Student Health Insurance

Open Choice PPO
Medical and Outpatient Prescription Drug Plan

Schedule of benefits

Prepared exclusively for:

Policyholder:	New York Film Academy Los Angeles Campus
Policyholder number:	686187
Student policy effective date:	08/31/2024
Plan effective date:	08/31/2024
Plan issue date:	04/11/2025
Actuarial value and metallic level:	89.49% - Platinum

Underwritten by Aetna Life Insurance Company in the State of California

Schedule of benefits

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

How to read your schedule of benefits

- When we say:
  - "In-network coverage", we mean you get care from our **in-network providers**.
  - "Out-of-network coverage", we mean you can get care from **out-of-network providers**.
- The **policy year deductibles**, **copayments** and **coinsurance** listed in the schedule of benefits below reflect the **policy year deductibles**, **copayments** and **coinsurance** amounts under your plan.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount that the plan pays. You are responsible for paying any remaining **coinsurance**.
- You are responsible for paying any **policy year deductibles**, **copayments** and your **coinsurance**.
- You are responsible for full payment of any health care services you receive that are not **covered benefits**.
- 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**
  - **Copayments**
  - Maximums
  - **Coinsurance**
  - **Maximum out-of-pocket limits**

Important note:
All **covered benefits** are subject to the **policy year deductible**, **copayment** and **coinsurance** unless otherwise noted in the schedule of benefits below. The No Surprises Act may limit your **out-of-network** cost share in some instances. The *Surprise bill* section of the certificate explains your protection from a surprise bill.

How to contact us for help

We are here to answer your questions.

- Log in to your **Aetna®** website at https://www.aetnastudenthealth.com
- Call Member Services at the toll-free number on your ID card.

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

Important note about your cost sharing

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

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

Plan features

Policy year deductibles

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

Deductible type	In-network coverage	Out-of-network coverage
Student	$250 per **policy year**	$500 per **policy year**
Spouse	$250 per **policy year**	$500 per **policy year**
Each child	$250 per **policy year**	$500 per **policy year**

Policy year deductible waiver

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

- In-network care for Preventive care and wellness,
- In-network care for Pediatric Dental services,
- In-network care for Pediatric Vision Care Services,
- In-network care and out-of-network care for Well Newborn Nursery Care
- In-network care and out-of-network care for Outpatient Prescription Drugs.

Maximum out-of-pocket limits

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

Maximum out-of-pocket type	In-network coverage	Out-of-network coverage
Student	$3,000 per **policy year**	Unlimited
Spouse	$3,000 per **policy year**	Unlimited
Each child	$3,000 per **policy year**	Unlimited
Family	$6,000 per **policy year**	Unlimited

Precertification covered benefit penalty

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

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

- Up to $500 benefit penalty will be applied separately to each type of **eligible health service**

This is not a **covered benefit**. This amount will not exceed the cost of the **eligible health service** and will not be applied to the out-of-network **policy year deductible** amount or the **maximum out-of-pocket limit**, if any.

Eligible health services

Coinsurance listed in the schedule of benefits

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

1. Preventive care and wellness

Routine physical exams

Performed at a **physician's** office

Description	In-network coverage	Out-of-network coverage
Routine physical exam	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Routine physical exam limits for **covered persons** through age 21: maximum age and visit limits per **policy year**	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Routine physical exam limits for **covered persons** age 22 and over: maximum visits per **policy year**	1 visit	

Preventive care immunizations

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

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

Well woman preventive visits

Routine gynecological exams (including Pap smears)

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

Preventive screening and counseling services

Description	In-network coverage	Out-of-network coverage
Obesity and/or healthy diet counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Misuse of alcohol and/or drugs counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Depression screening counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Use of tobacco products counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Sexually transmitted infection counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit

Description	In-network coverage	Out-of-network coverage
Genetic risk counseling for breast and ovarian cancer office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Stress management counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Chronic condition counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit

Routine cancer screenings

Performed at a **physician** office, **specialist** office or facility

Description	In-network coverage	Out-of-network coverage
Routine cancer screenings	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Routine cancer screening maximums	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF Comprehensive guidelines supported by the Health Resources and Services Administration For details, contact your **physician** or Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Lung cancer screening maximums	1 screening every 12 months	

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

Prenatal and postpartum care

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

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

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

Comprehensive lactation support and counseling services

Facility or office visits

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

Breast feeding durable medical equipment

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

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

Family planning services – contraceptives

Counseling services

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

Contraceptives (prescription drugs and devices)

Description	In-network coverage	Out-of-network coverage
Contraceptive **prescription drugs** and devices provided, administered, or removed, by a **provider** during an office visit For each 30 day supply or 12 month supply	100% (of the **negotiated charge**) per item No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per item

Voluntary sterilization, including vasectomy services

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

2. Physicians and other health professionals

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

Description	In-network coverage	Out-of-network coverage
Office hours visits (non-surgical and non-preventive care by a **physician** or **specialist**, includes **telemedicine** consultations)	$20 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit	$20 **copayment** then the plan pays 70% (of the balance of the **recognized charge**) per visit

Allergy testing and treatment

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

Physician and specialist – inpatient surgical services

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

Physician and specialist – outpatient surgical services

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

In-hospital non-surgical physician services

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

Consultant services (non-surgical and non-preventive)

Description	In-network coverage	Out-of-network coverage
Office hours visits (non-surgical and non-preventive care by a consultant, includes **telemedicine** consultations)	$20 **copayment** then the plan pay 100% (of the balance of the **negotiated charge**) per visit	$20 **copayment** then the plan pays 70% (of the balance of the **recognized charge**) per visit

Second surgical opinion

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

Alternatives to physician office visits

Walk-in clinic visits (non-emergency visit)

Description	In-network coverage	Out-of-network coverage
Walk-in clinic (non-emergency visit)	$50 **copayment** then the plan pays 100% (of the balance of the **negotiated charge)** per visit	$50 **copayment** then the plan pays 70% (of the balance of the **recognized charge**) per visit

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

3. Hospital and other facility care

Hospital care (facility charges)

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

Preadmission testing

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

Anesthesia and related facility charges for a dental procedure

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

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

Home health care

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

Hospice care

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

Skilled nursing facility

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

4. Emergency services and urgent care

Emergency services

Description	In-network coverage	Out-of-network coverage
Hospital emergency room	$150 **copayment** then the plan pays 80% (of the balance of the **negotiated charge**) per visit	Paid the same as in-network coverage
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

Emergency services important note:

- **Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, or call Member Services for an address at 1-877-480-4161 and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.
- A separate **hospital** emergency room **copayment** will apply for each visit to an emergency room. If you are admitted to a **hospital** as an inpatient right after a visit to an emergency room, your emergency room **copayment** will be waived and your inpatient **copayment** will apply.
- **Covered benefits** that are applied to the **hospital** emergency room **copayment** cannot be applied to any other **copayment** under the plan. Likewise, a **copayment** that applies to other **covered benefits** under the plan cannot be applied to the **hospital** emergency room **copayment**.
- Separate **copayment** amounts may apply for certain services given to you in the **hospital** emergency room that are not part of the **hospital** emergency room benefit. These **copayment** amounts may be different from the **hospital** emergency room **copayment**. They are based on the specific service given to you.
- Services given to you in the **hospital** emergency room that are not part of the **hospital** emergency room benefit may be subject to **copayment** amounts that are different from the **hospital** emergency room **copayment** amounts.

Urgent care

The cost share below does not include complex imaging services, lab work and radiological services performed during an urgent medical care visit. See the cost-sharing that applies to these **covered benefits** in this schedule of benefits.

Description	In-network coverage	Out-of-network coverage
Urgent medical care provided by an urgent care **provider**	$50 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit	$50 **copayment** then the plan pays 70% (of the balance of the **recognized charge)** per visit
Non-urgent use of urgent care **provider**	Not covered	Not covered

5. Pediatric dental care

Pediatric dental care

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

Description	In-network coverage	Out-of-network coverage
Type A services	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Type B services	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Type C services	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit
Orthodontic services	100% (of the **negotiated charge**) per visit No **copayment** or **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.

6. Specific conditions

Abortion

Description	In-network coverage	Out-of-network coverage
Abortion services (including pre abortion and follow-up abortion related services)	100% (of the **negotiated charge**) No **policy year deductible** applies	100% (of the **recognized charge)** No **policy year deductible** applies

Birthing center (facility charges)

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

Diabetic services and supplies (including equipment and training)

Description	In-network coverage	Out-of-network coverage
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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

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

Impacted wisdom teeth

Description	In-network coverage	Out-of-network coverage
Impacted wisdom teeth	80% (of the **negotiated charge**)	60% (of the **recognized charge**)

Accidental injury to sound natural teeth

Description	In-network coverage	Out-of-network coverage
Accidental injury to **sound natural teeth**	80% (of the **negotiated charge**)	60% (of the **recognized charge**)

Blood and body fluid exposure

Description	In-network coverage	Out-of-network coverage
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

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

Maternity care that is not considered preventive care

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

Well newborn nursery care

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

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

Gender affirming treatment

Description	In-network coverage	Out-of-network coverage
Gender affirming treatment, including surgical, hormone replacement therapy, and counseling treatment	Covered according to the Behavioral health section.	Covered according to the Behavioral health section.

Behavioral health

Medically necessary treatment of **mental health conditions** and **substance use disorders** are covered under the same terms and conditions applied to other medical conditions and in accordance with the federal Mental Health Parity and Addiction Equity Act.

Mental health treatment – inpatient

Description	In-network coverage	Out-of-network coverage
Inpatient **hospital mental health conditions** treatment (**room and board** and other miscellaneous **hospital** services and supplies) Inpatient **residential treatment facility mental health conditions** treatment (**room and board** and other miscellaneous **residential treatment facility** services and supplies) Subject to **semi-private room rate** unless **intensive care unit** is required **Mental health conditions room and board** intensive care	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

Mental health treatment – outpatient

Description	In-network coverage	Out-of-network coverage
Outpatient **mental health conditions** office visits to a **physician** or **behavioral health provider** (Includes **telemedicine** consultations)	$20 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit	$20 **copayment** then the plan pays 70% (of the balance of the **recognized charge**) per visit
Other outpatient **mental health conditions** treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive outpatient program	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Substance use disorders treatment – inpatient

Description	In-network coverage	Out-of-network coverage
Inpatient **hospital substance use disorders** (**room and board** and other miscellaneous **hospital** services and supplies) Inpatient **residential treatment facility substance use disorders** (**room and board** and other miscellaneous **residential treatment facility** services and supplies) Subject to **semi-private room rate** unless **intensive care unit** is required **Substance use disorders room and board** intensive care	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

Substance use disorders treatment – outpatient

Description	In-network coverage	Out-of-network coverage
Outpatient **substance use disorders** office visits to a **physician** or **behavioral health provider** (Includes **telemedicine** consultations)	$20 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit	$20 **copayment** then the plan pays 70% (of the balance of the **recognized charge**) per visit
Other outpatient **substance use disorder** services Partial hospitalization treatment Intensive outpatient program	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Obesity (bariatric) surgery

Description	In-network coverage	Out-of-network coverage
Obesity **surgery** – inpatient and outpatient facility and **physician** 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.

