the schedule of benefits, these benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

Prenatal care

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

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

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

Important note:

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

Comprehensive lactation support and counseling services

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

Breast feeding durable medical equipment

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

Breast pump

Eligible health services include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**
- The buying of:
 - An electric breast pump (non-**hospital** grade, cost is covered by your plan once every 3 years) or
 - A manual breast pump (cost is covered by your plan once per pregnancy)

If an electric breast pump was purchased within the previous 3 year period, the purchase of another electric breast pump will not be covered until a 3 year period has elapsed since the last purchase.

Breast pump supplies and accessories

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

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

Family planning services –contraceptives counseling, devices and voluntary sterilization

Eligible health services include family planning services such as:

Counseling services

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

Contraceptives

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

Voluntary sterilization

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

Important note:

See the following sections for more information:

- *Family planning services - other*
- *Maternity care*
- *Well newborn nursery care*
- *Treatment of basic infertility*
- *Outpatient prescription drugs*

2. Physicians and other health professionals

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

Eligible health services include services 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** or **telehealth**

Allergy testing and treatment

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

- Allergy testing
- Allergy injections treatment

Physician and specialist –surgical services

Eligible health services include the services of:

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

When your **surgery** requires two or more surgical procedures:

- Using the same approach and at the same time or
- Right after each other

we will pay for the one that costs the most.

Your surgeon may perform two or more surgical or bilateral procedures on your during one operation but in separate operative fields. When this happens, we will pay:

- 100% of the surgery for the primary procedures
- 50% of the surgery for the secondary procedure
- 25% of the surgery for each of the other procedures, if any

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

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

Anesthetist

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

Surgical assistant

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

Physician and specialist – outpatient surgical services

Eligible health services include the services of:

- The surgeon who performs your **surgery** in the outpatient department of a **hospital** or **surgery center**
- Your surgeon who you visit before and after the **surgery**

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

Anesthetist

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

In-hospital non-surgical physician services

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

Consultant services (non-surgical and non-preventive)

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

Covered benefits include treatment by the consultant.

The consultation may happen by way of **telemedicine**.

Second surgical opinion

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

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

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

Alternatives to physician and specialist office visits

Walk-in clinic

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

- Unscheduled, non-medical emergency **illnesses** and **injuries**
- The administration of immunizations administered within the scope of the clinic’s license

3. Hospital and other facility care

Hospital care

Eligible health services include inpatient and outpatient **hospital** care.

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

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **health professionals** employed by the **hospital**
- Operating and recovery rooms
- **Intensive care units** of a **hospital**
- Administration of blood and blood derivatives, including the cost of the blood or blood product
- Radiation therapy
- Inhalation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a **hospital**

Preadmission testing

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

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

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

Anesthesia and related facility charges for a dental procedure

Eligible health services include:

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

for your dental procedure.

Your **physician** will also tell us you:

- Have a physical, mental, or medical condition that requires you be treated in a **hospital** or **surgery center**
- Are developmentally disabled
- Are in poor health and have a medical need for general anesthesia

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

Alternatives to hospital stays

Outpatient surgery (facility charges)

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

Eligible health services also include the following oral **surgery** services:

- Removal of tumors, cysts, all malignant and premalignant lesions and growths of the jaws, cheeks, lips, tongue, roof and floor of the mouth
- Incision and drainage of facial abscess
- **Surgical procedures** involving salivary glands and ducts and non-dental related procedures of the accessory sinuses
- Removal of complete bony impacted teeth

Important note:

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

Home health care

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

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

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

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

Hospice care

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

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

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

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

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

Skilled nursing facility

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

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

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

For your **stay** in a **skilled nursing facility** to be eligible for coverage, the following conditions must be met:

- The **skilled nursing facility** admission will take the place of:
 - An admission to a **hospital** or sub-acute facility or
 - A continued **stay** in a **hospital** or sub-acute facility.
- There is a reasonable expectation that your condition will improve enough to go home within a reasonable amount of time
- The **illness** or **injury** is severe enough to require constant or frequent skilled nursing care on a 24-hour basis

4. Emergency services and urgent care

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

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

- A medical screening examination or other evaluation, required by state or federal law and provided to you in a **hospital** emergency facility or comparable facility, necessary to determine if an **emergency medical condition** exists
- Treatment to stabilize your condition
- **Care** in an emergency facility or comparable facility after you become stable. But only if the treating **provider** asks us and we approve the service. We will approve or deny the request within an hour after receiving the request

As always, you can get **emergency services** from **in-network providers**. However, you can also get **emergency services** from **out-of-network providers**. When you are treated by an **out-of-network provider** when an **in-network provider** is not reasonably available or for an **emergency medical condition**, we will reimburse the **out-of-network provider** at the usual and customary charge. Please contact Member Services if you receive a bill from the **out-of-network provider**. We will work to resolve the outstanding balance so that all you pay is the appropriate **network deductible**, **coinsurance**, or **copayments** under your plan.

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

You will be credited for:

- Any amounts due to you that would have been paid if the **provider** were an **in-network provider**
- Any out-of-pocket amounts that you paid to the **provider**, in excess of the allowed amount. Such amounts will be credited to your **calendar year deductible** amount and plan **coinsurance** limits, as applicable

For follow-up care, you are covered when:

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

In case of a medical emergency

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

Non-emergency condition

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

In case of an urgent condition

Urgent condition

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

Non-urgent care

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

Examples of non-urgent care are:

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

5. Pediatric dental care

Eligible health services include dental services and supplies provided by a **contracting** or **non-contracting dental provider**.

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

Dental emergencies

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

If you have a **dental emergency**, you should consider calling your dental **contracting dental provider** who may be more familiar with your dental needs. However, you can get treatment from any **dentist** including one that is a non-contracting dental provider. If you need help in finding a **dentist**, call Member Services at the toll-free number on your ID card.

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

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

What rules and limits apply to dental care?

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

When does your plan cover orthodontic treatment?

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

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

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

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

When does your plan cover replacements?

The plan's "replacement rule" applies to:

- Crowns
- inlays
- onlays
- veneers
- complete dentures
- removable partial dentures
- fixed partial dentures (bridges)
- other prosthetic services

The "replacement rule" is that certain 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.

Getting an advance claim review

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

Important note:

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

When to get an advance claim review

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

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

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

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

What is a course of dental treatment?

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

When does your plan cover other treatment?

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

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

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

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

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

6. Specific conditions

Birthing center

Eligible health services include prenatal (non-preventive care) and postpartum care and obstetrical services from your **provider**. A **provider** includes, but is not limited to, a licensed mid-wife.

After your child is born, **eligible health services** include:

- 48 hours of care in a **birthing center** after an uncomplicated vaginal delivery
- 96 hours of care in a birthing center after an uncomplicated cesarean delivery
- A shorter **stay** if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier
- The mother could be discharged earlier. If so, the plan will pay for 1 post-delivery home visits by a health care **provider**

These time frames apply if your child is born without any problem. If your **provider** tells us that you had a problem during your pregnancy or during childbirth, we will cover the **stay** the same as we would for any other **illness** or **injury**.

Eligible health services also include charges made by:

- An operating **physician** for:
 - Delivery
 - Pre- and post-natal care

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

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

Diabetic services and supplies (including equipment and training)

Eligible health services include:

- Services and supplies
 - Foot care to minimize the risk of infection
 - Insulin and insulin analog preparations
 - Hypodermic needles and syringes used for the treatment of diabetes
 - Injection aids, including devices used to assist with insulin injection and needleless systems
 - Diabetic test agents, including, but not limited to, visual reading and urine test strips and tablets
 - Lancets/lancing devices
 - Prescribed oral medications whose primary purpose is to influence blood sugar
 - Non-**prescription** medications for the purpose of controlling blood sugar
 - Alcohol swabs
 - Injectable glucagons
 - Glucagon emergency kits
- Biohazard disposal containers equipment
 - External and implantable insulin pumps and pump supplies
- Repairs and necessary maintenance of insulin pumps if not covered by manufacturer's warranty or purchase agreement
 - Rental fees for pumps during repair and maintenance Blood glucose meters without special features, unless required due to blindness

- Podiatric appliances, including therapeutic shoes to prevent complications of diabetes Training
 - Self-management training provided by a health care **provider** certified in diabetes self-management training. We will also cover training for a person who cares for you, if a provider sends a written order.

“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.

See your **pharmacy** plan benefits for coverage of blood glucose meters and external insulin pumps.

Eligible health services also include new or improved diabetic treatment, equipment and supplies that become available. They must be:

- Approved by the United States Food and Drug Administration
- Prescribed by your **provider**
- Sent to us in writing by your **provider**

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

Family planning services – other

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

- Voluntary sterilization for males
- Abortion to the extent the pregnancy places the woman’s life in serious danger or at a serious risk of substantial impairment of a major bodily function

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

Eligible health services include the:

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

for **TMJ** and **CMJ**) by a **provider**.

Impacted wisdom teeth

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

Accidental injury to sound natural teeth

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

Blood and body fluid exposure

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

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

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

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

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

Dermatological treatment

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

For coverage of lab work, radiological services and surgery, see the *Outpatient diagnostic testing* and *Physician and specialist surgical services* sections.

Maternity care

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

After your child is born, **eligible health services** include:

- Not less than 48 hours of inpatient care in a health care facility after an uncomplicated vaginal delivery
- Not less than 96 hours of inpatient care in a health care facility after an uncomplicated cesarean delivery
- A shorter **stay** if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier
- If you and your **physician** agree to a shorter **stay**, you and your newborn will receive timely post-delivery care. A physician, registered nurse, or other licensed health care **provider** can provide post-delivery care. You can choose to get the post-delivery care in:
 - Your home
 - A health care **provider's** office
 - A health care facility
 - Another location determined to be appropriate under applicable Texas law

We will cover congenital defects for a newborn the same as we would for any other **illness or injury**.

Well newborn nursery care

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

- Well newborn nursery care during the mother's **stay** but for not more than four days for a normal delivery
- **Hospital** visits and consultations for the well newborn by a **physician** but for not more than 1 visit per day

Pregnancy complications

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

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

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

We will cover pregnancy complications the same as we would for any other **illness** or **injury**.

Alzheimer's disease

Eligible health services include the following services by a physician to diagnose Alzheimer's disease:

- A history and physical
- A neurological evaluation
- A psychological evaluation
- Lab services

Autism spectrum disorder

Autism spectrum disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or pervasive development disorder – not otherwise specified.

Eligible health services include the "generally recognized services" provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder.