Obesity (bariatric) surgery travel and lodging

Description	In-network coverage	Out-of-network coverage
Maximum benefit payable for travel expenses for each round trip – three round trips covered (one pre-surgical visit, the surgery and one follow-up visit)	$130	
Maximum benefit payable for travel expenses per companion for each round trip – two round trips covered (the surgery and one follow-up visit)	$130	
Maximum benefit payable for lodging expenses per patient and companion for the pre-surgical and follow-up visits	$100 per day up to two days	
Maximum benefit payable for lodging expenses per companion for surgery stay	$100 per day up to four days	

Reconstructive surgery and supplies

Description	In-network coverage	Out-of-network coverage
Reconstructive **surgery** and supplies (includes reconstructive breast **surgery**)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Transplant services

Description	In-network coverage (IOE facility)	Out-of-network coverage (Includes **providers** who are otherwise part of **Aetna's** network but are non-IOE **providers**)
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Inpatient and outpatient transplant **physician** and **specialist** services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Transplant services – travel and lodging

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

Infertility services

Basic infertility

Description	In-network coverage	Out-of-network coverage
Treatment of basic **infertility**	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Fertility preservation services

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

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

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

Diagnostic lab work and radiological services

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

Chemotherapy

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

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

Description	In-network coverage (GCIT-designated facility/provider)	Out-of-network coverage (Including **providers** who are otherwise part of **Aetna's** network but are not GCIT-designated facilities/**providers**)
Services and supplies	Covered according to the type of benefit and the place where the service is received.	Not covered

Outpatient infusion therapy

Description	In-network coverage	Out-of-network coverage
Outpatient infusion therapy performed in a **covered person's** home, **physician's** office, outpatient department of a **hospital** or other facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Outpatient radiation therapy

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

Specialty prescription drugs

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

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

Outpatient respiratory therapy

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

Transfusion or kidney dialysis of blood

Description	In-network coverage	Out-of-network coverage
Transfusion or kidney dialysis of blood	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation and habilitation therapy services

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

Chiropractic services

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

Diagnostic testing for learning disabilities

Description	In-network coverage	Out-of-network coverage
Diagnostic testing for learning disabilities	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

8. Other services

Acupuncture

Description	In-network coverage	Out-of-network coverage
Acupuncture	$20 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit	$20 **copayment** then the plan pays 70% (of the balance of the **recognized charge**) per visit

Ambulance service

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

Clinical trial therapies (experimental or investigational)

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

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

Durable medical equipment (DME)

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

Nutritional support

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

Orthotic devices

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

Osteoporosis (non-preventive care)

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

Prosthetic devices

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

Hearing aids

Description	In-network coverage	Out-of-network coverage
Hearing aids	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Hearing aids maximum per ear	One hearing aid per ear every 24 month consecutive period	

Hearing exams

Description	In-network coverage	Out-of-network coverage
Hearing exams	100% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Podiatric (foot care) treatment

Description	In-network coverage	Out-of-network coverage
Physician and **specialist** non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Vision care

Pediatric vision care

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

Pediatric routine vision exams (including refraction)

Description	In-network coverage	Out-of-network coverage
Performed by a legally qualified ophthalmologist or optometrist	100% (of the **negotiated charge)** per visit No **policy year deductible** applies	70% (of the **recognized charge**) per visit

Pediatric comprehensive low vision evaluations

Description	In-network coverage	Out-of-network coverage
Performed by a legally qualified ophthalmologist or optometrist	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum	One comprehensive low vision evaluation every five **policy years**	

Pediatric vision care services and supplies

Description	In-network coverage	Out-of-network coverage
Office visit for fitting of contact lenses	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	70% (of the **recognized charge**) per visit
Maximum contact lens fitting visits per **policy year**	1 visit	
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	100% (of the **negotiated charge**) per item No **policy year deductible** applies	70% (of the **recognized charge**) per item
Maximum number of eyeglass frames per **policy year**	One set of eyeglass frames	
Maximum number of **prescription** lenses per **policy year**	One pair of **prescription** lenses	

Description	In-network coverage	Out-of-network coverage
Maximum number of **prescription** contact lenses per **policy year** (includes non-conventional **prescription** contact lenses and aphakic lenses prescribed after cataract **surgery**)	Daily disposable: up to one year supply Extended wear disposable: one year supply Non-disposable: one year supply	
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per **policy year**	One optical device	

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

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

Adult vision care

Limited to **covered persons** age 19 and over

Adult routine vision exams (including refraction)

Description	In-network coverage	Out-of-network coverage
Performed by a legally qualified ophthalmologist or optometrist	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	1 visit	

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

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

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

9. Outpatient prescription drugs

Plan features

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

Outpatient prescription drug copayment waiver for risk reducing breast cancer

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

Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs

The outpatient **prescription drug copayment** will not apply to treatment regimens 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%.

Outpatient prescription drug copayment waiver for contraceptives

The outpatient **prescription drug 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:

- All FDA approved contraceptive **prescription drugs** and devices, including over-the-counter (OTC) contraceptive **prescription drugs** and devices. Related services and supplies needed to administer covered devices will also be paid at 100%.

- A **therapeutic equivalent prescription drug** or device when a **prescription drug** or device not available or is deemed medically inadvisable by your provider when you are granted a medical exception.

The certificate of coverage explains how to get a medical exception.

Generic prescription drugs (including specialty drugs)

Your cost-share may not exceed $250 for each 30 day supply of an individual **prescription**. This does not include any **policy year deductible.**

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	$10 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$10 **copayment** per supply then the plan pays 100% (of the balance of the **recognized charge**) No **policy year deductible** applies

Preferred brand-name prescription drugs (including specialty drugs)

Your cost-share may not exceed $250 for each 30 day supply of an individual **prescription**. This does not include any **policy year deductible.**

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

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

Your cost-share may not exceed $250 for each 30 day supply of an individual **prescription**. This does not include any **policy year deductible.**

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	$40 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$40 **copayment** per supply then the plan pays 100% (of the balance of the **recognized charge**) No **policy year deductible** applies

Anti-cancer drugs taken by mouth

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

Contraceptives (birth control)

Description	In-network coverage	Out-of-network coverage
For each fill up to a 12 month supply of generic and OTC drugs and devices filled at a **retail pharmacy**	100% (of the **negotiated charge**) No **policy year deductible** applies	100% (of the **recognized charge**) No **policy year deductible** applies
For each fill up to a 12 month supply of **brand-name prescription drugs** and devices filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits, above A brand-name contraceptive is 100% (of the **negotiated charge**), No **policy year deductible** applies, if there are no generic **therapeutic equivalent** or when a medical exception has been granted.	Paid according to the type of drug per the schedule of benefits, above
Contraceptive important note: The **prescription** drug cost share will not apply to contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes over-the-counter (OTC) contraceptive **prescription drugs** and devices for each of the methods identified by the FDA. If a **prescription drug** is not available or inadvisable by your provider, the **therapeutic equivalent prescription drug** for that method will be paid at 100%. The **prescription** drug cost share will apply to **prescription** drugs that have a **therapeutic equivalent** obtained at a network pharmacy unless you receive a medical exception. You can fill up to a 12 month supply at one time.		

Preventive care drugs and supplements

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

Risk reducing breast cancer prescription drugs

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

Tobacco cessation prescription and over-the-counter drugs (preventive care)

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

Outpatient prescription drugs important note:

If a **provider** prescribes a covered **brand-name prescription drug** when a generic equivalent is available and not covered by the plan, you will pay the generic price for the brand name drug. If a provider prescribes a covered **brand-name prescription drug** when a **generic prescription drug** equivalent is available and covered by the plan, you will pay the cost share for the generic drug if the brand is **medically necessary**. If the **brand-name prescription drug** is not **medically necessary**, you will be responsible for the cost share that applies to the brand-name drug.

General coverage provisions

This section provides detailed explanations about these features:

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

Policy year deductible provisions

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

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

Individual

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

Copayments

In-network coverage

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

Out-of-network coverage

This is a specified dollar amount or percentage that must be paid by your 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.

Coinsurance

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

Maximum out-of-pocket limits provisions

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

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments**, **coinsurance** and **policy year deductibles** for **eligible health services** during the **policy year**. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual

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

Family

Once the amount of the **copayments**, **coinsurance** and **policy year deductibles** you and your **covered dependents** have paid for **eligible health services** during the **policy year** meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **eligible health services** that would apply toward the limit for the remainder of the **policy year** for all covered family members.

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

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

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **eligible health services** during the **policy year**. This plan has an individual and family **maximum out-of-pocket limit**.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a **covered benefit**, your **copayment** and **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

Calculations; determination of recognized charge; determination of benefits provisions

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

Student Health Insurance

Open Choice PPO

Medical and Outpatient Prescription Drug Plan

Certificate of Coverage

Prepared exclusively for:

Policyholder:	New York Film Academy Los Angeles Campus
Policyholder number:	686187
Student policy effective date:	08/31/24
Plan effective date:	08/31/24
Plan issue date:	04/11/25

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). Visit https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx to find out more.
- **Right to examine the student policy:**
  You have 30 days after you receive this **student policy** to read and review it. During that 30-day period, if you decide you do not want the **student policy**, you may return it to **Aetna Life Insurance Company**. As soon as it is returned, this **student policy** will be void from the beginning. **Premium** paid will be returned to you.

California requires residents and their dependents to obtain, and maintain, health coverage or pay a penalty, unless they qualify for an exemption. Enrolling in student health insurance offered by the college or university you are attending is one way to meet this requirement.

You may be eligible to get free or low-cost health coverage through Medi-Cal regardless of immigration status. In addition, you may be eligible for free or low-cost health coverage through Covered California. Visit Covered California at www.coveredca.com to learn about health coverage options that are available for you and your dependents, and how you might qualify to get financial assistance with the cost of coverage.

If you are under 26 years of age, you may be eligible for coverage as a dependent in a group health plan of your parent's employer or under your parents' individual market coverage. In addition, you may be eligible to buy individual health insurance directly from a health insurer or health plan, regardless of immigration status.

Please examine your options carefully to see if other options are more affordable and whether you are currently eligible to enroll in these other forms of coverage pursuant to an open or special enrollment period.

Welcome

Thank you for choosing **Aetna®**.

This is your certificate of coverage. It is one of three documents that together describe the benefits covered by your **Aetna** plan.

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

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

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

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

Welcome to your **Aetna** plan.

How to contact us for help

We are here to answer your questions, receive complaints, including those regarding *Timely access to care*, or you can request a confidential communication to keep your medical information private.

You can 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**
- **Visiting https://www.aetnastudenthealth.com to register and access your Aetna website and to obtain Aetna's directory of network providers**

You can also contact the California Department of Insurance at:

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

OBTAINING MEDICALLY APPROPRIATE CARE - OUT-OF-NETWORK PROVIDERS

IN-NETWORK PROVIDER NOT REASONABLY AVAILABLE – YOU CAN GET ELIGIBLE HEALTH SERVICES UNDER YOUR PLAN FROM OUT-OF-NETWORK PROVIDERS IF AN APPROPRIATE IN-NETWORK PROVIDER IS NOT REASONABLY AVAILABLE. WE WILL ARRANGE FOR THE REQUIRED CARE WITH AVAILABLE AND ACCESSIBLE PROVIDERS OUTSIDE THE NETWORK. YOU WILL BE RESPONSIBLE FOR PAYING ONLY THE COST-SHARING IN AN AMOUNT EQUAL TO THE COST-SHARING THEY WOULD HAVE PAID FOR PROVISION OF THAT OR SIMILAR SERVICE IN NET-WORK. IN ADDITION TO IN-NETWORK COPAYMENTS AND COINSURANCE, IN-

NETWORK COST SHARING INCLUDES APPLICABILITY OF THE IN-NETWORK DEDUCTIBLE AND ACCRUAL OF COST SHARING TO THE IN-NETWORK OUT-OF-POCKET MAXIMUM

WARNING: THE INSURANCE DESCRIBED IN THIS CERTIFICATE IS A PREFERRED PROVIDER ORGANIZATION (PPO) PLAN. YOU WILL BE COVERED FOR BOTH IN-NETWORK AND OUT-OF-NETWORK BENEFITS REGARDLESS OF WHERE YOU LIVE.

WE WILL PAY FOR EMERGENCY SERVICES AT THE IN-NETWORK LEVEL, WHETHER YOU USE AN IN-NETWORK OR OUT-OF-NETWORK PROVIDER.

GENERALLY, SERVICES WILL NOT BE PAID AT THE IN-NETWORK LEVEL IF THE THEY ARE RECEIVED FROM AN OUT-OF-NETWORK PROVIDER. ANY SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER:

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

SEE THE *SURPRISE BILL* SECTION FOR EXCEPTIONS TO THIS RULE.

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

Table of contents

Let's get started!

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

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

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

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

What your plan does – providing covered benefits

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

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

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 and exclusions* section.
- They are not carved out in the *What your plan doesn't cover – general exclusions* section.
- They are not beyond any limits in the schedule of benefits.

Paying for eligible health services– the general requirements

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

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

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

Paying for eligible health services– sharing the expense

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

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

Disagreements

We know that people sometimes see things differently.

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

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

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

Your in-network coverage helps you:

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

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

Aetna's network of providers

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

If you can't find an **in-network provider** for a service or supply that you need, call Member Services at the toll-free number 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.

Timely access to care

In-network providers agree to provide timely access to care. You will see your **provider** when you call for an appointment within these timeframes:

- Urgent care within 48 hours of the request, for services that do not require prior authorization
- Urgent care appointments within 96 hours of the request, for services that require prior authorization
- Non-urgent appointments for primary care services within 10 business days of the request
- Non-urgent appointments for specialty care within 15 business days of the request

- Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health conditions within 15 business days of the request
- Non-urgent appointments with a non-physician **mental health condition** or **substance use disorder provider** within 10 business days of the request
- Non-urgent follow-up appointments with a non-physician **mental health condition** or **substance use disorder provider** within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing **mental health condition** or **substance use disorder**
- Telephone screening within 30 minutes of the request

Standards for timely access to pediatric vision and oral essential health benefits include:

- Urgent care within 48 hours of the request
- Non-urgent care within 36 business days of the request
- Preventive care within 40 days of the request

We may have exceptions to appointment wait times when the Department of Insurance allows such exceptions. Interpreter services will be made available to you at the time of your appointment.

Service area

Your plan generally pays for **eligible health services** only within a specific geographic area, called a **service area**. There are some exceptions, such as for **emergency services**, urgent care and transplants. See the *Who provides the care* section.

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

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

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

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

Your out-of-network coverage:

- Means you can get care from **providers** who are not part of the **Aetna** network.
- Means you may have to pay for services at the time that they are provided. You may 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**. Refer to *Assignment of benefits* section for more information.
- Means that when you use out-of-network coverage, it is your responsibility to start the **precertification** process with **providers**.
- Means you may pay a higher cost share when you use an **out-of-network provider**.

You will find details on:

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

Important note:
You will be covered for in-network and out-of-network benefits regardless of where you live. See *Who provides the care* section for details.

You will be covered for **emergency services** at the in-network level.

Surprise bill

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

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

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

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

Ancillary services mean any professional services including:

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

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

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

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

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

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

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

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

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

Your ID card

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

Remember, only you 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 https://www.aetnastudenthealth.com.

Who the plan covers

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

You will find information in this section about:

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

Important note: California requires residents and their dependents to obtain, and maintain, health coverage or pay a penalty, unless they qualify for an exemption.

Enrolling in student health insurance offered by the college or university you are attending is one way to meet this requirement.

You can waive this coverage if you have minimum essential coverage that meets the requirements of the state Minimum Essential Coverage Individual Mandate.

Who is eligible?

You are eligible if you are a:

- New York Film Academy degree and long-term certificate program student

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.

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

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

- Your legal spouse that resides with you
- Your civil union partner that resides with you

- Your domestic partner that resides with you
- Your parent or stepparent, who is a qualifying relative under Section 152(d) of IRS rules and lives in the service area
- Your dependent children – your own or those of your spouse, civil union partner or domestic partner
  - The children must be under 26 years of age, and they include:
    - Biological children
    - Stepchildren
    - Legally adopted children
    - A child legally placed with you for adoption (including a foster child)

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 *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

Adding new dependents

You can add new dependents during the year. These include any dependents described in the *Who can be on your plan (who can be your dependent)* section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage
- Civil union
- Domestic partnership
- Legal guardianship
- Court or administrative order

We must receive your completed enrollment information not more than 31 days after the event date.

Newborn child

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

Adopted child or a child legally placed with you for adoption

A child that you, or you and your spouse, civil union partner or domestic partner adopt, or that is placed with you for adoption is covered on your plan for the first 31 days after the adoption or the placement is complete.

- To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption or placement for adoption.
- You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional **premium** contribution for the child.

- If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
- If your coverage ends during this 31 day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31 day period has not ended.

Dependent coverage due to a court order
If you must provide coverage to a dependent because of a court order, your dependent is covered on your health plan for the first 31 days from the court order.

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

Notification of change in status

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

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

Special times you and your dependents can join the plan

Federal and state law allows you to enroll in these situations:

- You or your dependent have lost minimum essential coverage.
- When you or your dependent did not enroll in this plan before because:
  - You or your dependent were covered by another health plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
  - You or your dependent no longer receive employer contributions or government subsidies for COBRA coverage.
  - You become a dependent or gain a dependent, including 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 Medi-Cal or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.
- You or your dependents lose your eligibility for enrollment in Medi-Cal or an S-CHIP plan.
- When a court orders that you cover a current spouse, civil union partner, domestic partner, your qualified parent or stepparent under Section 152(d) of IRS rules 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.
- You or your dependent are released from incarceration
- You or your dependent are eligible for new health benefit plans because you have moved to a new permanent location

- You or your dependent is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code
- You or your dependent's prior health plan substantially violated a material provision of its health coverage contract
- You did not enroll in a health benefit plan during the immediately preceding enrollment period available to you because you were misinformed that you were covered under minimum essential coverage, if you provide us satisfactory proof that you have demonstrated this to the California Department of Insurance.
- You were receiving services from a contracting provider under another health benefit plan for an acute condition, serious chronic condition, during pregnancy (the three trimesters and the immediate postpartum period), a maternal mental health condition or terminal illness and the period of transitional care ends as a result of the provider leaving the other health plan's network as a contracted provider

The completed enrollment form must be submitted within 60 days of the event.

Effective date of coverage

Enrollment

Student coverage

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

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

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

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

Late enrollment

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

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

Medical necessity and precertification requirements

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

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

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

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

Medically necessary; medical necessity

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

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

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. For gender affirming treatment and behavioral health services, we use the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty to determine **medical necessity** in accordance with state law.

Precertification

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

Precertification for medical services and supplies

In-network care

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

Out-of-network care

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

Precertification call
Precertification should be secured within the timeframes specified below. To obtain **precertification**, call Member Services at the toll-free number on your ID card You, your **physician** or the facility must call us within these timelines:

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

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

Written notification of precertification decisions
We will provide a written notification to you and your **physician** of the **precertification** decision**,** within 5 business days or within 72 hours for urgent requests. If your **precertified** services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

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

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

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

What if you don't obtain the required precertification when you go to an out-of-network provider?
If you don't obtain the required **precertification**:

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

What types of services and supplies require precertification?

Precertification is required only for the following types of services and supplies when you use an out-of-network provider:

Inpatient –

- Gene-based, cellular and other innovative therapies (GCIT)
- Obesity (bariatric) **surgery**
- **Stays** in a **hospice facility**
- **Stays** in a **hospital**
- **Stays** in a rehabilitation facility
- **Stays** in a **residential treatment facility** for treatment of **mental health conditions** and **substance use disorders**
- **Stays** in a **skilled nursing facility**

Outpatient –

- ART services
- Certain **prescription drugs** and devices
- Complex imaging
- Comprehensive **infertility** services
- Gene-based, cellular and other innovative therapies (GCIT)
- Home health care
- **Hospice care**
- Injectables, (immunoglobulins, growth hormones*, hormone blockers*, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
- Non-emergency transportation by airplane
- Obesity (bariatric) **surgery**
- Private duty nursing services
- Reconstructive **surgery***

Precertification is not required for these services when provided for the treatment of gender dysphoria

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

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

Precertification for prescription drugs and devices

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

For certain **prescription drugs** and devices, your **prescriber** or your pharmacist needs to get approval from us before we will agree to cover the **prescription drug** or device for you. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain **prescription drugs** and devices and makes sure there is a **medically necessary** need for the **prescription drug** or device. We will tell your provider the decision within 72 hours or within 24 hours when you have an **emergency medical condition**. Your advance approval request is approved if we do not respond within the timeframe. For the most up-to-date information, call Member Services at the toll-free number on your ID card or log in to your **Aetna** website at https://www.aetna.com.

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

Step therapy

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

For the most up-to-date information about **step therapy prescription drugs**, call Member Services at the toll-free number on your ID card or log in to your **Aetna** website at https://www.aetna.com. Your **provider** can find additional details about the **step therapy prescription drugs** in our clinical policy bulletins.

Requesting a medical exception

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

- Contact Member Services at the toll-free number 1-877-480-4161
- Log in to your **Aetna** website at https://www.aetnastudenthealth.com
- Submit the request in writing to CVS Health, ATTN: **Aetna** PA, 1300 E Campbell Road, Richardson, TX 75081

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your **provider** of our decision. You can request an external review if we deny your medical exception request. We will tell you, someone who represents you and your **provider** the decision within 72 hours or within 24 hours when you have an **emergency medical condition**.

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

Your **provider** can continue to prescribe the same **prescription drug** for your medical condition under this plan if you had approval for a **prescription drug** under a prior Aetna plan.

Eligible health services and exclusions

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

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

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

For example:

- **Physician** care generally is covered but **physician** care for **cosmetic surgery** is never covered. This is an exclusion.
- Home health care is generally covered but may only be covered up to a set number of visits per year. This is a limitation.

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

Preventive care covered services under the Patient Protection and Affordable Care Act (ACA) and in accordance with state law have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations as listed below:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- United States Preventive Services Task Force
- Health Resources and Services Administration (HRSA)
- 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.

Please consult with your **physician** to determine what preventive services are appropriate for you.

- Diagnostic testing for the treatment or diagnosis of a medical condition will not be covered under the preventive care and wellness benefit, except for COVID-19 screening and diagnostic testing. For those types of tests and treatment, you will pay the cost sharing specific to **eligible health services** for diagnostic testing and treatment.

- In compliance with state and federal law, the preventive care and wellness benefit includes **eligible health services** for COVID-19 screening, testing, and immunizations:
  - Screening and testing for COVID-19, including a visit to a medical office, emergency room, urgent care setting, hospital, or telemedicine visit when the purpose of the visit is screening and/or testing for COVID-19, and associated lab testing and radiology services
  - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), regardless of whether the immunization is recommended for routine use.
  - Therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for treatment of COVID-19 at no cost share when prescribed or furnished by a licensed health care provider acting within their scope of practice and standard of care.

- 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.

- For more information regarding preventive services, contact your **physician** or contact Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or by calling the toll-free number on your ID card in the *How to contact us for help* section. This information can also be found at the https://www.healthcare.gov website.

- Decisions regarding whether you are part of a high-risk population and should therefore receive a specific preventive item or service identified for those at high-risk, will be made by your attending **provider**.

- Preventive items and services are covered as prescribed unless this certificate states otherwise.

- When the Governor issues a public health emergency declaration, your coverage will continue and we will waive your cost share, **precertification**, **prescription** quantity limits, and any other utilization management in accordance with state law, for testing, screening, and related services; immunizations and necessary items and services; and therapeutics that have been approved or granted emergency use authorization by the federal Food and Drug Administration for treatment. No other person – including the **policyholder** or **provider** – can waive a requirement of your plan.