We will cover screenings of your dependent children for autism spectrum disorder. This is done at ages 18 months and 24 months.

Treatment for autism spectrum disorder is covered from the date of diagnosis.

We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan. You can receive treatment from a **provider** that meets at least one of the following criteria:

- Is licensed, certified or registered by an appropriate agency of Texas
- Has professional credentials that are recognized and accepted by an appropriate agency of the United States
- Is certified as a provider under the TRICARE military health system

You can also receive treatment from someone working under the supervision of a **provider** as described above.

As used here, “generally recognized services” can include:

- Evaluation and assessment services
- applied behavior analysis
- Behavior training and behavior management
- Speech therapy
- Occupational therapy
- Physical therapy
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder

Important note:

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

Services for children with developmental delays

Eligible health services for a child with developmental delays include:

- Occupational therapy evaluations and services
- Physical therapy evaluations and services
- Speech therapy evaluations and services
- Dietary or nutrition evaluations

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- If the child is **homebound**, therapy services may be provided in the child’s home.

Mental health treatment

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

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

A general medical **hospital** is not usually equipped to treat **mental disorders**. Once it has stabilized your condition, it will either:

- Admit you to its separate psychiatric section or unit or
- Transfer you to a **psychiatric hospital** or **residential treatment facility**

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

- Outpatient treatment received while not confined as an inpatient in a general medical **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
 - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (includes **telemedicine** and **telehealth** consultations)
 - Individual, group and family therapies for the treatment of mental health
 - Other outpatient mental health treatment such as:
 - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**

- **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**
- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
 - You are homebound
 - Your **physician** orders them
 - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
 - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
- Electro-convulsive therapy (ECT)
- Mental health injectables
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- 23 hour observation

Substance abuse related disorders treatment

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

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

A general medical **hospital** is not usually equipped to treat **substance abuse**. Once a general medical **hospital** has stabilized your condition, it will either:

- Admit you to its separate **substance abuse** section or unit
- Transfer you to a **psychiatric hospital** or **residential treatment facility**

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

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

- Outpatient treatment received while not confined as an inpatient in a general medical **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
 - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (includes **telemedicine** and **telehealth** consultations)
 - Individual, group and family therapies for the treatment of **substance abuse**
 - Other outpatient **substance abuse** treatment such as:
 - Outpatient **detoxification**
 - **Partial hospitalization treatment** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
 - **Intensive outpatient program** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
 - Ambulatory **detoxification** which are outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications

- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
 - You are homebound
 - Your **physician** orders them
 - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
 - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
- Treatment of withdrawal symptoms
- Substance use disorder injectables
- 23 hour observation

Oral and maxillofacial treatment (mouth, jaws and teeth)

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

- Non-surgical treatment of infections or **illness**.
 - **Surgery** needed to:
 - Treat a fracture, dislocation, or wound.
 - Cut out teeth partly or completely impacted in the bone of the jaw, teeth that will not erupt through the gum, other teeth that cannot be removed without cutting into bone, the roots of a tooth without removing the entire tooth, cysts, tumors, or other diseased tissues.
 - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
 - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- **Hospital** services and supplies received for a **stay** required because of your condition.
 - Dental work, **surgery** and **orthodontic treatment** needed to remove, repair, restore or reposition:
 - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair, and are firmly attached to your jaw bone at the time of your **injury**.
 - Other body tissues of the mouth fractured or cut due to **injury**.
- Crowns, dentures, bridges, or in-mouth appliances only for:
 - The first denture or fixed bridgework to replace lost teeth.
 - The first crown needed to repair each damaged tooth.
 - An in-mouth appliance used in the first course of **orthodontic treatment** after an **injury**.
- **Accidental injuries** and other trauma. Oral **surgery** and related dental services to return **sound natural teeth** to their pre-trauma functional state. **Sound natural teeth** are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.
 - If a child needs oral surgery as the result of **accidental injury** or trauma, surgery may be postponed until a certain level of growth has been achieved.
- Removal of tumors and cysts requiring pathological examination.
- Fluoride treatment, removal of teeth and hyperbaric oxygen therapy in connection with covered radiation therapy.
- Oral **surgery** and related dental services to correct a gross anatomical defect present at birth that results in significant functional impairment of a body part, if the services or supplies will improve function.
 - Related dental services are limited to:
 - The first placement of a permanent crown or cap to repair a broken tooth
 - The first placement of dentures or bridgework to replace lost teeth
 - Orthodontic therapy to preposition teeth

Reconstructive surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed. Services and supplies include:
 - An implant.
 - Areolar and nipple reconstruction.
 - Areolar and nipple re-pigmentation.
 - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
 - Treatment of physical complications of all stages of the mastectomy, including lymphedema and prosthetic devices.
- Unless you or your **physician** decides that a shorter time period for inpatient care is appropriate, **eligible health services** for reconstructive breast **surgery** include:
 - 48 hours of inpatient care following a mastectomy
 - 24 hours of inpatient care in an **in-network** health care facility after a lymph node dissection for treatment of breast cancer
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
 - The defect results in severe facial disfigurement or major functional impairment of a body part.
 - The purpose of the **surgery** is to improve function.
- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.
- Your **surgery** corrects a craniofacial abnormality defect. This includes the abnormality that is caused by a congenital defect, developmental deformity, trauma or **illness**. The purpose of the **surgery** is to:
 - Improve function
 - Attempt to create a normal appearance

Transplant services

Organ transplants

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

Organ means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow

Aetna's network of transplant specialist facilities

When you get transplant services from an **in-network provider**, the amount you will pay for covered transplant services is determined by where you get the in-network transplant services.

You can choose in-network transplant services from either:

- An **Institutes of Excellence™ (IOE) facility** we designate to perform the transplant you need or
- A Non-IOE facility

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

Travel and lodging expenses

If you live 100 or more miles from the **facility that will provide your transplant**, **eligible health services** include travel and lodging expenses for you and a companion to travel between your home and the **facility**. **Eligible health services** will be reimbursed by the plan and include coach class round-trip air, train, or bus travel and lodging costs.

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

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

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

Treatment of infertility

Basic infertility

Eligible health services include seeing a **physician** or **infertility specialist**:

- To diagnose and evaluate the underlying medical cause of **infertility**.
- To do **surgery** to treat the underlying medical cause of **infertility**. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Eligible health services include complex imaging services by a **provider**, including:

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

Diagnostic lab work and radiological services

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

Cardiovascular disease testing

Eligible health services include certain lab tests for the early detection of cardiovascular disease when you have:

- Diabetes, or
- An intermediate or higher risk of getting coronary heart disease based on the Framingham Heart Study prediction algorithms

The following lab tests may be done to screen for hardening and abnormal artery structure and function:

- Computed tomography (CT) scanning
- Ultrasonography

Chemotherapy

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

Eligible health services also include oral anti-cancer **prescription drugs** for chemotherapy. Coverage for oral anti-cancer **prescription drugs** will not be less favorable than for intravenously or injected anti-cancer medications covered as a medical benefit rather than as a **prescription drug** benefit. Also, the cost-sharing for anti-cancer **prescription drugs** will not exceed the **coinsurance** or **copayment** applicable to a chemotherapy visit or cancer treatment visit. Your **prescriber** or your pharmacist may need to get approval from us before we will agree to cover the drug for you. See the *Preauthorization* section for details.

Outpatient infusion therapy

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

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

You can access the list of preferred infusion locations by contacting Member Services at the toll-free number on your ID card or by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com.

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

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

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

Outpatient radiation therapy

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

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

Specialty prescription drugs

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

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

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

Outpatient respiratory therapy

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

Transfusion or kidney dialysis of blood

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

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

Short-term cardiac and pulmonary rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

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

Short-term rehabilitation and habilitation therapy services

Short-term rehabilitation therapy services

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

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

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

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

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

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

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

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

Eligible health services include treatment for an acquired brain **injury**. An acquired brain **injury** does not include a congenital or degenerative **illness** or **injury**. It means a neurological **injury** to the brain, after birth, that results in loss of:

- Physical function
- Sensory processing
- Cognition
- Psychosocial behavior

The therapy is coordinated with us as part of a treatment plan intended to:

- Maintain or restore previous cognitive function
- Slow further loss of function

Eligible health services include the following therapies related to an acquired brain **injury**:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment
- Neurofeedback therapy
- Remediation
- Post-acute transition services
- Community reintegration services
- Post-acute care treatment due to, and related to, an acquired brain **injury**. If you have been unresponsive to treatment, this also includes checking from time to time to see if you become responsive

Eligible health services also include care in an assisted living facility that is:

- Within the scope of their license, and
- Within the scope of the services provided under and accredited rehabilitation program for brain **injury**

Short-term habilitation therapy services

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

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

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

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

Outpatient physical, occupational, and speech habilitation therapy

Eligible health services include:

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

Chiropractic services

Eligible health services include chiropractic services to correct a muscular or skeletal problem.

Your **provider** must establish or approve a treatment plan that details the treatment, and specifies frequency and duration.

Diagnostic testing for learning disabilities

Eligible health services include diagnostic testing for:

- Attention deficit disorder
- Attention deficit hyperactive disorder

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

8. Other services

Acupuncture in lieu of anesthesia

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

Ambulance service

Eligible health services include transport by professional **ambulance** services.

For **emergency services**:

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

For non-**emergency** services:

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

Your plan also covers transportation to a **hospital** by professional air or water **ambulance** when:

- Professional ground **ambulance** transportation is not available
- Your condition is unstable, and requires medical supervision and rapid transport
- You are travelling from one **hospital** to another and
 - The first **hospital** cannot provide the **emergency services** you need
 - The two conditions above are met

Clinical trial therapies (experimental or investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an "approved clinical trial" only when you have cancer or **terminal illnesses** and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate
- Your **provider** determines, and we agree that, based on published, peer-reviewed scientific evidence that you may benefit from the treatment

An "approved clinical trial" is a clinical trial that meets all of these criteria:

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

Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred to you by a **provider** in connection with participation in a phase I, phase II, phase III or phase IV "approved clinical trial" as a "qualified individual" for the prevention, detection or treatment of cancer or other life-threatening **illness** or condition, as those terms are defined in the federal Public Health Service Act, Section 2709. An approved clinical trial must satisfy one of the following:

- Federally funded trials:
 - The study or investigation is approved or funded by one or more of the following:
 - The National Institutes of Health
 - The Centers for Disease Control and Prevention
 - The Agency for Health Care Research and Quality
 - The Centers for **Medicare** & Medicaid Services
 - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
 - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
 - The Department of Veterans Affairs
 - The Department of Defense
 - The Department of Energy
 - The Food and Drug Administration
 - An institutional review board of a Texas institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services:
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

Durable medical equipment (DME)

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

Coverage includes:

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

We:

- Assume no responsibility
- Make no express or implied warranties

concerning the outcome of any covered **DME** items.