Routine physical exams

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

- Abdominal aortic aneurysm one-time screening for men age 65 to 75 who have ever smoked
- Anxiety screenings in children and adolescents age 8 to 18, and all adolescent and adult women, including those who are pregnant or postpartum
- Bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause
- Blood pressure screening for adults
- Colorectal cancer screening for adults age 45 to 75
- Depression screening for adults, children and adolescents
- Diabetes (Type 2) screening for adults 35 to 70 years who are overweight or obese, and effective preventive interventions, including lifestyle interventions that focus on diet, physical activities, and metformin, for patients with prediabetes
- Falls prevention for community-dwelling adults 65 years or older who are at increased risk for falls
- Hepatitis B screening for adolescents and adults at increased risk for infection and pregnant persons
- Hepatitis C screening for adults
- Interventions, including education and brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents who have not started to use tobacco
- Latent tuberculosis infection screening for asymptomatic persons at increased risk for infection
- Anemia screening
- Behavioral assessments
- Bilirubin concentration screening for newborns
- Blood pressure screening
- Cholesterol screening
- Developmental/autism screening
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns and children
- Lead screening
- Maternal depression screening, and counseling interventions for pregnant and postpartum persons who are at increased risk of perinatal depression
- Obesity screening and counseling
- Oral health risk assessment for young children
- Tuberculin testing for children at higher risk
- Vision screenings for children 6 months to 21 years
- Screening and counseling services on topics such as:
  - Interpersonal and domestic violence
  - Sexually transmitted diseases, such as chlamydia, gonorrhea and syphilis, including sexually transmitted disease home test kits and laboratory costs for processing the kits when ordered by an in-network provider
  - Human Immune Deficiency Virus (HIV) infections
- Screening for gestational diabetes for women
- High-risk Human Papillomavirus (HPV) DNA testing for women age 18and older and limited to once every three years
- Screening for urinary incontinence for women
- Screening for osteoporosis

- Screening for all disorders on the Recommended Uniform Screening Panel
- Adverse childhood experiences (ACEs) screenings
- Discussion of use of risk-reducing medications such as tamoxifen, raloxifene, or aromatase inhibitors, with women who are age 35 years or older and who are at increased risk for breast cancer and at low risk for adverse medication effects. The risk reducing medications will also be covered as preventive care under the *Outpatient prescription drugs* section when indicated.
- Folic acid supplements for women who plan to or could become pregnant to prevent neural tube defects
- Oral fluoride supplementation at currently recommended doses to children older than 6 months of age through 16 years of age whose primary water source is deficient in fluoride
- Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, as soon as teeth are present, for the prevention of dental caries in children through 5 years of age
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial **hospital** checkup and screening, including ocular prophylaxis
- Screenings for asymptomatic bacteriuria using urine culture for pregnant persons
- FDA approved low to moderate dose statin prescription drugs for the prevention of cardiovascular disease events and mortality when all the following criteria are met:
  - You are aged 40-75 years;
  - You have one or more cardiovascular risk factors; and
  - You have a calculated 10-year risk of a cardiovascular event of 10% or greater

Preventive care immunizations

Eligible health services include immunizations, including for Acquired Immune Deficiency Syndrome (AIDS), provided by your **physician** or other **health professional** for infectious diseases.
These services include immunizations for:

- Diphtheria
- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus (HPV)
- Influenza (flu shot)
- Measles
- Meningococcal
- Mumps
- Pertussis
- Pneumococcal
- Polio
- Pre exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. In addition, the following related services for HIV PrEP initiation and follow-up care are covered:
  - Services for initiation of HIV Prep, including:
    - HIV testing
    - Kidney function testing
    - Serologic testing for hepatitis B and C virus
    - Hepatitis B vaccination
    - Testing for Sexually Transmitted Infections (STIs)
    - Pregnancy testing (when appropriate)

Follow-up and monitoring services, including:
    - HIV testing every 3 months
    - Office visits to a primary care provider or specialist for prescribing and medication management
    - Lab testing to monitor effects of medication
- Rotavirus
- Rubella
- Tetanus
- Varicella (Chickenpox)
- Zoster (Shingles)
- State or federal government mandated immunizations intended to prevent or mitigate a disease in the event of a declared public health emergency, including COVID-19 vaccines

The following is not covered under this benefit:

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

Well woman preventive visits

Eligible health services include:

- Your routine well woman preventive office visit. This includes all visits necessary for the delivery and coordination of recommended preventive services, and any necessary services integral to the furnishing of a recommended preventive service regardless if billed separately. Well woman visits include routine preconception care, prenatal care and postpartum and interpregnancy visits. 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**. It includes necessary preventive services, including those described in other *Preventive care* sections.
- Human papillomavirus (HPV) DNA testing for women age 30 and older, including HPV/Pap co-testing for women age 30-65, if you and your physician, PCP, OB, GYN or OB/GYN determines this testing strategy is best for you
- Low-dose aspirin use when prescribed by a licensed **provider** for women who are at least 12 weeks pregnant and at high risk for preeclampsia
- Pap smears, including to screen for cervical dysplasia
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment
- Screening for those with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing
- Rh (D) incompatibility screening for pregnant women
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence for women yearly
- Effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy

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
  - Behavioral counseling interventions to promote healthy diet and physical activity for persons with cardiovascular disease risk factors

- **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, counseling services and behavioral health interventions to help you to stop the use of tobacco products:
  - Preventive counseling visits
  - Treatment visits
  - Class visits
  - **Physician** or nurse advice, individual or group-based counseling and telephone and mobile phone-based interventions)
  - Tobacco cessation prescription and OTC drugs (see the Tobacco cessation prescription and OTC drugs - Outpatient prescription drug section for information on drug therapy coverage)

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

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

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

- **Skin cancer**:
  Eligible health services include counseling and evaluation services for young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer

- **Stress management**
  Eligible health services include counseling and evaluation services to help you prevent and reduce stress.

- **Chronic conditions**
  Eligible health services include counseling and evaluation services to help prevent or maintain chronic conditions.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies (includes:
  - Bowel preparation medications
  - Anesthesia
  - Removal of polyps performed during a screening procedure
  - Pathology exam on any removed polyps)
  - A follow-up colonoscopy after a positive result on any of the recommended tests or procedures for colorectal cancer screening
- Lung cancer screenings

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:

- Anemia screening
- Blood pressure
- Chlamydia infection screening
- Fetal genetic disorders screening
- Fetal heart rate check
- Fundal height
- Gestational diabetes screening
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening
- Maternal weight
- Preeclampsia screening
- Rh incompatibility screening
- Syphilis screening
- Tobacco use screening, counseling and behavioral interventions
- Urinary tract or other infection 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 and exclusions – Maternity care* and *Well newborn nursery care* section of this certificate of coverage for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services

Eligible health services include comprehensive lactation support (assistance and training in breast feeding) services, including any clinically indicated interventions to support lactation, consultations, counseling and education by clinicians and peer support services during pregnancy or at any time following delivery to optimize the successful initiation and maintenance of 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:

- Any equipment and supplies as clinically indicated to support women and babies with breast feeding difficulties
- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**
- The buying of a manual or electric breast pump (non-**hospital** grade) including pump parts and maintenance and breast milk storage supplies

Breast pump supplies and accessories
Eligible health services include renting or buying equipment you need to pump and store breast milk.

Coverage for the purchase of breast pump equipment (including a hospital grade breast pump and double breast pump kit) is limited to one item of equipment, for the same or similar purpose, and 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 and clinical services

Eligible health services include all FDA approved, FDA granted or FDA cleared contraceptive drugs, devices, and other products including over-the-counter (OTC) prescribed by your **provider,** family planning services and any follow-up care**.**

- This includes:
  - Drugs, cervical caps, vaginal rings, continuous extended oral contraceptives, patches and condoms. In addition, fertility awareness-based methods, including the lactation amenorrhea method, although less effective, is covered for women desiring an alternative method.
  - Contraceptives which require medical administration in your **provider**'s office, implanted devices and professional services to implant them, sterilization procedures and device removal, and items and services that are integral to the furnishing of a recommended preventive service such as a pregnancy test needed before provision of certain contraceptives is included in contraceptive coverage.
- FDA approved, FDA granted or FDA cleared over-the-counter contraceptives and contraceptive devices do not require a prescription at a network pharmacy and will be provided without cost to you and without medical management.

Counseling services and patient education
Eligible health services include counseling and education services provided by a **provider** on contraceptive methods, management of side effects or adherence. 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 and FDA approved, FDA granted or FDA cleared over the counter contraceptive devices (including any related services or supplies) when they are provided by, administered, or removed by a **provider**.

- FDA approved, granted or cleared over-the-counter contraceptives and contraceptive devices do not require a prescription at a network pharmacy and will be provided without cost to you and without medical management.

Voluntary sterilization
Eligible health services include voluntary sterilization procedures and related services and supplies. This also could include tubal ligation, sterilization implants, and vasectomies.

Important note:
See the following sections for more information:

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

The following are not covered under this benefit:
Any contraceptive methods that are only "reviewed" by the FDA and not "approved", “granted” or “cleared” by the FDA

2. Physicians and other health professionals

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

Eligible health services include services provided by your **physician** to treat an **illness** or **injury** such as radiological supplies, services and tests. You can get those services:

- At the **physician's** or **specialist's** office
- In your home
- From any other inpatient or outpatient facility
- By way of **telemedicine**

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

Telemedicine provided by a **physician** or **specialist** may have different cost sharing than other outpatient services. See the schedule of benefits for more information.

Allergy testing and treatment

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

- Allergy testing
- Allergy injections treatment

Physician and specialist – inpatient surgical services

Eligible health services include the services of:

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

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

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

we will pay for the one that costs the most.
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**.

The following are not covered under this benefit:

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

Physician and specialist – outpatient surgical services

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**.

The following are not covered under this benefit:

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

In-hospital non-surgical physician services

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

Consultant services (non-surgical and non-preventive)

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

Covered benefits include treatment by the consultant.

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

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

Telemedicine provided by a **physician** or **specialist** may have different cost sharing than other outpatient services. See the schedule of benefits for more information.

Second surgical opinion

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

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

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

Alternatives to physician and specialist office visits

Walk-in clinic (non-emergency visit)

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

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

3. Hospital and other facility care

Hospital care (facility charges)

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
- 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 doctor must certify that the dental care cannot be performed in the dentist's office due to either age or medical condition.

Alternatives to hospital stays

Outpatient surgery (facility charges)

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

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

The following are not covered under this benefit:

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

Home health care

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

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

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

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

The following are not covered under this benefit:

- Nursing and **home health aide** services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Homemaker or housekeeper services
- Food or home delivered services
- Maintenance therapy

Hospice care

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

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

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

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

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

The following are not covered under this benefit:

- Funeral arrangements
- 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

Skilled nursing facility

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

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

- **Room and board**, up to the **semi-private room rate.** Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services and supplies that are provided during your **stay** in a **skilled nursing facility**

4. Emergency services and urgent care

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

Emergency services

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

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

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

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

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

For follow-up care, you are covered when:

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

In case of a medical emergency

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

Eligible health services include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room. You can get **emergency services** from **network providers** or **out-of-network providers**.

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

- You are evaluated and your condition is stabilized

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

Non-emergency condition

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

The following are not covered under this benefit:

- Non-emergency services in a **hospital** emergency room facility

Urgent care

In case of an urgent condition

Urgent condition

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

Non-urgent care

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

Examples of non-urgent care are:

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

The following is not covered under this benefit:

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

5. Pediatric dental care

Eligible health services include dental services and supplies provided by a **dental provider** as listed below.

Dental emergencies

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

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

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

Diagnostic and Preventive Care (Type A Expenses):		
Visits and Images		
D0120	Periodic oral evaluation – established patient	once every six months, per provider
D0140	Limited oral evaluation-problem focused	once per Member per provider
D0145	Oral evaluation - child under three years of age and counseling with primary caregiver	once every six months, per provider
D0150	Comprehensive oral exam – new or established patient	once per Member per provider for the initial evaluation
D0160	Detailed and extensive oral evaluation, problem focused by report	once per Members per provider
D0170	Reevaluation-limited, problem focused (not post-operative visit)	for ongoing symptomatic care of temporomandibular joint dysfunction: a. up to 6 times in a 3 month period; and b. up to a maximum of 12 in a 12 month period.
D0171	Re-evaluation – post-operative office visit	
D0180	Comprehensive periodontal evaluation – new or established patient	
D0190	Screening of patient	
D0191	Assessment of patient	
D0210	Intraoral - comprehensive series of radiographic images	once per provider every 36 months
D0220	Intraoral - periapical - first radiographic image	maximum of 20 periapicals in a 12- month period by the same provider,
D0230	Intraoral - periapical - each additional radiographic image	maximum of 20 periapicals in a 12 month period to the same provider
D0240	intraoral - occlusal image	maximum of two in a six-month period per provider
D0250	Extraoral – first radiographic image	once per date of service

D0251	Extra-oral posterior dental radiographic image	once per date of service
D0270	Bitewing - single radiographic image	once per date of service
D0272	Bitewing - two radiographic images	once every six months per provider
D0273	Bitewing - three radiographic images	once every six months per provider
D0274	Bitewing - four radiographic images	once every six months per provider
D0277	Vertical Bitewings - 7 to 8 radiographic images	once every six months per provider as (D0274)
D0310	Sialography	
D0320	Temporomandibular joint arthrogram, including injection	maximum of three per date of service, limited to the survey of trauma or pathology
D0322	Tomographic survey	twice in a 12 month period per provider
D0330	Panoramic radiographic image	Once in a 36-month period per provider
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	twice in a 12- month period per provider
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	maximum of four per date of service
D0351	3D photographic image	covered for medically necessary orthodontics
D0372	Intraoral tomosynthesis-comprehensive series of radiographic images	once per provider every 36 months
D0373	Intraoral tomosynthesis – bitewing radiographic image	once every six months per provider
D0374	Intraoral tomosynthesis – periapical radiographic image	maximum of 20 periapicals in a 12 month period to the same provider
D0387	Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	once per provider every 36 months
D0388	Intraoral tomosynthesis – bitewing radiographic image – image capture only	once every six months per provider
D0389	Intraoral tomosynthesis – periapical radiographic image – image capture only	maximum of 20 periapicals in a 12 month period to the same provider
D0372	Intraoral tomosynthesis-comprehensive series of radiographic images	once per provider every 36 months
D0460	Pulp vitality tests	
D0470	Diagnostic casts	for the evaluation of orthodontic benefits only once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment)
D0502	Other oral pathology procedures, by report	(must be provided by a certified oral pathologist)
D0601	Caries risk assessment and documentation, with a finding of low risk	
D0602	Caries risk assessment and documentation, with a finding of moderate risk	
D0603	Caries risk assessment and documentation, with a finding of high risk	

D0701	Panoramic radiographic image – image capture only	Once in a 36-month period per provider
D0702	2-D cephalometric radiographic image – image capture only	twice in a 12- month period per provider
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	maximum of four per date of service
D0706	Intraoral – occlusal radiographic image – image capture only	maximum of two in a six-month period per provider
D0707	Intraoral – periapical radiographic image – image capture only	maximum of 20 periapicals in a 12- month period by the same provider,
D0708	Intraoral – bitewing radiographic image – image capture only	once per date of service
D0709	Intraoral – comprehensive series of radiographic images – image capture only	once per provider every 36 months
D0999	Unspecified diagnostic procedure, by report	
D1110	Prophylaxis - adult	once in a 12 month period
D1120	Prophylaxis - child	once in a six month period
D1206	Topical application of fluoride varnish	once in a six month period
D1208	Topical application of fluoride - excluding varnish	once in a six month period
D1310	Nutritional counseling for control and prevention of oral disease	
D1320	Tobacco counseling for the control and prevention of oral disease	
D1330	Oral hygiene instructions	
D1351	Sealant - per tooth - for 1st,2nd & 3rd, permanent molars	once per tooth (occlusal surfaces that are free of decay and/or restorations) every 36 months per provider
D1352	Preventive resin restoration in a moderate to high caries risk patient - for 1st,2nd & 3rd, permanent molars	once per tooth every 36 months per provider
D1353	Sealant repair – per tooth	
D1354	Interim caries arresting medicament application – per tooth	
D1355	Caries preventive medicament application – per tooth	once per tooth every 36 months per provider
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	once in a 12 month period
D9997	Dental case management - patients with special health care needs	
Space Maintainers		
D1510	Space maintainers fixed (unilateral)	once per quadrant per Member under the age of 18 to maintain the space for a single tooth

D1516	Space maintainer – fixed – bilateral, maxillary	once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant for members under the age of 18
D1517	Space maintainer – fixed - bilateral, mandibular	once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant for members under the age of 18
D1520	Space maintainer – removable (unilateral)	once per quadrant per Member to maintain the space for a single tooth for members under the age of 18
D1526	Space maintainer – removable – bilateral, maxillary	once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant for members under the age of 18
D1527	Space maintainer – removable – bilateral, mandibular	once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant for members under the age of 18
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	once per provider, per applicable quadrant or arch for members under the age of 18
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	once per provider
D1553	Re-cement or re-bond bilateral space maintainer - per quadrant	once per provider
D1556	Removal of fixed unilateral space maintainer - per quadrant	
D1557	Removal of fixed bilateral space maintainer - maxillary	
D1558	Removal of fixed bilateral space maintainer - mandibular	(not a Benefit to the original provider who placed the space maintainer)
D1575	Distal shoe space maintainer – fixed – unilateral	once per provider, per applicable quadrant or arch
Basic Restorative Care (Type B Expenses):		
D9410	House/extended care facility call	once per date of service per provider
D9420	Hospital or ambulatory surgical center call	once per date of service per provider
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	
D9440	Office visit - after regularly scheduled hours	once per Member per date of service

Restorative Dentistry		
D2140	Amalgam - one surface primary or permanent	primary teeth -once in a 12- month period permanent teeth - once in a 36- month period
D2150	Amalgam - two surfaces primary or permanent	primary teeth -once in a 12- month period permanent teeth - once in a 36- month period
D2160	Amalgam - three surfaces primary or permanent	primary teeth -once in a 12- month period permanent teeth - once in a 36- month period
D2161	Amalgam - four or more surfaces primary or permanent	primary teeth -once in a 12- month period permanent teeth - once in a 36- month period
D2330	Resin-based composite - one surface, anterior	primary teeth -once in a 12- month period permanent teeth - once in a 36 - month period
D2331	Resin-based composite - two surfaces, anterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
D2332	Resin-based composite - three surfaces, anterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
D2335	Resin-based composite - four or more surfaces or involving incisal angle, anterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
D2390	Resin-based composite crown, anterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
D2391	Resin-based Composite - one surface, posterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
D2392	Resin-based composite - two surfaces, posterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
D2393	Resin-based composite - three surfaces, posterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
D2394	Resin-based composite - four or more surfaces, posterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
D2910	Recement or re-bond inlay, onlay, veneer or partial coverage restoration	once in a 12 month period, per provider
D2915	Recement or re-bond indirectly fabricated or prefabricated post and core	
D2920	Recement or re-bond crown	Not a benefit within 12 months of a previous re- cementation by the same provider
D2921	Reattachment of tooth fragment, incisal edge or cusp	
D2940	Protective resin	once per tooth in a six-month period, per provider

D2941	Interim therapeutic restoration – primary teeth	
D2949	Restorative foundation for an indirect restoration	
D2951	Pin retention - per tooth in addition to restoration (permanent teeth)	once per tooth regardless of the number of pins placed
D2955	Post removal	one per tooth
Periodontics		
D4910	Periodontal maintenance (only after completion of all necessary scaling and root planings)	once in a calendar quarter and only in the 24 month period following the last scaling and root planing
Major Restorative Care (Type C Expenses):		
Crowns		
D2710	Crown - resin-based composite (indirect)	once in a five-year period
D2712	Crown – ¾ resin-based composite (indirect)	once in a five-year period
D2721	Crown -resin with predominantly base metal	once in a five-year period
D2740	Crown - porcelain/ceramic substrate	once in a five-year period
D2751	Crown -porcelain fused to predominantly base metal	once in a five-year period
D2781	Crown -3/4 cast predominantly base metal	once in a five-year period
D2782	Crown - 3/4 cast noble metal	once in a five-year period
D2783	Crown – ¾ porcelain/ceramic	once in a five-year period
D2791	Crown - full cast predominantly based metal	once in a five-year period
D2799	Provisional crown	once per tooth, per provider and for permanent teeth only.
D2929	Prefabricated porcelain/ceramic crown-primary tooth	once in a 12- month period
D2930	Prefabricated stainless steel crown - primary tooth	once in a 12- month period
D2931	Prefabricated stainless steel crown - permanent tooth	once in a 12- month period
D2932	Prefabricated resin crown	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
D2933	Prefabricated stainless steel crown with resin window	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
D2950	Core buildup, including any pins	
D2952	Post and core in addition to crown, indirectly fabricated	once per tooth regardless of number of posts placed
D2953	Each additional indirectly fabricated post, same tooth	
D2954	Prefabricated post and core in addition to crown	once per tooth regardless of number of posts placed
D2957	Each additional prefabricated post - same tooth	once per tooth regardless of number of posts placed
D2971	Additional procedures to construct new crown under existing partial denture framework	once per tooth

D2980	Crown repair necessitated by restorative material failure	Not a benefit within 12 months of initial crown placement or previous repair for the same provider
D2999	Unspecified restorative procedure, by report	by report
D8210	Removable Appliance Therapy	once per member and includes all adjustments
D8220	Fixed Appliance Therapy	once per member and includes all adjustments
Endodontics		
D3110	Pulp cap - direct (excluding final restoration)	once per primary tooth
D3120	Pulp cap - indirect (excluding final restoration)	once per primary tooth
D3220	Therapeutic pulpotomy (excluding final restoration)	once per primary tooth
D3221	Pulpal debridement, primary and permanent teeth	once per tooth
D3222	Partial pulpotomy for apexogensis - permanent tooth with incomplete root development	once per permanent tooth
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	once per primary tooth
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	once per primary tooth
D3310	Endodontic therapy- anterior (excluding final restoration)	once per tooth for initial root canal therapy treatment
D3320	Endodontic therapy- premolar (excluding final restoration)	once per tooth for initial root canal therapy treatment
D3330	Endodontic therapy – molar tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment
D3331	Treatment of root canal obstruction-non surgical access	
D3332	Incomplete endodontic therapy, unrestorable or fractured tooth	once per tooth
D3333	Internal root repair of perforation defects	
D3346	Retreatment of previous root canal therapy - anterior	once per tooth
D3347	Retreatment of previous root canal therapy –bicuspid	once per tooth
D3348	Retreatment of previous root canal therapy - molar	once per tooth
D3351	Apexification / recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	once per permanent tooth
D3352	Apexification / recalcification - interim medication replacement	once per permanent tooth
D3410	Apicoectomy/periradicular surgery – anterior, permanent teeth	
D3421	Apicoectomy/periradicular surgery –bicuspid (first root) permanent teeth	

D3425	Apicoectomy - molar (first root) permanent teeth	
D3426	Apicoectomy (each additional root) permanent teeth	
D3430	Retrograde filling - per root	
D3471	Surgical repair of root resorption-anterior	
D3472	Surgical repair of root resorption-premolar	
D3473	Surgical repair of root resorption-molar	
D3910	Surgical procedure for isolation of tooth with rubber dam	
D3999	Unspecified endodontic procedure, by report	by report
Periodontal		
D4210	Gingivectomy/gingivoplasty, four or more contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older
D4211	Gingivectomy/gingivoplasty, one to three contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older
D4249	Clinical crown lengthening – hard tissue	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older
D4265	Biologic materials to aid in soft and osseous tissue regeneration	once per quadrant every 36 months and limited to Members age 13 or older
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	once per quadrant every 24 months and limited to Members age 13 or older
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	once per quadrant every 24 months and limited to Members age 13 or older
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis on a subsequent visit	once every 24 months
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff	once per Member per provider and limited to Members age 13 or older
D4999	Unspecified periodontal procedure, by report	by report

Prosthodontics		
D5110	Complete denture –maxillary (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once in a five year period
D5120	Complete denture – mandibular (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once in a five year period
D5130	Immediate denture – maxillary (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once per Member
D5140	Immediate denture – mandibular (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once per Member
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests and teeth) (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once in a five year period
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once in a five year period
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including. any conventional clasps, rests and teeth) (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once in a five year period
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once in a five year period
D5221	Immediate maxillary partial denture – resin base (including, retentive/clasping materials rests and teeth)	once in a five year period
D5222	Immediate mandibular partial denture – resin base (including retentative/claspings materials, rests and teeth)	once in a five year period

D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentative/clasping materials, rests and teeth)	once in a five year period
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentative/clasping materials, rests and teeth)	once in a five year period
D5225	Maxillary partial denture - flexible base (including any clasps, retentive/clasping materials, rests and teeth)	once in a five year period
D5226	Mandibular partial denture - flexible base (including any clasps, retentive/clasping materials, rests and teeth)	once in a five year period
D5227	Immediate maxillary partial denture – flexible base (including any clasps, rests and teeth)	once in a five year period
D5228	Immediate mandibular partial denture – flexible base (including any clasps, rests and teeth)	once in a five year period
D5282	Removable unilateral partial denture one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary	once in a five year period
D5283	Removable unilateral partial denture one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular	once in a five year period
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	once in a five year period
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	once in a five year period
D5410	Adjust complete denture – maxillary	once per date of service per provider
D5411	Adjust complete denture – mandibular	once per date of service per provider
D5421	Adjust partial denture – maxillary	once per date of service per provider
D5422	Adjust partial denture – mandibular	once per date of service per provider
D5511	Repair broken complete denture base, mandibular	once per arch, per date of service per provider
D5512	Repair broken complete denture base, maxillary	once per arch, per date of service per provider
D5520	Replace missing or broken teeth - complete denture (each tooth) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once per arch, per date of service per provider
D5611	Repair resin partial denture base, mandibular	once per arch, per date of service per provider