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

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

Enteral formulas and nutritional supplements

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

- Crohn's Disease
- Ulcerative colitis
- Gastroesophageal reflux
- Gastrointestinal motility;
- Chronic intestinal pseudoobstruction
- Eosinophilic gastrointestinal disorders
- Inherited diseases of amino acids and organic acids

Covered benefits also include **formula** and food products modified to be low in protein for the treatment or diagnosis of phenylketonuria or an inherited disease or disorder of amino acids and organic acids. This includes coverage for amino-acid based elemental formula.

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

Your **physician** must give you a written order s.

For coverage of drugs available only on the orders of a **physician** please refer to the *Eligible health services under your plan –Outpatient prescription drug* section.

Orthotic devices

Eligible health services include the initial orthotic device and subsequent replacement that your **physician** orders and administers.

We will cover the same type of devices that are covered by Medicare. Your **provider** will tell us which device best fits your needs. But we cover it only if we **preauthorize** the device.

Orthotic device means a customized medical device applied to a part of the body to:

- Correct a deformity
- Improve function
- Relieve symptoms of a disease

Coverage includes:

Repairing or replacing the original device unless you misuse or lose the device. Examples include:

Osteoporosis (non-preventive care)

Eligible health services include services to detect and prevent osteoporosis for:

- A postmenopausal woman not receiving estrogen replacement therapy
- An individual with:
 - Vertebral abnormalities
 - Primary hyperparathyroidism
 - A history of bone fracture
- An individual who is:
 - Receiving long-term glucocorticoid therapy

Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Prosthetic devices

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

We will cover the same type of devices that are covered by **Medicare**. Your **provider** will tell us which device best fits your needs.

Prosthetic device means:

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

Coverage includes:

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

Hearing aids and exams

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

Hearing aid means:

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

Hearing aid services are:

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

Hearing Aids Alternate Treatment Rule

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

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

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

Podiatric (foot care) treatment

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

Non-routine treatment means:

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

Vision care

Pediatric vision care

Routine vision exams

Eligible health services include a routine vision exam provided by an ophthalmologist, optometrist, therapeutic optometrist, or any other **providers** acting within the scope of their license. The exam will include refraction and glaucoma testing.

Vision care services and supplies

Eligible health services include:

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

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

Adult vision care

Routine vision exams

Eligible health services include a routine vision exam provided by an ophthalmologist, optometrist, therapeutic optometrist or any other providers acting within the scope of their license. The exam will include refraction and glaucoma testing.

Vision care services and supplies

Eligible health services include:

- Office visits to an ophthalmologist, optometrist, therapeutic optometrist, optician or any other providers acting within the scope of their license 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.

9. Outpatient prescription drugs

What you need to know about your outpatient prescription drug benefits

Read this section carefully so that you know:

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

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

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

How to access in-network pharmacies

How do you find an in-network pharmacy?

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

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

You may go to any the **in-network pharmacies**.

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

Pharmacies include **in-network retail**, **mail order** and **specialty pharmacies**.

How to access out-of-network pharmacies

You can directly access an **out-of-network pharmacy** to get covered outpatient **prescription drugs**.

If you use an **out-of-network pharmacy** to obtain outpatient **prescription drugs**, you are subject to a higher out-of-pocket expense and are responsible for:

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

Eligible health services under your outpatient prescription drug benefit

What does your outpatient prescription drug benefit cover?

Eligible health services under your outpatient **prescription drug benefit** include:

Any **pharmacy** service that meets these three requirements:

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

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

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

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

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

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

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

Partial fill dispensing for certain prescription drugs

We allow a partial fill of your **prescription** if:

- Your **pharmacy** or **prescriber** tells us that:
 - The quantity requested is to synchronize the dates that the **pharmacy** fills your **prescription drugs**
 - The synchronization of the dates is in your best interest
- You agree to the synchronization

Your out-of-pocket expenses will be prorated based on the number of days' supply.

What outpatient prescription drugs are covered

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

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

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

Types of pharmacies

Retail pharmacy

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

When you get **prescription drugs** from a **pharmacy**, the **pharmacy** will only require you at that time to pay the lowest amount out of the following:

- The applicable **copayment**
- The allowable claim amount for the **prescription drug**
- The amount you would pay for the **prescription drug** if you bought it without using your plan or any other **prescription drug** benefits or discounts.

You may later have to pay additional cost sharing for these **prescription drugs**. For example, if you have not met your **prescription drug deductible** (if applicable), you may owe additional cost sharing.

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

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

Mail order pharmacy

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

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

Specialty pharmacy

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

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

Specialty prescription drugs may fall under various drug tiers regardless of their names.

Other services

Preventive contraceptives

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

We cover over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA at no cost share. If a **generic prescription drug or device** is not available for a certain method, you may obtain certain **brand-name prescription drug** for that method at no cost share.

Important Note:

You may qualify for a medical exception if your **provider** determines that the contraceptives covered standardly as preventive are not medically appropriate. Your **prescriber** may request a medical exception and submit the exception to us.

Diabetic supplies

Eligible health services include but are not limited to the following diabetic supplies upon **prescription** by a **prescriber**:

- Injection devices including insulin syringes, needles and pens
- Test strips - blood glucose, ketone and urine monitoring and/or visual reading
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs
- Insulin and insulin analogs
- Prescriptive and nonprescriptive oral agents for controlling blood sugar levels
- Glucagon emergency kits

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

Immunizations

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

You should contact:

- Your **school health services** for **pharmacies**
- Member Services at the toll-free number on your ID card to find a participating **in-network pharmacy**

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

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

Nutritional supplements

Eligible health 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. This includes coverage for amino-acid based elemental formula.

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.

Off-label use

U.S. Food and Drug Administration (FDA) approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your conditions. Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your condition in one of the following standard compendia:
 - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information)
 - Thomson Micromedex DrugDex System (DrugDex)
 - Clinical Pharmacology (Gold Standard, Inc.)
 - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium or
 - Any **prescription drug** reference compendium approved by the Texas Insurance Commissioner
- Substantially accepted peer-reviewed medical literature Use for your condition(s) has been proven as safe and effective by at least one well-designed controlled clinical trial, (i.e., a Phase III or single center controlled trial, also known as Phase II). Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
 - The dosage of a drug for your condition(s) is equal to the dosage for the same condition(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above or
 - The dosage has been proven to be safe and effective for your condition(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

Health care services related to off-label use of these drugs may be subject to **preauthorization, step therapy** or other requirements or limitations.

Orally administered anti-cancer drugs, including chemotherapy drugs

Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication. Coverage for oral anti-cancer **prescription drugs** will not be less favorable than for intravenously or injected anti-cancer medications covered as a medical benefit rather than as a **prescription drug** benefit. Also, the cost sharing for anti-cancer **prescription drugs** will not exceed the **coinsurance** or **copayment** applicable to a chemotherapy visit or cancer treatment visit. Your **prescriber** or your pharmacist may need to get approval from us before we will agree to cover the drug for you. See the *Preauthorization* section for details.

Over-the-counter drugs

Eligible health services include certain over-the-counter medications, as determined by the plan. Coverage of the selected over-the-counter medications requires a **prescription**. You can access the list by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling Member Services at the toll-free number on your ID card.

Prescription eye drops

You may refill **prescription** eye drops to treat a chronic eye disease or condition if:

- The original **prescription** states that additional quantities are needed
- The refill does not exceed the total quantity of dosage units stated on the original **prescription**, including refills
- The refill is dispensed on or before the last day of the prescribed dosage period and not earlier than the:
 - 21st day after the date a 30-day supply is dispensed
 - 42nd day after the date a 60-day supply is dispensed
 - 63rd day after the date a 90-day supply is dispensed

Preventive care drugs and supplements

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

Risk-reducing breast cancer prescription drugs

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

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

Tobacco cessation prescription and over-the-counter drugs

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

How you get an emergency prescription filled

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

Type of pharmacy	Your cost share
In-network pharmacy	<ul style="list-style-type: none">• You pay the copayment.
Out-of-network pharmacy	<ul style="list-style-type: none">• You pay the pharmacy directly for the cost of the prescription. Then you fill out and send a prescription drug refund form to us, including all itemized pharmacy receipts.• Submission of a claim doesn't guarantee payment. If your claim is approved, you will be reimbursed the cost of your prescription less your copayment.

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** you are prescribed
- Where you fill your **prescription**

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

How your copayment works

Your **copayment** is the amount you pay for each **prescription** fill or refill. Your schedule of benefits shows you which **copayments** you need to pay for specific **prescription** fill or refill. You will pay any cost sharing directly to the **in-network pharmacy**. When you get **prescription drugs** from a **pharmacy**, the **pharmacy** will only require you at that time to pay the lowest amount out of the following:

- The applicable **copayment**
- The allowable claim amount for the **prescription drug**
- The amount you would pay for the **prescription drug** if you bought it without using your plan or any other **prescription drug** benefits or discounts.

You may later have to pay additional cost sharing for these **prescription drugs**. For example, if you have not met your **prescription drug deductible** (if applicable), you may owe additional cost sharing.

How your outpatient prescription drug maximum out-of-pocket limit works

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

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

What preauthorization requirements apply?

Preauthorization

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

Step therapy

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

You will find the **step therapy prescription drugs** on the **preferred drug guide**. For the most up-to-date information, call the Member Services toll-free number on the back of your ID card or log on to your Aetna Navigator® secure website at www.aetnastudenthealth.com.

How do I request a medical exception?

Sometimes you or your **prescriber** may ask for a medical exception to get health care services for drugs not covered or for **brand-name, specialty or biosimilar prescription drugs** or for which health care services are denied through **preauthorization** or **step therapy**. You or your **prescriber** can contact us. You will need to provide us with the required clinical documentation. We will make a coverage determination within 72 hours after we receive your request and any information and will tell you and your **prescriber** of our decision. Any exception granted is based upon an individual, case by case decision, and will not apply to other members. If approved by us, you will receive the **preferred** or **non-preferred drug** benefit level and the exception will apply for the entire time of the **prescription**.

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

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

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

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

Prescribing units

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

Any outpatient **prescription drug** that has duration of action extending beyond one (1) month shall require the number of **copayments** per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) **copayments**.

What your plan doesn't cover – some eligible health service exceptions

We already told you about the many health care services and supplies that are eligible for coverage under your plan in the *Eligible health services under your plan* section. And we told you there, that some of those health care services and supplies have exceptions (“exclusions”). For example, **physician** care is an **eligible health service** but **physician** care for **cosmetic surgery** is never covered. This is an exception (exclusion).

In this section we tell you about the exceptions. And just a reminder, you'll find coverage limitations in the schedule of benefits.

General exceptions

Acupuncture therapy

- Maintenance treatment
- Acupuncture when provided for the following conditions:
 - Acute low back pain
 - Addiction
 - AIDS
 - Amblyopia
 - Allergic rhinitis
 - Asthma
 - Autism spectrum disorders
 - Bell's Palsy
 - Burning mouth syndrome
 - Cancer-related dyspnea
 - Carpal tunnel syndrome
 - Chemotherapy-induced leukopenia
 - Chemotherapy-induced neuropathic pain
 - Chronic pain syndrome (e.g., RSD, facial pain)
 - Chronic obstructive pulmonary disease
 - Diabetic peripheral neuropathy
 - Dry eyes
 - Erectile dysfunction
 - Facial spasm
 - Fetal breech presentation
 - Fibromyalgia
 - Fibrotic contractures
 - Glaucoma
 - Hypertension
 - Induction of labor
 - Infertility(e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
 - Insomnia
 - Irritable bowel syndrome
 - Menstrual cramps/dysmenorrhea
 - Mumps
 - Myofascial pain
 - Myopia
 - Neck pain/cervical spondylosis
 - Obesity
 - Painful neuropathies

- Parkinson's disease
- Peripheral arterial disease (e.g., intermittent claudication)
- Phantom leg pain
- Polycystic ovary syndrome
- Post-herpetic neuralgia
- Psoriasis
- Psychiatric disorders (e.g., depression)
- Raynaud's disease pain
- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

Air or space travel

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

This exclusion does not apply if:

- You are traveling solely as a fare-paying passenger
- You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
- You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
 - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved
 - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the **policyholder** performing duties for the **policyholder**
- You are enrolled in the **policyholder's** "Bachelor of Science in Aviation" program

Allergy testing and allergy injections treatment

- Allergy sera and extracts administered via injection

Alternative health care

- Services and supplies given by a **provider** for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and traditional Chinese medicine.

Ambulance services

- Non-emergency fixed wing air **ambulance** from an **out-of-network provider**
- Non-emergency **ambulance** transports except as covered under the *Eligible health services under your plan* section of this certificate of coverage

Armed forces

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

Artificial organs

- Any non-FDA approved device that would perform the function of a body organ

Beyond legal authority

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

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of blood to the **hospital**, other than blood derived clotting factors
- The services of blood donors, apheresis or plasmapheresis
- For allogenic and autologous blood donations, only administration and processing expenses are covered

Breasts

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

Clinical trial therapies (experimental or investigational)

- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the *Eligible health services under your plan - Clinical trial therapies (experimental or investigational)* section

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies)
- In-network coverage limited to benefits for routine patient services provided within the network

Cornea or cartilage transplants

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

Cosmetic services and plastic surgery

- Any treatment, **surgery** (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body. Whether or not for psychological or emotional reasons. This **cosmetic** services exclusion does not apply to **surgery** after an **accidental injury** when performed as soon as medically feasible. **Injuries** that occur during medical treatments are not considered accidental **injuries** even if unplanned or unexpected.

Counseling

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

Court-ordered services and supplies

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

Custodial care

Examples are:

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

Dermatological treatment

- **Cosmetic** treatment and procedures

Dental care for adults

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

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

Durable medical equipment (DME)

Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems
- Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a **physician**

Early intensive behavioral interventions

Examples of these services are:

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

Educational services

Examples of these services are:

- Any service or supply for education, training or retraining services or testing. This includes:
 - Special education
 - Remedial education
 - Wilderness treatment program
 - Job training
 - Job hardening programs
- Services provided by a governmental school district

Elective treatment or elective surgery

- **Elective treatment** or elective surgery except as specifically covered under the **student policy** and provided while the **student policy** is in effect

Enteral formulas and nutritional supplements

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

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Emergency services and urgent care

- **Non-emergency services** in a **hospital** emergency room facility, freestanding emergency medical care facility or comparable emergency facility
- Non-urgent care in an **urgent care facility**(at a non-hospital freestanding facility)

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities, except if you have an acquired brain injury. See the *Specific therapies and test* section.
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Family planning services - other

- Reversal of voluntary sterilization procedures, including related follow-up care
- Family planning services received while confined as an inpatient in a **hospital** or other facility
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

Felony

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

Gender reassignment (sex change) treatment

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

Genetic care

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

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 aids and exams except provided in the *Hearing aids and cochlear implants and other services* section of the *Eligible health services* section

Home health care

- Nursing and **home health aide** services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Homemaker or housekeeper services
- Food or home delivered services
- Maintenance therapy

Hospice care

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

Incidental surgeries

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

Jaw joint disorder

- 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 therapeutics services related to **jaw joint disorders** including associated myofascial pain

This exclusion does not apply to **covered benefits** for treatment of **TMJ** and **CMJ** as described in the *Eligible health services under your plan –Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment* section.

Judgment or settlement

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

Mandatory no-fault laws

- Treatment for an **injury** to the extent benefits are payable under any state no-fault automobile coverage or first party medical benefits payable under any other mandatory no-fault law

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. Under the *Eligible health services under your plan – Habilitation therapy services* section and under the *Eligible health services under your plan – Services for children with developmental delays* section.

Maternity care

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

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. These items are usually included in the cost of other services and are not billed separately. Examples of these are:
 - Sheaths
 - Bags
 - Elastic garments
 - Support hose
 - Bandages
 - Bedpans
 - Syringes, except for treatment of diabetes
 - Blood or urine testing supplies, except for treatment of diabetes
 - Other home test kits
 - Splints
 - Neck braces
 - Compresses
 - Other devices not intended for reuse by another patient

Medicare

- Services and supplies to the extent they would have been covered under **Medicare** Part A or enrolled in Part B, or if you are not entitled to premium-free **Medicare** Part A or enrolled in **Medicare** Part B because you refused it, dropped it, or did not make a proper request for it

Mental health treatment

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

Motor vehicle accidents

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

Non-medically necessary services and supplies

- Services and supplies which are not **medically necessary** for the diagnosis, care, or treatment of an **illness** or **injury** or the restoration of physiological functions. This includes behavioral health services that are not primarily aimed at the treatment of **illness, injury**, restoration of physiological functions or that do not have a physiological or organic basis. This applies even if they are prescribed, recommended, or approved by your **physician, dental provider, or vision care provider**. This exception does not apply to *Preventive care and wellness* benefits.

Non-U.S .citizen

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

Obesity (bariatric) surgery

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

Organ removal

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

Outpatient infusion therapy

- 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 prescription or non-prescription drugs and medicines

- Outpatient **prescription drugs** or non-prescription drugs and medicines provided by the **policyholder**
- Preventive contraceptives and **brand-name prescription drug** forms of contraception in each of the methods identified by the FDA
- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient **prescription drug** plan

Outpatient surgery and physician surgical services

- The services of any other **physician** who helps the operating **physician**
- A **stay** in a **hospital** (**Hospital stays** are covered in the *Eligible health services under your plan – Hospital and other facility care* section)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Pediatric dental care

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

Personal care, comfort or convenience items

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

Podiatric (foot care) treatment

- Services and supplies for:
 - The treatment of calluses, bunions, toenails, hammertoes, or 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 (other than as specifically described in the *Eligible health services under your plan* section), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, except for complications of diabetes. See the *Specific conditions* section.
 - Routine pedicure services, such as routine cutting of nails, when there is no **illness** or **injury** in the nails

Preventive care and wellness

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

Private duty nursing (outpatient only)

Prosthetic devices

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Repair and replacement due to loss, misuse, abuse or theft
- Communication aids
- Cochlear implants, except as provided in the *Eligible health services under your plan - Hearing aids and cochlear implants and related services--Other services* section

Riot

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

Routine exams

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

School health services

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

by **health professionals** who

- Are employed by
 - Are Affiliated with
 - Have an agreement or arrangement with, or
- Are otherwise designated by the **policyholder**.

Services provided by a family member

- Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member, except when that family member is a **dentist** who is licensed in the State of Texas to provide the service rendered.

Services, supplies and drugs received outside of the United States

- **Non-emergency services**, outpatient **prescription drugs** or supplies received outside of the United States. They are not covered even if they are covered in the United States under this certificate of coverage.

Sexual dysfunction and enhancement

- Any treatment, **prescription drug**, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
 - **Surgery, prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
 - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Sinus surgery

- Any services or supplies given by **providers** for sinus surgery except for acute purulent sinusitis

Sleep apnea

- Any services or supplies given by **providers** for the treatment of obstructive sleep apnea and sleep disorders

Specialty prescription drugs

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

Strength and performance

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

Students in mental health field

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

Suicide or attempted suicide

- Any services or supplies given by **providers** as a result of suicide, attempted suicide, or intentionally self-inflicted **injury**. This does not apply to an **injury** caused from an act of domestic violence or a physical or **mental disorder** condition

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

- Dental implants

Therapies and tests

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

Tobacco cessation

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

Transplant services

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

Treatment in a federal, state, or governmental entity

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

Treatment of infertility

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

Vision Care

Pediatric vision care services and supplies

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Adult vision care

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Adult vision care services and supplies

Your plan does not cover adult vision care services and supplies, except as described in the *Eligible health services under your plan – Other services* section.

- Special supplies such as non-**prescription** sunglasses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a **hospital** or other facility for health care
- Eye exams for contact lenses or their fitting
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Wilderness Treatment Programs

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

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered "non-occupational" regardless of cause.

Exceptions that apply to outpatient prescription drugs

Allergy sera and extracts administered via injection

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

Biological sera

Compounded prescriptions

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

Cosmetic drugs

- Medications or preparations used for cosmetic purposes

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

Drugs or medications

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

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

Genetic care

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

Immunizations related to travel or work

Immunization

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

Infertility

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

Injectables

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

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as specifically provided in the *Eligible health services under your plan – Diabetic equipment, supplies and education* section

Prescription drugs:

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

Refills

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

Replacement of lost or stolen prescriptions

Test agents except diabetic test agents

Tobacco cessation

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

We reserve the right to exclude:

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

Who provides the care

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

In-network providers

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

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section
- **Urgent care** – refer to the description of emergency services and urgent care in the *Eligible health services under your plan* section
- **In-network provider not reasonably available** – You can get **eligible health services** under your plan that are provided by an **out-of-network provider** regardless of whether an **in-network provider** is reasonably available. However, if an appropriate **in-network provider** is not reasonably available, and you need to see an **out-of-network provider**, we will:
 - Pay the claim at the usual or customary charge, minus any cost-sharing you owe
 - Pay the claim at the preferred **coinsurance** level
 - Apply to your **policy year deductible** and annual network **maximum out-of-pocket limit** any amounts over the allowed amount that you paid to the **out-of-network provider** for **covered benefits**.