D5612	Repair resin partial denture base, maxillary	once per arch, per date of service per provider
D5621	Repair cast partial framework, mandibular	once per arch, per date of service per provider
D5622	Repair cast partial framework, maxillary	once per arch, per date of service per provider
D5630	Repair or replace broken retentive/clasping materials per tooth(all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	maximum of three, per date of service per provider
D5640	Replace broken teeth - per tooth	maximum of four, per arch, per date of service per provider
D5650	Add tooth to existing partial denture (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	maximum of three, per date of service per provider
D5660	Add clasp to existing partial denture – per tooth (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	maximum of three, per date of service per provider
D5730	Reline complete maxillary (upper) denture, (chairside) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period
D5731	Reline complete mandibular (lower) denture (chairside) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period
D5740	Reline maxillary (upper) partial denture (chairside) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period
D5741	Reline mandibular (lower) partial denture (chairside) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period
D5750	Reline complete maxillary (upper) denture (laboratory) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period

D5751	Reline complete mandibular (lower) denture (laboratory) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period
D5760	Reline maxillary (upper) partial denture (laboratory) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period
D5761	Reline mandibular (lower) partial denture (laboratory) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period
D5765	Soft liner for complete or partial removable denture - indirect	once in a 12- month period
D5850	Tissue conditioning, upper (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	twice per prosthesis in a 36- month period
D5851	Tissue conditioning, lower (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	twice per prosthesis in a 36- month period
D5862	Precision attachment, by report	by report
D5863	Overdenture – complete maxillary (upper)	once in a five year period
D5864	Overdenture - partial maxillary (upper)	once in a five year period
D5865	Overdenture - complete mandibular (lower)	once in a five year period
D5866	Overdenture – partial mandibular (lower)	once in a five year period
D5876	Add metal substructure to acrylic full denture (per arch)	once per arch, per date of service per provider
D5899	Unspecified removable prosthodontic procedure, by report	by report
Maxillofacial Prosthetics		
D5911	Facial moulage - sectional	
D5912	Facial moulage - complete	
D5913	Nasal prosthesis	
D5914	Auricular prosthesis	
D5915	Orbital prosthesis	
D5916	Ocular prosthesis	
D5919	Facial prosthesis	
D5922	Nasal septal prosthesis	
D5923	Ocular prosthesis, interim	
D5924	Cranial prosthesis	
D5925	Facial augmentation implant prosthesis	

D5926	Nasal prosthesis, replacement	
D5927	Auricular prosthesis, replacement	
D5928	Orbital prosthesis, replacement	
D5929	Facial prosthesis, replacement	
D5931	Obturator prosthesis, surgical	
D5932	Obturator prosthesis, definitive	
D5933	Obturator prosthesis, modification	twice in a 12- month period
D5934	Mandibular resection prosthesis with guide flange	
D5935	Mandibular resection prosthesis without guide flange	
D5936	Obturator prosthesis, interim	
D5937	Trismus appliance (not for TMJ)	
D5951	Feeding aid	
D5952	Speech aid prosthesis, pediatric	
D5953	Speech aid prosthesis, adult	
D5954	Palatal augmentation prosthesis	
D5955	Palatal lift prosthesis	
D5958	Palatal lift prosthesis, interim	
D5959	Palatal lift prosthesis, modification	twice in a 12- month period
D5960	Speech aid prosthesis, modification	twice in a 12- month period
D5982	Surgical stent	
D5983	Radiation carrier	
D5984	Radiation shield	
D5985	Radiation cone locator	
D5986	Fluoride gel carrier	A benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.
D5987	Commissure splint	
D5988	Surgical splint	
D5991	Topical vesiculobullous disease medicament carrier	
D5999	Unspecified maxillofacial prosthesis, by report	by report
Implant Services		
D6010	Surgical placement of implant body: endosteal implant	only when there are exceptional medical conditions
D6011	Surgical access to an implant body (second stage implant surgery)	only when there are exceptional medical conditions
D6013	Surgical placement of mini implant	only when there are exceptional medical conditions
D6040	Surgical placement eposteal implant	only when there are exceptional medical conditions
D6050	Surgical placement: transosteal implant	only when there are exceptional medical conditions
D6055	Connecting bar - implant supported or abutment supported	only when there are exceptional medical conditions
D6056	Prefabricated abutment - includes modification and placement	only when there are exceptional medical conditions

D6057	Custom abutment- includes placement	only when there are exceptional medical conditions
D6058	Abutment supported porcelain/ceramic crown	only when there are exceptional medical conditions
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	only when there are exceptional medical conditions
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	only when there are exceptional medical conditions
D6061	Abutment supported porcelain fused to metal crown (noble metal)	only when there are exceptional medical conditions
D6062	Abutment supported cast metal crown (high noble metal)	only when there are exceptional medical conditions
D6063	Abutment supported cast metal crown (predominately base metal)	only when there are exceptional medical conditions
D6064	Abutment supported cast metal crown (noble metal)	only when there are exceptional medical conditions
D6065	Implant supported porcelain/ceramic crown	only when there are exceptional medical conditions
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	only when there are exceptional medical conditions
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	only when there are exceptional medical conditions
D6068	Abutment supported retainer for porcelain/Ceramic FPD	only when there are exceptional medical conditions
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	only when there are exceptional medical conditions
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	only when there are exceptional medical conditions
D6071	Abutment supported retained for porcelain fused to metal FPD (noble metal)	only when there are exceptional medical conditions
D6072	Abutment supported retained for cast metal FPD (high noble metal)	only when there are exceptional medical conditions
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	only when there are exceptional medical conditions
D6074	Abutment supported retainer for cast FPD (Noble metal)	only when there are exceptional medical conditions
D6075	Implant supported retainer for ceramic FPD	only when there are exceptional medical conditions
D6076	Implant supported retainer for porcelain fused metal FPD (titanium, titanium alloy, or high noble metal)	only when there are exceptional medical conditions
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	only when there are exceptional medical conditions
D6080	Implant maintenance procedures, when prostheses are removed and reinserted, including cleansing of prosthesis and abutments	only when there are exceptional medical conditions

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	only when there are exceptional medical conditions
D6082	Implant supported crown - porcelain fused to predominantly base alloys	only when there are exceptional medical conditions
D6083	Implant supported crown - porcelain fused to noble alloys	only when there are exceptional medical conditions
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	only when there are exceptional medical conditions
D6085	Provisional implant crown	only when there are exceptional medical conditions
D6086	Implant supported crown - predominantly base alloys	only when there are exceptional medical conditions
D6087	Implant supported crown - noble alloys	only when there are exceptional medical conditions
D6088	Implant supported crown - titanium and titanium alloys	only when there are exceptional medical conditions
D6090	Repair implant supported prosthesis, by report	only when there are exceptional medical conditions
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	only when there are exceptional medical conditions
D6092	Re-cement or re-bond implant/abutment supported crown	not a benefit within 12 months of a previous re- cementation by the same provider
D6093	Re-cement or re-bond Implant/abutment supported fixed partial denture	not a benefit within 12 months of a previous re- cementation by the same provider
D6094	Abutment supported crown – (titanium)	only when there are exceptional medical conditions
D6095	Repair implant abutment, by report	only when there are exceptional medical conditions
D6096	Remove broken implant retaining screw	only when there are exceptional medical conditions
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	only when there are exceptional medical conditions
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	only when there are exceptional medical conditions
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	only when there are exceptional medical conditions
D6100	Surgical removal of implant body	only when there are exceptional medical conditions
D6105	Removal of implant body not requiring bone removal or flap elevation	
D6110	Implant/abutment supported removable denture for completely edentulous arch - maxillary (upper)	only when there are exceptional medical conditions
D6111	Implant/abutment supported removable denture for completely edentulous arch - mandibular (lower)	only when there are exceptional medical conditions

D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary (upper)	only when there are exceptional medical conditions
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular (lower)	only when there are exceptional medical conditions
D6114	Implant/abutment supported fixed denture for completely edentulous arch - maxillary (upper)	only when there are exceptional medical conditions
D6115	Implant/abutment supported fixed denture for completely edentulous arch - mandibular (lower)	only when there are exceptional medical conditions
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary (upper)	only when there are exceptional medical conditions
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular (lower)	only when there are exceptional medical conditions
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	only when there are exceptional medical conditions
D6121	Implant supported retainer for metal FPD – predominantly base alloys	only when there are exceptional medical conditions
D6122	Implant supported retainer for metal FPD – noble alloys	only when there are exceptional medical conditions
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	only when there are exceptional medical conditions
D6190	Radiographic/surgical implant index, by report	only when there are exceptional medical conditions
D6191	Semi-precision attachment abutment placement	only when there are exceptional medical conditions
D6194	Abutment supported retainer crown for full partial denture (titanium)	only when there are exceptional medical conditions
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	only when there are exceptional medical conditions
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	
D6199	Unspecified implant procedure, by report	by report
Fixed Prosthodontics		
D6211	Pontic - cast predominantly base metal (for Members age of 13 and older)	once in a five year period
D6241	Pontic - porcelain fused to base metal (for Members age of 13 and older)	once in a five year period
D6245	Pontic - porcelain/ceramic (for Members age of 13 and older)	once in a five year period
D6251	Pontic - resin with predominantly base metal (for Members age of 13 and older)	once in a five year period
D6721	Retainer crown - resin with predominantly base metal (for Members age of 13 and older)	once in a five year period

D6740	Retainer crown - porcelain/Ceramic (for Members age of 13 and older)	once in a five year period
D6751	Retainer crown - porcelain fused to predominantly base metal (not a benefit for Members under the age of 13.)	once in a five year period
D6781	Retainer crown - 3/4 cast predominantly base metal (not a benefit for Members under the age of 13.)	once in a five year period
D6783	Retainer Crown - 3/4 porcelain/ceramic (not a benefit for Members under the age of 13.)	once in a five year period
D6784	Retainer crown ¾ - titanium and titanium alloys	once in a five year period
D6791	Retainer Crown - full cast predominantly base metal (not a benefit for Members under the age of 13.)	once in a five year period
D6930	Recement or re-bond fixed partial denture	Not a benefit within 12 months of a previous recementation by the same provider.
D6980	Fixed partial denture repair necessitated by restorative material failure	Not a benefit within 12 months of initial placement or previous repair, same provider.
D6999	Unspecified, fixed prosthodontic procedure, by report	by report
Oral Surgery		
D7111	Extract, coronal remnants - primary tooth	
D7140	Extraction - erupted tooth or exposed root	
D7210	Surgical removal of erupted tooth requiring elevation of flap and removal of bone and/or sectioning of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - full bony	
D7241	Removal of impacted tooth -complete bony with unusual surgical complications	
D7250	Surgical removal of residual tooth roots requiring cutting of soft tissue and bone	
D7260	Oroantral fistula closure	
D7261	Primary closure of a sinus perforation	
D7270	Tooth re-implantation of accidental displaced tooth (permanent anterior teeth only)	once per arch regardless of the number of teeth involved
D7280	Surgical access of unerupted tooth (for 3rd molars)	
D7283	Placement of device to facilitate eruption of impacted tooth	for Members in active orthodontic treatment
D7285	Incisional biopsy of oral tissue-hard (bone/tooth)	once per arch, per date of service regardless of the areas involved
D7286	Incisional biopsy of oral tissue-soft	up to a maximum of three per date of service
D7290	Surgical repositioning of teeth (permanent teeth only)	for Members in active orthodontic treatment

D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	for Members in active orthodontic treatment
D7310	Alveoloplasty in conjunction with extraction-four or more teeth or tooth spaces, per quadrant	only in conjunction with extractions- four or more teeth or tooth spaces, per quadrant
D7311	Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces, per quadrant	on the same date of service with two or more extractions in the same quadrant
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	
D7321	Alveoloplasty not in conjunction with extraction, one to three teeth	alveoloplasty not in conjunction with extractions- four or more teeth or tooth spaces, per quadrant
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	once in a five year period per arch
D7350	Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	once per arch
D7410	Excision of benign lesion up to 1.25 cm	
D7411	Excision of benign lesion greater than 1.25	
D7412	Excision of benign lesion, complicated	
D7413	Excision of malignant lesion up to 1.25	
D7414	Excision of malignant lesion greater than 1.25	
D7415	Excision of malignant lesion complicated	
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	
D7450	Removal of benign odontogenic cyst/tumor - lesion diameter up to 1.25cm	
D7451	Removal of benign odontogenic cyst/tumor - lesion diameter greater than 1.25cm	
D7460	Removal of benign non-odontogenic cyst/tumor - lesion diameter up to 1.25cm	
D7461	Removal of benign non-odontogenic cyst/tumor - lesion diameter greater than 1.25cm	
D7465	Destruction of lesion(S) by physical or chemical method, by report	by report
D7471	Removal of lateral exostosis, maxilla (upper) or mandible (lower)	once per quadrant
D7472	Removal of torus palatinus	once per patient
D7473	Removal of torus mandibularis	once per quadrant
D7485	Reduction of osseous tuberosity	once per quadrant
D7490	Radical resection - of maxilla (upper)/mandible(lower) with bone graft	

D7509	Marsupialization of odontogenic cyst	
D7510	Incision and drainage of abscess intraoral soft tissue	once per quadrant
D7511	Incision and drainage of abscess - intraoral soft tissue, complex	once per quadrant
D7520	Incision and drainage of abscess - extraoral, soft tissue	
D7521	Incision and drainage-extraoral complicated (includes drainage of multiple fascial spaces)	
D7530	Removal foreign body, mucosa, skin, or subcutaneous alveolar tissue	once per date of service
D7540	Removal of reaction producing foreign body, musculoskeletal system	once per date of service
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	once per date of service
D7560	Maxillary (upper) sinusotomy for removal of tooth fragment or foreign body	
D7610	Maxilla (upper) - open reduction (teeth immobilized, if present)	
D7620	Maxilla (upper) - closed reduction (teeth immobilized, if present)	
D7630	Mandible (lower) - open reduction (teeth Immobilized, if present)	
D7640	Mandible (lower) - closed reduction (teeth immobilized, if present)	
D7650	Malar and/or zygomatic arch open reduction	
D7660	Malar and/or zygomatic arch closed reduction	
D7670	Alveolus - closed reduction may include stabilization of teeth	
D7671	Alveolus - open reduction may include stabilization of teeth	
D7680	Facial bones complicated reduction with fixation and multiple surgical approaches	
D7710	maxilla (upper) - open reduction	
D7720	maxilla (upper) - closed reduction	
D7730	mandible (lower) - open reduction	
D7740	mandible (lower) - closed reduction	
D7750	Malar and/or zygomatic arch - open reduction	
D7760	Malar and/or zygomatic arch - closed reduction	
D7770	Alveolus - open reduction Stabilization of teeth	
D7771	Alveolus closed reduction Stabilization of teeth	
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches	
D7810	Open reduction of dislocation	

D7820	Closed reduction of dislocation	
D7830	Manipulation under anesthesia	
D7840	Condylectomy	
D7850	Surgical discectomy, with/without implant	
D7852	Disc repair	
D7854	Synovectomy	
D7856	Myotomy	
D7858	Joint reconstruction	
D7860	Arthrotomy	
D7865	Arthroplasty	
D7870	Arthrocentesis	
D7871	Non-arthrocentesis lysis and lavage	
D7872	Arthroscopy - diagnosis with/without biopsy	
D7873	Arthroscopy - surgical lavage and lysis of adhesions	
D7874	Arthroscopy -surgical disc repositioning and stabilization	
D7875	Arthroscopy - surgical synovectomy	
D7876	Arthroscopy - surgical discectomy	
D7877	Arthroscopy - surgical debridement	
D7880	Occlusal orthotic device, by report	
D7881	Occlusal orthotic device adjustment	
D7899	Unspecified TMD (Temporomandibular Joint Dysfunctions) therapy, by report	by report
D7910	Suture of recent small wound less than 5 cm	
D7911	Complicated suture - up to 5 cm	
D7912	Complicated suture greater than 5 cm	
D7920	Skin graft (identify defect covered, location and type of graft)	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	
D7940	Osteoplasty for orthognathic deformities	
D7941	Osteotomy - mandibular rami	
D7943	Osteotomy - rami, opened with bone graft	
D7944	Osteotomy-segmented or subapical	
D7945	Osteotomy - body of mandible	
D7946	Lefort I - (maxilla (upper) -total)	
D7947	Lefort I - (maxilla (upper) - segmented)	
D7948	Lefort II or Lefort III-osteoplasty of facial bones (osteoplasty of facial for midface hypoplasia or retrusion) – without bone graft	
D7949	Lefort II or Lefort III - with bone graft	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible (lower) or maxilla (upper) - autogenous or non autogenous, by report	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	

D7952	Sinus augmentation with bone or bone substitute via a vertical approach	
D7955	Repair of maxillofacial soft/hard tissue defect	
D7961	Buccal / labial frenectomy (frenulectomy)	once per arch per date of service
D7962	Lingual frenectomy (frenulectomy)	once per arch per date of service
D7963	Frenuloplasty(only when the permanent incisors and cuspids have erupted)	once per arch per date of service
D7970	Excision of hyperplastic tissue - per arch	once per arch per date of service
D7971	Excision of pericoronal gingiva	fee inclusive with other associated procedures performed on the same tooth, same day
D7972	Surgical reduction of fibrous tuberosity	once per arch per date of service
D7979	non-surgical sialolithotomy	
D7980	Surgical Sialolithotomy	
D7981	Excision of salivary gland, by report	by report
D7982	Sialodochoplasty	
D7983	Closure of salivary fistula	
D7990	Emergency tracheotomy	
D7991	Coronoidectomy	
D7995	Synthetic graft – mandible (lower) or facial bones, by report	
D7997	Appliance removal (not by dentist who placed appliance),including removal archbar	once per arch per date of service
D7999	Unspecified oral surgery procedure, by report	by report
Adjunctive		
D9110	Palliative treatment of dental pain, per visit	once per date of service per provider
D9211	Regional block anesthesia	once per date of service per provider
D9212	Trigeminal division block anesthesia	once per date of service per provider
D9120	Fixed partial denture sectioning	once per date of service per provider
D9210	Local anesthesia not in conjunction with outpatient surgical procedures	once per date of service per provider
D9215	Local anesthesia in conjunction with operative or surgical procedures	once per date of service per provider
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	
D9222	Deep sedation/general anesthesia – first 15 minutes	
D9223	Deep sedation/general anesthesia - each subsequent 15 minutes.	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	for uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's attempts to perform treatment

D9239	Intravenous moderate (conscious) sedation/ analgesia – first 15 minutes	
D9243	Intravenous conscious sedation/analgesia - each subsequent 15 minutes	
D9248	Non-intravenous conscious sedation	for uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's attempts to perform treatment
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	once per date of service per provider
D9311	Consultation with a medical health professional	once per date of service per provider
D9610	Therapeutic parenteral drug, single administration	for up to a maximum of four injections per date of service
D9612	Therapeutic parenteral drug, two or more administrations, different medications	
D9910	Application of desensitizing medicament	for up to a maximum of four injections per date of service
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	
D9930	Treatment of complications post surgical	once per date of service per provider
D9950	Occlusal analysis - mounted case (permanent dentition)	once in a 12-month
D9951	Occlusal adjustment-limited (natural teeth only)	once in a 12-month period per quadrant per provider
D9952	Occlusal adjustment-complete	once in a 12-month period following occlusion analysis- mounted case
D9999	Unspecified adjunctive procedure, by report	by report
Orthodontic Care		
Medically necessary orthodontic treatment (includes all appliances, removal of appliances and construction and placement of retainer)		
D0801	3D dental surface scan – direct	Medical necessity
D0802	3D dental surface scan – indirect	Medical necessity
D0803	3D facial surface scan – direct	Medical necessity
D0804	3D facial surface scan – indirect	Medical necessity
D8010	Limited orthodontic treatment of the primary dentition	Medical necessity
D8020	Limited orthodontic treatment of the transitional dentition	Medical necessity
D8030	Limited orthodontic treatment of the adolescent dentition	Medical necessity
D8050	interceptive orthodontic treatment of the primary dentition	Medical necessity
D8060	interceptive orthodontic treatment of the transitional dentition	Medical necessity

D8070	Comprehensive orthodontic treatment of the transitional dentition	Medical necessity
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Medical necessity
D8090	Comprehensive treatment of adult dentition	Medical necessity
D8660	Pre-orthodontic treatment examination to monitor growth and development	Medical necessity
D8670	periodic orthodontic treatment visit (as part of contract)	Medical necessity
D8680	orthodontic retention (removal of appliances, construction and placement of retainer(s)	Medical necessity
D8681	Removable orthodontic retainer adjustment	Medical necessity
D8696	Repair of orthodontic appliance – maxillary	Medical necessity
D8697	Repair of orthodontic appliance – mandibular	Medical necessity
D8698	Re-cement or re-bond fixed retainer – maxillary	Medical necessity
D8699	Re-cement or re-bond fixed retainer – mandibular	Medical necessity
D8692	Replacement of lost or broken retainer (that is no longer serviceable)	once per arch within 24 months following the date of service of orthodontic retention
D8701	Repair of fixed retainer, includes reattachment – maxillary	Medical necessity
D8702	Repair of fixed retainer, includes reattachment – mandibular	Medical necessity
D8703	Replacement of lost or broken retainer – maxillary	Medical necessity
D8704	Replacement of lost or broken retainer – mandibular	Medical necessity
D8999	Unspecified orthodontic treatment, by report	Medical necessity

Pediatric dental care exclusions

The following are not covered under this benefit:

- 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, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth
- Crown, inlays and onlays, and veneers unless:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be **medically necessary**), mouth guards
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - 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 and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another **eligible health service**
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in this section
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs
- 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
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a **provider**
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a **dental provider**

6. Specific conditions

Abortion (including pre-abortion and follow-up abortion related services)

Eligible health services include services provided and supplies used in connection with an abortion.

Abortion means any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth, which would include, for example, medication or surgical procedures (and related services) that are necessary to stop the progression of a pregnancy or to remove the pregnancy in the case of miscarriage or ectopic pregnancy.

Birthing center (facility charges)

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

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

Refer to the *Eligible health services and exclusions – 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 preparations
  - Hypodermic needles and syringes used for the treatment of diabetes
  - Injection aids for the visually impaired
  - Diabetic test agents - blood glucose, ketone and urine
  - Lancets/lancing devices
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Injectable glucagons
  - Glucagon emergency kits
- Equipment
  - External insulin pumps
  - Blood glucose meters without special features, unless required due to visual impairment
  - Over-the-counter (OTC) depth-inlay shoes
- Training
  - Self-management training provided by a health care **provider** certified in diabetes self-management training

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

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

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

Eligible health services include:

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

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

The following are not covered under this benefit:

- Dental implants

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**.

The following are not covered under this benefit:

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

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 s**pecialist** 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.

The following are not covered under this benefit:

- Services and supplies provided for the treatment of an **illness** that results from your **clinical related injury** as these are covered elsewhere in the **student policy**

Dermatological treatment

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

The following are not covered under this benefit:

- **Cosmetic** treatment and procedures

Maternity care

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

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

- 48 hours of inpatient care in a **hospital** or birthing center after a vaginal delivery
- 96 hours of inpatient care in a **hospital** or birthing center after a cesarean delivery
- A shorter **stay** if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier
- The mother could be discharged earlier. If so, the plan will pay for 2 post-delivery home visits by a health care **provider**

The following are not covered under this benefit:

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

Well newborn nursery care

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

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

Gender affirming treatment

Gender affirming treatment is subject to the provisions of the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and state mental health parity law, SB 855.