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

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

Out-of-network providers

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

- Paying your out-of-network **policy year deductible**
- Your out-of-network **coinsurance**
- Any charges over our **recognized charge**
- Submitting your own claims and getting **preauthorization**

Keeping a provider you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the network
- You are already covered under another **Aetna** plan and your **provider** stops being in our network

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

	If you are a new enrollee and your provider is an out-of-network provider	If you are a current enrollee and your provider stops participation with Aetna
Request for approval	You need to complete a Transition Coverage Request form and send it to us. You can get this form by contacting Member Services at the toll-free number on your ID card.	You or your provider should call Aetna for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. This date is based on the date the provider terminated their participation with Aetna.
	If you have a terminal illness and your provider stops participation with Aetna	
Request for approval	Your provider should call us for approval to continue any care. You can call Member Services at the toll-free number on the back of your ID card for information on continuity of care.	
Length of transitional period	Care will continue during a transitional period for up to nine (9) months. This date is based on the date the provider terminated their participation with Aetna .	
How claim is paid	Your claim will be paid at not less than the negotiated charge during the transitional period.	
	If you are pregnant and have entered your second trimester and your provider stops participation with Aetna	
Request for approval	Your provider should call us for approval to continue any care. You can call Member Services at the toll-free number on the back of your ID card for information on continuity of care.	
Length of transitional period	Care will continue during a transitional period through delivery, including the time required for postpartum care directly related to the delivery. This includes a post-delivery checkup within six weeks.	
How claim is paid	Your claim will be paid at not less than the negotiated charge during the transitional period.	

We will authorize coverage for the transitional period only if the **provider** agrees to our usual terms and conditions for contracting **providers**.

What the plan pays and what you pay

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

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

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

The general rule

When you get **eligible health services**:

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

And then

- The plan and you share the expense up to any **maximum out-of-pocket limit**. The schedule of benefits lists how much your plan pays and how much you pay for each type of health care service. Your share is called a **copayment/coinsurance**

And then

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

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

Important exception – when your plan pays all

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

Important exceptions – when you pay all

You pay the entire expense for an **eligible health service**:

- When you get a health care service or supply that is not **medically necessary**. See the *Medical necessity and preauthorization requirements* section.
- When your plan requires **preauthorization**, your **physician** requested it, we refused it, and you get an **eligible health service** without **preauthorization**. See the *Medical necessity and preauthorization requirements* section.

In all these cases, the **provider** may require you to pay the entire charge. Any amount you pay will not count towards your **policy year deductible** or towards your **maximum out-of-pocket limit**.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the **negotiated charge** for in-network **covered benefits**
- Standby charges made by a **physician**

Where your schedule of benefits fits in

How your policy year deductible works

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

How your copayment works

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

How your maximum out-of-pocket limit works

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

Important note:

See the schedule of benefits for any **policy year deductibles**, **copayments**, **coinsurance**, **maximum out-of-pocket limit** and maximum age, visits, days, hours, admissions that may apply.

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

For claims involving **out-of-network providers**:

Notice	Requirement	Deadline
Submit a claim	<ul style="list-style-type: none">You should notify and request a claim form from the policyholder not later than 20 days after the date of loss.The claim form will provide instructions on how to complete and where to send the form(s).	<ul style="list-style-type: none">We must send you a claim form within 15 business days of your requestIf the claim form is not sent on or by the 16th day, you are considered to have complied with the requirements for submitting proof of loss.You may send us:<ul style="list-style-type: none">A description of servicesItemized Bill of chargesAny medical documentation you received from your provider
Proof of loss (claim)	<ul style="list-style-type: none">A completed claim form and any additional information required by us.	<ul style="list-style-type: none">No later than 90 days after you have incurred expenses for covered benefits.We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But You must send us notice and proof as soon as reasonably possible. <p>Proof of loss may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.</p>

Benefit payment	<ul style="list-style-type: none"> • Written proof must be provided for all benefits. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss. 	<ul style="list-style-type: none"> • We will accept or reject a claim not later than 15 business days of receiving all items, statements and forms. • Benefits will be paid not later than 5 business days after the date the notice of acceptance is sent. • If we reject the claim the written notice will include the reason for denial. • All benefits payable will be paid no later than 60 calendar days from the proof of loss is received.
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Types of claims and communicating our claim decisions

You or your **provider** is required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the **provider** or to you as appropriate.

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

Urgent care claim

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

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

Pre-service claim

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

Retrospective claim

A retrospective claim is a claim that involves health care services you have already received.

Concurrent care claim extension decision

You or your provider may ask for a concurrent care claim extension to request more services. We will tell you when we make a decision for such a request. If we make an adverse determination, you will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an independent review organization if the situation is eligible for independent review.

We will not reduce or deny coverage for services that we have already approved. During the concurrent care claim extension 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 your request for extended services is not approved after your adverse determination appeal, and we support the decision to reduce or terminate such services, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of how much time we have to tell you about our decision on a **preauthorization** request, a concurrent care authorization request and a retrospective review.

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

Initial claim determinations				
Type of notice	Initial determination (us)	Extensions	Additional information request (us)	Response to additional information request (you)
Pre-service claim	No later than 3 calendar days after we receive the request	Not applicable	Not applicable	Not applicable
Concurrent care claim If you are hospitalized (may include concurrent care claim of hospital stays)	No later than 24 hours after we receive the request, followed by written notification within 3 business days	Not applicable	Not applicable	Not applicable
If you are not hospitalized	No later than 3 calendar days after we receive the request	Not applicable	Not applicable	Not applicable
If you are currently receiving prescription drugs or intravenous infusions	No later than the 30 th day before the date on which the prescription drugs or intravenous infusions will be discontinued	Not applicable	Not applicable	Not applicable
Care to make sure you are stable following emergency treatment (post-stabilization) or for a life-threatening condition	No later than one (1) hour after we receive the request	Not applicable	Not applicable	Not applicable
Requests for step therapy exception (non-emergency)	No later than 72 hours after we receive the request	Not applicable	Not applicable	Not applicable
Requests for step therapy exception (emergency)	No later than 24 hours after we receive the request	Not applicable	Not applicable	Not applicable
Acquired brain injury	No later than 3 business days after we receive the request	Not applicable	Not applicable	Not applicable
Retrospective review	30 days	15 days	30 days	45 days

* If we approve the care and services, we will send you a letter no later than 2 business days after we receive the request.

The **Adverse determinations** section explains how and when we tell you about an adverse determination.

Adverse determinations

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

An adverse determination is our determination that the health care services you have received, or may receive, are:

- **Experimental or investigational**
- Not **medically necessary**

It is also an adverse determination if our determination is based on:

- Your eligibility for coverage
- Your plan’s exceptions *What your plan doesn’t cover – some eligible health service exceptions* section

If we make an adverse determination, we will tell you in writing. Our written decision will tell you:

- The main reason for the denial
- The clinical basis for the denial
- The source of the screening criteria used as a guideline to make the decision
- How to ask for an appeal of the denial, including your right to appeal to an independent review organization (IRO) and how to obtain an independent review
- How to obtain an immediate review by the IRO when the claim denial involves:
 - A life-threatening condition
 - The provision of **prescription drugs** or intravenous infusions for which the patient is receiving health benefits under the certificate of coverage
 - Requests for **step therapy** exception

The chart below tells you how much time we have to tell you about an adverse determination.

<ul style="list-style-type: none"> • Type of notice 	<ul style="list-style-type: none"> • When you need care to make sure you are stable following emergency treatment (post-stabilization) 	<ul style="list-style-type: none"> • While you are in the hospital 	<ul style="list-style-type: none"> • When not hospitalized at the time of the decision 	<ul style="list-style-type: none"> • Prescription drugs or intravenous infusions that you are currently receiving 	<ul style="list-style-type: none"> • Retrospective review
<ul style="list-style-type: none"> • Initial decision 	<ul style="list-style-type: none"> • No later than 1 hour after the request to the treating provider 	<ul style="list-style-type: none"> • Within 1 business day by phone or email to your provider, followed by written notice within three 3 business days to you and your provider 	<ul style="list-style-type: none"> • Within 3 business days to you and your provider 	<ul style="list-style-type: none"> • No later than the 30th day before the date on which the prescription drugs or intravenous infusions will be discontinued 	<ul style="list-style-type: none"> • Within 30 days after the date on which the claim is received
<ul style="list-style-type: none"> • Extensions 	<ul style="list-style-type: none"> • Not applicable 	<ul style="list-style-type: none"> • Not applicable 	<ul style="list-style-type: none"> • Not applicable 	<ul style="list-style-type: none"> • Not applicable 	<ul style="list-style-type: none"> • 15 days
<ul style="list-style-type: none"> • Additional information request (us) 	<ul style="list-style-type: none"> • Not applicable 	<ul style="list-style-type: none"> • Not applicable 	<ul style="list-style-type: none"> • Not applicable 	<ul style="list-style-type: none"> • Not applicable 	<ul style="list-style-type: none"> • 30 days
<ul style="list-style-type: none"> • Response to additional information request (you) 	<ul style="list-style-type: none"> • Not applicable 	<ul style="list-style-type: none"> • Not applicable 	<ul style="list-style-type: none"> • Not applicable 	<ul style="list-style-type: none"> • Not applicable 	<ul style="list-style-type: none"> • 45 days

- **Important note:**

- We will tell you about an adverse determination within the time appropriate to the circumstances relating to the delivery of the services and your condition. We will always tell you no later than the times shown in the chart above.

The difference between a complaint and an appeal

A Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call Member Services at the toll-free number on your ID card or write Member Services. Your complaint should include a description of the issue. Some other examples of complaints are when you are not happy with:

- How we have administered the plan
- How we have handled the appeal process
- When we deny a service that is not related to **medical necessity** issues
- The manner in which a service is provided
- A disenrollment decision

But it is not a complaint if:

- We resolve a misunderstanding or misinformation, to your satisfaction, by providing an explanation or more information.
- You or your **provider** call or write to tell us you are unhappy with, or disagree with, an adverse determination. Instead, this is an appeal of the adverse determination. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determinations* sections for more information.

Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know that we have received your complaint within 5 business days. Our letter will tell you about our complaint procedures and timeframes. If you call us to complain, we will send you a complaint form to complete and return.

We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. If your complaint is for services that you have not already received, we will provide you with a written response within 15 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

If your complaint concerns an emergency, or denial of continued hospitalization or **prescription drugs** and intravenous infusions, we will do an expedited appeal review. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determinations* sections for more information.

An appeal

Your request to reconsider an adverse determination is an appeal of an adverse determination. It is also an appeal if you ask us to re-review a complaint because you are not happy with our initial response. The *Appeal of a complaint* and *Appeal of adverse determinations* sections below explain the appeal processes for both types of appeals.

Appeals of adverse determinations

You can appeal our adverse determination

We will assign your appeal to someone who was not involved in making the original decision.

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

- Your name
- The **policyholder's** name
- A copy of the adverse determination

- Your reasons for making the appeal
- Any other information you would like us to consider
- If you appealed verbally or in writing, we will send you a one page appeal form to be filled out by you or your authorized representative.

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

We will let you know that we have received your appeal of the adverse determination within 5 business days. This notice will describe the appeals process and your rights. If you call us to appeal, we will send you an appeal form to complete and return.

The review and decision of your appeal will be made by personnel not involved in making the initial adverse determination.

Expedited internal appeal

You are entitled to an expedited internal appeal process for emergency care denials, denials of care for life-threatening conditions, and denials of continued **stays** in a **hospital**. You can also ask for an expedited internal appeal if we deny a request for **step therapy** exception or a request for **prescription drugs** or intravenous infusions you are currently receiving.

The review and decision of your appeal will be made by personnel not involved in making the initial adverse determination.

Important note:

You can skip our standard and expedited internal appeal process and instead appeal to an independent review organization (IRO) in some situations. See the *Exhaustion of appeals process* section.

Timeframes for deciding appeals of adverse determinations

The amount of time that we have to tell you about our decision on an appeal of an adverse determination depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision. We may tell you about our decision verbally or in writing. If we tell you verbally, we will also send you a letter within 3 calendar days after the verbal notice.

Type of claim	Our response time
Urgent care claim	As soon as possible (based on the medical urgency of the case) but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received
Emergency medical condition	As soon as possible (based on the medical urgency of the case) but no later than 1 business day for 72 hours (whichever is less) from the date all information to complete the review is received
When you need care to make sure you are stable following emergency treatment (post-stabilization)	No later than 1 hour after the request

Type of claim	Our response time
If you are hospitalized at the time of the adverse determination (may include concurrent care claim of hospital stays)	No later than 1 business day from date all information to complete the review is received*
If you are receiving prescription drugs or intravenous infusions	As soon as possible, but no later than 1 business day from date all information to complete the review is received
Pre-service claim requiring preauthorization	As soon as possible but no later than 15 calendar days*
Requests for step therapy exception	As soon as possible (based on the medical or dental immediacy of the condition, procedure, or treatment under review) but no later than 1 business day from the date all information to complete the review is received
Acquired brain injury	No later than 3 business days after the request
Retrospective claim	As soon as possible, but no later than 30 calendar days from receipt of the request for appeal*

*If your appeal is denied, your **provider** may ask us in writing to have a certain type of specialty **provider** review your case. The request must show good cause for specialty review. The request must be made not later than 10 business days after the appeal was denied. A **provider** of the same or a similar specialty who would typically manage this type of condition will do the review. A decision will be made within 15 working days of the date we receive such a request.

Exhaustion of appeals process

- In most situations you must complete an appeal with us before you can Appeal through an independent review process
- We encourage you to complete an appeal with us before you pursue arbitration, litigation or other type of administrative proceeding

You do not have to complete the internal appeals process when:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the independent review process.
- We did not follow all of the claim determination and appeal requirements of the Federal Department of Health and Human Services. But, you will not be able to proceed directly to independent review if:
 - The rule violation was minor and not likely to influence a decision or harm you.
 - The violation was for a good cause or beyond our control.
 - The violation was part of an ongoing, good faith exchange between you and us.
- You have a life-threatening condition. You can have your appeal reviewed through the internal review process.
- You are receiving **prescription drugs** or intravenous infusion treatment and we deny them. You can have your appeal reviewed through the independent review process.
- Your request for a **step therapy** exception was denied. You can have your appeal reviewed through the independent review process.

Independent review

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

You have a right to independent review only if:

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

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

You must submit the Request for Independent Review Form:

- To **Aetna**
- Within 6 months of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

You will pay for any information that you send and want reviewed by the IRO. We will pay for information we send to the IRO plus the cost of the review.

Aetna will:

- Contact the IRO that will conduct the review of your claim. If your request is based on exigent circumstances your request will be sent as soon as possible. An “exigent circumstance” means when you are:
 - Experiencing a health condition that may seriously jeopardize your life, health or ability to regain maximum function
 - Undergoing a current course of treatment using a non-formulary drug.
- The IRO will:
 - Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
 - Consider appropriate credible information that you sent
 - Follow our contractual documents and your plan of benefits
 - Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

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

How long will it take to get an IRO decision?

We will tell you of the IRO decision not more than 45 calendar days after we receive your Notice of Independent Review Form with all the information you need to send in.

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

You may be able to get a faster independent review after an **adverse determination** if your **provider** tells us that a delay in your receiving health care services would:

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

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request or within 24 hours if your request is for an exigent circumstance.

Recordkeeping

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

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal. But we will pay the fees or expenses incurred for the review of the IRO.

Coordination of benefits

("COB") provision applies when a person has health care coverage under more than one 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). "Plan" is defined below in the *Key terms* section.

The order of benefit determination rules tell you the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms. Payment is made without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

Key terms

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

<p>Plan:</p> <p>A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate policies are used to provide coordinated coverage for members of a group, the separate policies are considered parts of the same plan and there is no COB among those separate policies.</p>	
<ul style="list-style-type: none">• It includes:	<ul style="list-style-type: none">• Group, blanket or franchise accident and health insurance policies, excluding disability income protection coverage• Individual and group health maintenance organization evidences of coverage• Individual accident and health insurance policies• Individual and group preferred provider benefit plans and exclusive provider benefit plans• Group insurance policies, individual insurance policies and subscriber policies that pay or reimburse for the cost of dental care• Medical care components of individual and group long-term care policies• Limited benefit coverage that is not issued to supplement individual or group in-force policies• Uninsured arrangements of group or group-type coverage• The medical benefits coverage in automobile insurance policies• Medicare or other governmental benefits, as permitted by law

<ul style="list-style-type: none"> It does not include: 	<ul style="list-style-type: none"> Disability income protection coverage The Texas Health Insurance Pool Workers' compensation insurance coverage Hospital confinement indemnity coverage or other fixed indemnity coverage Specified disease coverage Supplemental benefit coverage Accident only coverage Specified accident coverage School accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for policies that pay a fixed daily benefit without regard to expenses incurred or the receipt of services Medicare supplement policies A state plan under Medicaid A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan Other nongovernmental plan An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable policy year deductible
<ul style="list-style-type: none"> Each plan for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan. 	
<p>This plan:</p> <p>This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans.</p>	
<ul style="list-style-type: none"> How this plan coordinates with like benefits: 	<p>Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.</p>

<ul style="list-style-type: none"> The order of benefit determination rules for this plan: 	<p>The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the covered person has health care coverage under more than one plan.</p> <ul style="list-style-type: none"> When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100% of the total allowable expense
<p>Allowable expense: Allowable expense is a health or dental care expense, including policy year deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person.</p>	
<ul style="list-style-type: none"> Allowable expense for benefits provided in the form of services: 	<p>When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.</p>
<ul style="list-style-type: none"> Expenses that are not allowable expenses: 	<p>An expense that is not covered by any plan covering the covered person is not an allowable expense. In addition, any expense that a provider or physician, by law or in accordance with a contractual agreement, is prohibited from charging a covered person is not an allowable expense.</p> <p>Some expenses and services are not allowable expenses. Here are some examples:</p> <ul style="list-style-type: none"> The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses. If a covered person is covered by two or more plans that don't have a negotiated charge and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense. If a covered person is covered by two or more plans that provide benefits or services on the basis of negotiated charges, an

	<p>amount in excess of the highest of the negotiated charges is not an allowable expense.</p> <ul style="list-style-type: none"> • If a covered person is covered by one plan that does not have negotiated charges and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides it benefits or services based on negotiated charges, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated charge or payment amount that is different than the primary plan's payment arrangement and if the health care provider's or physician's contract permits, the negotiated charge or payment must be the allowable expense used by the secondary plan to determine its benefits. • The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, preauthorization of admissions, and in-network provider and physician arrangements.
<p>Allowed amount:</p> <p>Allowed amount is the amount of a billed charge that a carrier determines to be covered for services by an out-of-network provider. The amount includes both the carrier's payment and any applicable policy year deductible, copayment, or coinsurance amounts for which the insured is responsible.</p>	
<p>Closed panel plan:</p> <p>Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency by a panel member.</p>	
<p>Custodial parent:</p> <p>Custodial parent is the parent with the right to designate the primary residence of a child by court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.</p>	

Order of benefit determination rules

When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows:

<ul style="list-style-type: none">• The primary plan pays according to its terms of coverage and without regard to the benefits under any other plan.• A plan that does not have a COB provision is always primary unless the provisions of both plans state that the complying plan is primary, except:<ul style="list-style-type: none">– Coverage that you have because of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the policyholder. Examples of these types of situations are:<ul style="list-style-type: none">○ Major medical coverages that are superimposed over base plan hospital and surgical benefits○ Insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
<ul style="list-style-type: none">• A plan may consider the benefits paid by another plan in calculating payment of its benefits only when it is secondary to that other plan.
<ul style="list-style-type: none">• If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay benefits as if it were the primary plan when a covered person uses an out-of-network provider or physician, except for emergency services that are paid or provided by the primary plan.
<ul style="list-style-type: none">• When multiple policies providing coordinated coverage are treated as a single plan, this applies only to the plan as a whole. Coordination among the component policies is governed by the terms of the policies. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with these rules.
<ul style="list-style-type: none">• If a covered person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

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

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or dependent	The plan covering you as a student.	The plan covering you as a dependent.
Exception to the rule above when you are eligible for Medicare	If you or your spouse has Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us: <ul style="list-style-type: none">• Online: Log on to your Aetna Navigator® secure website at www.aetnastudenthealth.com. Select Find a Form, then select Your Other Health Plans• By phone: Call the toll-free number on the back of your ID card	
COB rules for dependent children Unless there is a court order stating otherwise, the order of benefits is determined using the following rules that apply.		
Child of: <ul style="list-style-type: none">• Parents who are married or living together, whether or not they have ever been married	The “birthday rule” applies. The plan of the parent whose birthday* (month and day only) falls earlier in the calendar year . *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*. *Same birthdays--the plan that has covered a parent longer is primary
Child of: <ul style="list-style-type: none">• Parents separated or divorced or not living together, whether or not they have ever been married• With court-order	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other spouse’s plan is primary.	The plan of the other parent. But if that parent has no coverage, then their spouse’s plan is primary.
Child of: <ul style="list-style-type: none">• Parents separated or divorced or not living together , whether or not they have ever been married– court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
Child of: <ul style="list-style-type: none">• Parents separated or divorced or not living together, whether or not they have ever been married• and there is no court-order	The order of benefit payments is: <ul style="list-style-type: none">• The plan of the custodial parent pays first• The plan of the spouse of the custodial parent (if any) pays second• The plan of the noncustodial parents pays next• The plan of the spouse of the noncustodial parent (if any) pays last	

Child of: Persons, who are not the child's parents	The rules shown for parents will apply, as if the persons were parents of the child.
• Child of: Parents, who is also covered under a spouse's plan	The plan that has covered the person longer is primary. If coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.
Other rules do not apply	If none of the above rules apply, the plans share expenses equally. This plan will not pay more than it would have paid had it been the primary plan

Effect on the benefits of this plan

- When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan:
 - Will calculate the benefits it would have paid in the absence of other health care coverage. The calculated amount will be applied to any allowable expense under its plan that is unpaid by the primary plan.
 - May reduce its payment so that the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim.
 - Must credit to its plan **policy year deductible** any amounts it would have credited to its **policy year deductible** in the absence of other health care coverage.
- If a **covered person** is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel **provider**, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with federal and state laws concerning confidential information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give us any facts it needs to apply those rules and determine benefits.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid. Or, we may recover from any other person or organization that may be responsible for the benefits or services provided for the **covered person**. The "amount of the payments made" includes the reasonable cash value of the benefits provided in the form of services.

Other health coverage updates – contact information

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

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

When coverage ends

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

When will your coverage end?

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

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

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

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

When will your continuation of coverage plan end?

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

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

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

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

See the *Continuation of coverage for other reasons* section to learn how you can extend your coverage.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- For a dependent child, on the first **premium** due date following the child's 26th birthday.
- Your dependent is no longer eligible for coverage.
- The date dependents are no longer an eligible class.
- You do not make the required **premium** contribution toward the cost of dependents' coverage.
- Your coverage ends for any of the reasons listed above.
- For your spouse, the date the marriage ends in divorce or annulment.
- They are covered under a continuation of coverage plan and it ends. Coverage for dependents ends on the date the continuation of coverage plan ends.

In addition, coverage for your domestic partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners.
- The date the domestic partnership ends. For domestic partnerships, you should provide the **policyholder** a completed and signed Declaration of Termination of Domestic Partnership.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

Why would we suspend paying claims or end your and your dependents' coverage?

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

We may immediately end your and your dependents coverage if:

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

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

We will not end your coverage because you used your rights under the *When you disagree – claim decisions and appeals procedures* section of this certificate of coverage.

Special coverage options after your plan coverage ends

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

Continuation of coverage plan

If your or your dependent's coverage under the **student policy** will end, you can elect to continue coverage under the **student policy** if:

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

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

Continuation of coverage- State of Texas

Continuation privilege for certain dependents

There are events that may cause your dependents to lose coverage. For some events, certain dependents are eligible to continue their coverage for a time. Here are the events, eligible dependents and time periods:

Qualifying event causing loss of coverage	Covered persons eligible for continued coverage	Length of continued coverage (starts from the day you lose current coverage)
<ul style="list-style-type: none">• Death of covered student	<ul style="list-style-type: none">• Dependent who has been covered under the plan for at least 1 year• An infant under 1 year of age	3 years
<ul style="list-style-type: none">• Divorce		

When do I receive state continuation information?

The chart below lists who must give the notice, the type of notice required, and the time period to give the notice:

Notice	Requirement	Deadline
You or your covered spouse	Send written notice to your policyholder	Within 15 days of the qualifying event
Your policyholder	Will provide you with: <ul style="list-style-type: none">• An enrollment form to continue coverage• The amount of premium to be charged (in the case of the covered student's death)	Immediately after they receive notification
You or your covered spouse	Complete the enrollment form to continue coverage	Within 60 days of the qualifying event.

You must send the completed enrollment form within 60 days of the qualifying event. If you don't, you will lose the right to continue coverage. We will cover your dependent during this period as long as the **premiums** and administrative charges are paid.

Continuation of coverage for other reasons

To request an extension of coverage, just call the Member Services toll-free number on the back of your ID card.

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

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

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

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

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

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

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

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

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

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

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

Your disabled child's coverage will end:

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

How can your dependents continue coverage after you die?

Your dependents can continue coverage after your death if:

- You were covered at the time of your death
- The request is made within 31 days after your death
- Payment is made for the coverage

Your dependent's coverage will end on the earliest date:

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

To request extension of coverage, the dependent or their representative can just call Member Services at the toll-free number on your ID card.

General provisions – other things you should know

Entire student policy

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

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

Administrative provisions

How you and we will interpret this certificate of coverage

We prepared this certificate of coverage according to federal laws and state laws that apply. You and we will interpret it according to these laws.

How we administer this plan

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

Who's responsible to you

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

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

Coverage and services

Your coverage can change

Your coverage is defined by the **student policy**. This document may have amendments or riders too. Under certain circumstances, we or the **policyholder** or the law may change your plan at the time of renewal and according to requirements of the **student policy**. Only **Aetna** may waive a requirement of your plan. No other person – including **provider** – can do this.

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

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

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

If a service cannot be provided to you

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

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

Legal action

We encourage you to complete the appeal process before you take any legal action against us for any expense or bill. See the *When you disagree - claim decisions and appeals procedures* section. You cannot take any action until the 61st day 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.

Physical examinations and evaluations

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

Records of expenses

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

Things that would be important to keep are:

- Names of **physicians, dental providers** and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

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

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage as follows:

- We will give you 30 days advanced written notice of any rescission of coverage
- You have the right to an **Aetna** appeal
- You have the right to a third party review conducted by an independent review organization

We won't rescind your coverage due to an intentional deception if the deception happened more than 2 years after the certificate of coverage effective date.

In the absence of fraud, any statement made is considered a representation and not a warranty. We will only use a statement during a dispute if it is shared with you and your beneficiary, or the person making the claim.

Some other money issues

Assignment of benefits

When you see a **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. If you assign benefits to a provider, we will pay them directly.

Notice of claim

We must receive your claim within 20 days (or as soon as reasonably possible) after you get a covered medical service. You can send the claim to us or to one of our authorized agents. 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. See the *Proof of loss* section below.

Proof of loss

We must receive written proof of loss from you within 90 days after your loss occurs. If you couldn't reasonably provide this proof within 90 days, we will still accept your claim. But you must provide the proof as soon as possible, but no later than one year after the 90 days ends (unless you were legally incapacitated).

Time of payment of claims

We will pay benefits to you or your assignee. After we receive your timely proof of loss, we will pay claims within 60 days after we receive the proof of loss. Please see the *Proof of loss* section above for more information.

Grace period

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

Payment of premiums

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

Recovery of overpayments

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

When you are injured by a third party

If a third party caused you to need care – say, a careless driver who injured you in a car crash – you may have a legal right to get money for your injuries. If you have a legal right to get money from a third party for causing your injuries, then We are entitled to that money, up to the amount we pay for your care.

When you have a legal right to get money from one or more third parties for causing your **injuries** and you pursue that legal right.

- You are agreeing to repay us from money you receive from those third parties because of your **injuries**.
- You are giving us a right to seek money in your name, from those third parties because of your injuries.
- You are agreeing to cooperate with us so we can get paid back in full, up to the applicable amount noted below. For example, you'll tell us within 30 days of when you seek money from those third parties for your **injury or illness**. You'll hold any money you receive until we are paid in full. And you'll give us the right to our portion of the money you get, ahead of everyone else.
- You are agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money. Notify us by calling Member Services at the toll-free number on your member ID card.

We will only seek money from your own uninsured/underinsured motorist or medical payments coverage (if any) if you or your immediate family member did not pay premiums for coverage

If you are represented by an attorney, then we can recover the lessor of:

- One-half of the money you receive, less attorney's fees and costs for the recovery, or
- The total amount paid by us, less attorney's fees and costs for the recovery

If you are not represented by an attorney, then we can recover the lessor of:

- One-half of the money you receive, or
- The total amount paid by us

Important note:

If a declaratory judgment action is brought, the court may not award costs or attorney's fees to any party in the action.

How will attorney's fees be determined?	
If we do not use an attorney	<ul style="list-style-type: none">• We (and any other payors) will pay your attorney a fee agreed to between us (and other payors) and your attorney plus a pro rata share of the recovery expenses• If no agreement exists, then the court will award your attorney a reasonable fee payable for our (and any other payors') share of the recovery, not to exceed 1/3 of the recovery
If we use an attorney	<ul style="list-style-type: none">• The court will award attorney's fees to our attorney and your attorney based on the benefit accruing as a result of each attorney's service. The total attorney's fees may not exceed 1/3 of our (and any other payors') recovery.
<p>Payor means a plan issuer that:</p> <ul style="list-style-type: none">• Has a contractual right of subrogation, and• Pays benefits to you or on your behalf as a result of personal injuries caused by someone else's tortious conduct <p>A payor includes, but is not limited to, an issuer of:</p> <ul style="list-style-type: none">• A health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness• A disability benefit plan• An employee welfare benefit plan	

Payment to a conservator, other than you

Sometimes a court order gives another person certain rights and duties to act on behalf of your dependent child. Such a person is called a managing or possessory conservator. We may pay that person benefits on behalf of your dependent child. To receive benefits, they must send us a written certified copy of the court order with the claim form. But they are not entitled to benefits if:

- We received a valid assignment of benefits on an unpaid medical bill
- You sent us a claim for benefits for an **eligible health service** that you paid

Reimbursement to Texas Department of Human Services

We will repay the actual costs of medical expenses the Texas Department of Human Services pays through medical assistance for you or your dependent if you or your dependent are entitled to payment for the medical expenses.

Repayment of these medical expenses for your dependent child will be paid to the Texas Department of Human Services if, when you submit proof of loss, you notify us in writing that:

- Your dependent child is covered under the financial and medical assistance service program in Texas and you either:
 - Have possession or access to the child through a court order; or
 - Are not entitled to possession of or access to the child and are required by the court to pay child support

You will need to ask us to make direct payment to the Texas Department of Human Services.

Your health information

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

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

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

Effect of benefits under other plans

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

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

Glossary A-M

Accident or accidental

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

Aetna

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

Ambulance

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

Behavioral health provider

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

Brand-name prescription drug

A U.S. Food and Drug Administration (FDA) approved **prescription drug** marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Calendar year

A period of 12 months beginning January 1st and ending on December 31st.

Clinical related injury

As used within the *Blood and body fluid exposure covered benefit*, this is any **incident** which exposes you, acting as a student in a clinical capacity, to an **illness** that requires testing and treatment. Incident means unintended:

- Needlestick pricks
- Exposure to blood and body fluid
- Exposure to highly contagious pathogens

Coinsurance

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

Contracting dental provider

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

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, . except as covered in the *Reconstructive surgery and supplies* section.

Covered benefits

Eligible health services that meet the requirements for coverage under the terms of this plan.

Covered dependent

A person who is insured under the **student policy** as a dependent of a **covered student**.

Covered person

A **covered student** or a **covered dependent** of a **covered student** for whom all of the following applies:

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

Covered student

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

Craniomandibular joint dysfunction (CMJ)

This is a disorder of the jaw joint.

Crisis stabilization unit

An institution licensed or certified by the Texas Department of Mental Health and Mental Retardation to provide a 24-hour residential program to treat a moderate to severe psychiatric crisis. The program is prescribed by a **physician** or other **health professional** to provide short-term, intensive and structured care.

Custodial care

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

Dental emergency

Any dental condition that:

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

Dental emergency services

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

Dental provider

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

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

Dentist(s)

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

Detoxification

The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

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

Directory

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

Durable medical equipment (DME)

Equipment and the accessories needed to operate it, that is:

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

Effective date of coverage

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

Elective treatment

Services and supplies provided to you when there is no evidence of pathology, dysfunction, or **illness** in any part of your body. Examples of elective treatment are:

- Breast reduction
- Sub mucous resection and/or other surgical correction for deviated nasal septum, other than the treatment of covered acute purulent sinusitis

Eligible health services

The health care services and supplies and outpatient **prescription drugs** listed in the *Eligible health services under your plan* section and not carved out or limited in the *Exceptions* section of this certificate of coverage or in the schedule of benefits.

Emergency admission

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

Emergency medical condition

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

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus
- Serious disfigurement 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 a **hospital's** emergency room, freestanding emergency facility or comparable emergency facility for an **emergency medical condition**. This includes evaluation of, and treatment to stabilize an **emergency medical condition**.

Experimental or investigational

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

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

Formulary exclusions list

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

Generic prescription drug

A **prescription drug** with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Health professional

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, 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 state and federal laws

Hospital does not include a:

- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility for substance abuse**

- **Residential treatment facility for mental disorders**
- Extended care facility
- Intermediate care facility
- Skilled nursing facility

Hospital stay

This is your **stay** of 18 or more hours in a row as a resident bed patient in a **hospital**.

Illness or illnesses

Poor health resulting from disease of the body or mind.

In-network pharmacy

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

In-network provider

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

Infertile or infertility

A disease defined by the failure to become pregnant:

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

Injectable drug(s)

These are **prescription drugs** when an oral alternative drug is not available.

Injury or injuries

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

Institutes of excellence™ (IOE) facility

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

Intensive care unit

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

Intensive outpatient program (IOP)

The clinical treatment provided must be:

- No more than 5 days per week
- No more than 19 hours per week
- A minimum of 2 hours each treatment day

Services must be **medically necessary** and delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a **mental disorder** or **substance abuse** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder

This is:

- A disorder of the jaw joint
- A Myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

Lifetime maximum

This is the most this plan will pay for **eligible health services** incurred by a **covered person** during their lifetime. Lifetime maximums do not apply to essential health benefits as classified by the Affordable Care Act (ACA) unless permitted.

Mail order pharmacy

A **pharmacy** where **prescription drugs** are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit

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

Medically necessary/Medical necessity

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

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

Generally accepted standards of medical practice means:

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

Medicare

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

Mental disorder

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

Glossary N-Z

Negotiated charge

Health coverage

This is either:

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

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

The **negotiated charge** does not reflect any amount an affiliate or we may receive under a rebate arrangement between us or an affiliate and a drug manufacturer for any **prescription drug**.

The rebates will not change the **negotiated charge** under this plan.

Prescription drug coverage from an in-network pharmacy

In-network pharmacy

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

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

We may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Non-contracting dental provider

A **dental provider** who is not a **contracting dental provider** and does not appear in the **directory** for your plan.

Non-preferred drug

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

Out-of-network dental provider

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

Out-of-network pharmacy

A **pharmacy** that is not an **in-network pharmacy**, a National Advantage Program (NAP) **provider** and does not appear in the directory for your plan.

Out-of-network provider

A **provider** who is not a **in-network provider** or National Advantage Program (NAP) **provider** and does not appear in the **directory** for your plan.

Partial hospitalization treatment

Clinical treatment provided must be **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental disorder** or **substance abuse** issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Care is delivered according to accepted medical practice for the condition of the person.

Pharmacy

An establishment where **prescription drugs** are legally dispensed. This includes a **in-network retail pharmacy**, **mail order pharmacy** and **specialty pharmacy**. It also includes an out-of-network **retail pharmacy**.

Physician

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

Policyholder

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

Policy year

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

Policy year deductible

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

Preauthorization, preauthorize

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

Preferred drug

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

Preferred drug guide

A list of **prescription drugs** and devices established by **Aetna** or an affiliate. It does not include all **prescription drugs** and devices. This list can be reviewed and changed by **Aetna** or an affiliate only upon renewal and with 60 days notice to you. A copy of the **preferred drug guide** is available at your request. You can also find it on the **Aetna** website at www.aetnastudenthealth.com/formulary.

Preferred in-network pharmacy

A **network retail pharmacy** that **Aetna** has identified as a **preferred in-network pharmacy**.

Premium

The amount you or the **policyholder** are required to pay to **Aetna** to continue coverage.

Prescriber

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

Prescription

As to hearing care:

A written order for the dispensing of **prescription** electronic hearing aids by otolaryngologist, otologist or audiologist.

*As to **prescription drugs**:*

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

As to vision care:

A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

Prescription drug

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

Provider(s)

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

Psychiatric hospital

An institution specifically licensed as a **psychiatric hospital** by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of **substance abuse** and **mental disorders**.

Mental disorders includes related **substance abuse** disorders.

Psychiatrist

A **psychiatrist** generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

Recognized charge

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The **recognized charge** depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Service or supply	Recognized charge
Professional services and other services or supplies not mentioned below	105% of the Medicare allowed rate
Services of hospitals and other facilities	105% 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.	

Special terms used

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

Our reimbursement policies

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

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

Our reimbursement policies are based on our review of:

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

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

R.N.

A registered nurse.

Residential treatment facility (mental disorders)

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

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

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

Residential treatment facility (substance abuse)

An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for **substance abuse** residential treatment programs. And is credentialed by **Aetna** or accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for **substance abuse** residential treatment programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a **physician**
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

In addition to the above requirements, for **substance abuse detoxification** programs within a residential setting:

- An **R.N.** must be onsite 24 hours per day for 7 days a week within a residential setting
- Residential care must be provided under the direct supervision of a **physician**

Respite care

This is care provided to you when you have a **terminal illness** for the sole purpose of providing temporary relief to your family (or other care givers) from the daily demands of caring for you.

Retail pharmacy

A community **pharmacy** that dispenses outpatient **prescription drugs** at retail prices.

Room and board

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

School health services

Any:

- Organization
- Facility
- Clinic
- **Pharmacy**

that is operated, maintained, or supported by the **policyholder** (or other entity under contract to the **policyholder**) which provides health care services to **covered students** and their **covered dependents**. **School health services** will either provide or coordinate the care provided to **covered students**.

Semi-private room rate

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

Service area

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

Skilled nursing facility

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

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

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of **mental disorders** or **substance abuse**.

Skilled nursing services

Services provided by an **R.N.** or **L.P.N.** within the scope of his or her license.

Sound natural teeth

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

Specialist

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

Specialty prescription drugs

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

You can access the list of these **specialty prescription drugs** by calling Member Services at the toll-free number on your ID card or by logging on to your Aetna Navigator® secure website at www.aetnastudenthealth.com.

Specialty pharmacy

This is a **pharmacy** designated by Aetna as an **in-network pharmacy** to fill **prescriptions** for **specialty prescription drugs**.

Stay

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

Step therapy

A form of **preauthorization** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate only upon renewal and with 60 days' notice to you. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.aetnastudenthealth.com/formulary.

Student policy

The **student policy** consists of several documents taken together. The list of documents can be found in the *Entire student policy* section of this certificate of coverage.

Substance abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a **mental disorder** that are a focus of attention or treatment. Or an addiction to nicotine products, food or caffeine intoxication.

Surgery center

A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all **Medicare** accreditation standards (even if it does not participate in **Medicare**).

Surgery, surgeries or surgical procedures

The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution or
- Otherwise physically changing body tissues and organs

Telehealth

A health service, other than a **telemedicine** medical service, delivered by a **health professional** licensed, certified or otherwise entitled to practice in the State of Texas and acting within the scope of their license, certification, or entitlement to a patient at a different physical location than the **health professional** using telecommunications or information technology.

Telemedicine

A health care service delivered by a **physician** licensed in the State of Texas, or a **health professional** acting under the delegation and supervision of a **physician** licensed in the State of Texas, and acting within the scope of their license to a patient at a different physical location than the **physician** or **health professional** using telecommunications or information technology.

Temporomandibular joint dysfunction

This is a disorder of the jaw joint.

Terminal illness

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

Urgent care facility

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

Urgent condition

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

Urgent admission

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

Walk-in clinic

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

- An emergency room
- The outpatient department of a **hospital**

10,20,30,40,50,60,70,80,90,95,100,102,110,120,130,140,150,160,170,180,190

Assistive Technology

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

Smartphone or Tablet

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

Non-Discrimination

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

Aetna:

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

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

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

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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

Language Assistance

TTY: 711

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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