Eligible health services include all **medically necessary** services and supplies for gender affirming treatment and **surgery**. These services include but are not limited to:

- Hormone therapy
- Hysterectomy
- Mastectomy
- Fertility preservation for iatrogenic infertility for a **mental health condition** or **substance use disorder** diagnosis
- Reconstructive **surgery** to create a normal appearance for the gender with which you identify
- Speech therapy

These services will not be denied if you enrolled as a member of the opposite sex or are in the process of a gender transition.

Important note:
We apply **medical necessity** review (precertification, concurrent and retrospective) to all inpatient services, including inpatient visits for any mental health or substance use disorder as specified in the Certificate of Coverage. In making determinations of **medical necessity** for gender affirming treatment we use the most recent version of the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People developed by the World Professional Association for Transgender Health (WPATH).

Behavioral health

Medically necessary treatment of **mental health conditions** and **substance use disorders** are covered under the same terms and conditions applied to other medical conditions and in accordance with the federal Mental Health Parity and Addiction Equity Act.

Mental health treatment

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

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

- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
  - You are **homebound**
  - Your **physician** orders them
  - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
  - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- Observation
- Behavioral health crisis services provided by a 988 Crisis Hotline Center or mobile crisis team
- Peer counseling support by a peer support specialist (including **telemedicine** consultation)
  - A peer support specialist serves as a role model, mentor, coach, and advocate. Peer support must be supervised by a **behavioral health provider**.

Substance use disorders treatment

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

- **Inpatient room and board** at the **semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Other services and supplies that are provided during your **stay** in a general medical **hospital**, **psychiatric hospital** or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a general medical **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes individual, group and family therapies in an office setting and **telemedicine** consultations)
  - Other outpatient **substance use disorders** treatment such as:
    - Individual, group and family therapies in a non-office setting for the treatment of **substance use disorders**
    - Outpatient **detoxification**
    - Partial hospitalization treatment provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are **homebound**
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness**, or disease
    - Ambulatory **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Treatment of withdrawal symptoms

- Observation
- Behavioral health crisis services provided by a 988 Crisis Hotline Center or mobile crisis team
- Peer counseling support by a peer support specialist (including **telemedicine** consultation)
  - A peer support specialist serves as a role model, mentor, coach, and advocate. Peer support must be supervised by a **behavioral health provider**.

Important notes:
Your **student policy** covers **telemedicine** for **mental health conditions** and **substance use disorders**. All in-person **physician** or **behavioral health provider** office visits that are **covered benefits** are also covered if you use **telemedicine** provided by a **physician** or **behavioral health provider** instead.

Telemedicine provided by a **physician** or **behavioral health provider** may have different cost sharing than other outpatient services. See the schedule of benefits for more information.

Obesity (bariatric) surgery and services

Obesity **surgery** is a type of procedure performed on people who are **morbidly obese** for the purpose of losing weight. Your **physician** will determine whether you qualify for obesity **surgery**.

Eligible health services include**:**

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- A multi-stage procedure when planned and approved by us
- Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting
- Other related outpatient services
- Travel and lodging expenses for you and a companion (if you live 50 miles or more from the facility)

The following are not covered under this benefit:

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity** except as described above and in the *Eligible health services and exclusions – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Reconstructive surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed. Services and supplies include:
  - An implant
  - Areolar and nipple reconstruction
  - Areolar and nipple re-pigmentation
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema and prosthetic devices
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects or repairs abnormal structures of the body caused by:
  - anatomical defect present at birth
  - cleft palate (includes medically necessary dental or orthodontic services
  - developmental abnormalities
  - disease
  - infection
  - trauma
  - tumors
- The purpose of the **surgery** is to improve function or create normal appearance

Transplant services

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

This includes the following transplant types even when you are infected with the human immune deficiency virus (HIV):

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

Network of transplant facilities

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

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

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

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

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

The following are not covered under this benefit:

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

Infertility services

Basic infertility

Eligible health services include seeing a **provider**:

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

Advanced reproductive technology (ART)

Fertility preservation

Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use, including all standard fertility preservation services when a medical treatment may directly or indirectly cause a need for fertility preservation services.

Eligible health services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned services that are proven to result in **infertility** such as:
  - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**
  - Other gonadotoxic therapies
  - Removing the uterus
  - Removing both ovaries or testicles
- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the FSH level and ovarian responsiveness criteria outlined in **Aetna's infertility** clinical policy

Advanced reproductive technology, also called “assisted reproductive technology”, is a more advanced type of **infertility** treatment.

Infertility services exclusions

The following are not covered under the **infertility** services benefit except as described as an **eligible health service** for fertility preservation:

- All **infertility** services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- **Infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.
- Intrauterine (IUI)/intracervical insemination (ICI) services.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- **Infertility** treatment when a successful pregnancy could have been obtained through less costly treatment.
- **Infertility** treatment when either partner has had voluntary sterilization **surgery**, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- I**nfertility** treatment when **infertility** is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna’s **infertility** clinical policy.

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. Other services include biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of your condition to guide treatment decisions.

Chemotherapy

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

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

Eligible health services include GCIT provided by a **physician**, **hospital** or other **provider**.

Key Terms

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

Gene

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

Molecular

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

Therapeutic

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

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

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

Eligible health services for GCIT include:

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

Facilities/providers for gene-based, cellular and other innovative therapies
We designate facilities to provide GCIT services or procedures. GCIT **physicians**, **hospitals** and other **providers** are GCIT-designated facilities/**providers** for **Aetna** and CVS Health.

Important note:
You must get GCIT **eligible health services** from a GCIT-designated facility/**provider**. If there are no GCIT-designated facilities/**providers** assigned in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your GCIT services at the facility/**provider** we designate, they will not be **eligible health services**.

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 in to your **Aetna** website at https://www.aetnastudenthealth.com.

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

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

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

The following are not covered under this benefit:

- Enteral nutrition
- Blood transfusions and blood products

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 the office
  - A home care **provider** in your home
- Listed on our **specialty prescription drug** list as covered under this certificate of coverage

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

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 in to your **Aetna** website at https://www.aetnastudenthealth.com to determine if coverage is under the outpatient **prescription drug** benefit of this certificate of coverage.

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

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**.

Rehabilitation and habilitation therapy services

Rehabilitation therapy services

Rehabilitation therapy services are services needed to restore or develop your skills and functioning for daily living.

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

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

Rehabilitation therapy services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, 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.

Habilitation therapy services

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

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

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

Habilitation therapy services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient physical, occupational, and speech habilitation therapy

Eligible health services include:

- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function or maintain 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 or maintain 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 or maintain function. 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
- Dyslexia

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

8. Other services

Acupuncture

Eligible health services include manual or electro acupuncture.

The following is not covered under this benefit:

- Acupressure

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:

- **Precertified** transportation by a licensed ambulance or psychiatric transport van when it is the only safe way to transport you.

The following are not covered under this benefit:

- **Ambulance** services for routine transportation to receive outpatient or inpatient care

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, a life-threatening disease or condition or **terminal illnesses** and all of the following conditions are met:

- You are eligible to participate in the approved clinical trial
- Your participation is appropriate to treat the disease or condition based on your **provider's** conclusion or based on medical and scientific information provided by you

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

Clinical trials (routine patient costs)

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

The following are not covered under this benefit:

- 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** or **investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies)

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:

- Bone stimulator
- Cervical traction (over door)
- Dry pressure pad for a mattress
- Enteral pump and supplies
- IV pole
- Nebulizer and supplies
- Peak flow meters
- Phototherapy blankets for treatment of jaundice in newborns
- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Tracheostomy tube and supplies

Coverage also includes:

- 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.

The following are not covered under this benefit:

- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids

- Vision aids
- Telephone alert systems
- Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a **physician**

Nutritional support

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.

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

The following are not covered under this benefit:

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

Orthotic devices

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

Osteoporosis (non-preventive care)

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

Prosthetic devices

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

Prosthetic device means:

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

Coverage includes:

- The prosthetic device
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- The fitting, instruction and other services (such as attachment or insertion) so you can properly use the device
- Specifically but not limited to:
    - Contact lenses to treat anirida (missing iris) or aphakia (absence of the crystalline lens of the eye)

The following are not covered under this benefit:

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

Hearing aids

Eligible health services include prescribed hearing aids and hearing aid services as described below.

Hearing aid means:

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

Hearing aid services are:

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

Hearing aids alternate treatment rule

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

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

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

The following are not covered under this benefit:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 24 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist

Hearing exams

Eligible health services include hearing exams for evaluation and treatment of **illness**, **injury** or hearing loss when performed by a hearing **specialist**.

The following are not covered under this benefit:

- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**

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.

The following are not covered under this benefit:

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - Routine pedicure services, such as cutting of nails, corns and calluses when there is no **illness** or **injury** of the feet

Telemedicine

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

Eligible health services for **telemedicine** consultations are available from a number of different kinds of **providers** under your plan. Contact us to get more information about your options, including specific cost sharing amounts.

Vision care

Pediatric vision care

Routine vision exams

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

Vision care services and supplies

Eligible health services include:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses
- Eyeglass frames, **prescription** lenses or **prescription** contact lenses and their fitting, and follow-up care
- 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
- Coatings and special lenses, including:
  - Ultraviolet protective coating
  - Standard progressives
  - Plastic photosensitive lenses (Transitions)
  - Blended segment lenses
  - Intermediate vision lenses
  - Premium progressive lenses
  - Select or ultra-progressive lenses
  - Photochromic glass lenses
  - Polarized lenses
  - Anti-reflective coating (standard/premium/ultra)
- High-index lenses

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

The following are not covered under this benefit:

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

Adult vision care

Routine vision exams

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

The following are not covered under this benefit:

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

- 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

9. Outpatient prescription drugs

Prescription drugs

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

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

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

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

Eligible health services are based on the drugs in the **drug guide**. We exclude **prescription drugs** listed on the formulary exclusions list unless we approve a medical exception. The formulary exclusions list is a list of **prescription drugs** not covered under the plan. This list is subject to change. If it is **medically necessary** for you to use a **prescription drug** that is not on this **drug guide**, you or your **provider** must request a medical exception. See the *Requesting a medical exception* section or just contact us. ***END DRAFTING NOTE***

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

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

The **pharmacy** may substitute a **generic prescription drug** for a **brand-name prescription drug**.

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

Prescription drug synchronization

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

Partial fill dispensing for Schedule II controlled substances

You or your **provider** may request your pharmacist to dispense a partial fill of a Schedule II controlled substance. We will apply a prorated daily cost share rate to a partial fill.

How to access in-network pharmacies

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

If you don't get your **prescription** at an **in-network pharmacy**, it will not be an **eligible health service** under the plan.

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 31 day supply of a **prescription drug**.

Mail order pharmacy

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

Specialty pharmacy

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

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

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

How to access out-of-network pharmacies

You can directly access an **out-of-network pharmacy** to get covered outpatient **prescription drugs**.
When you use an **out-of-network pharmacy**, you pay your in-network **copayment** or **coinsurance** then you pay any remaining **deductible** and then you pay your out-of-network **coinsurance**. If you use an **out-of-network pharmacy** to obtain outpatient **prescription drugs**, you are subject to a higher out-of-pocket expense and are responsible for:

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

Other covered services

Abortion drugs

Eligible health services include **prescription drugs** used for termination of pregnancy.

Anti-cancer drugs taken by mouth

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

Asthma supplies for children
Eligible health services include but are not limited to the following:

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

Contraceptives (birth control)

Eligible health services include all drugs and devices that the FDA has approved, granted or cleared to prevent pregnancy at no cost to you. You will need a **prescription** from your **provider** and must fill it at an **in-network pharmacy**.

This includes over-the-counter (OTC) and **generic prescription drugs** and devices for each method of birth control approved, granted or cleared by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the **brand-name prescription drug** or device at no cost share. A **prescription** is not required for FDA approved, FDA granted or FDA cleared over-the-counter contraceptives, drugs, devices and products at a network pharmacy and will be provided:

- At no cost to you and
- Without medical management.

You may get a 12-month supply per **prescription**. The prescribed contraceptive **prescription drug** may be filled all at once or over the course of the 12 months as prescribed by your **prescriber**. For specific cost sharing see your **schedule** of benefits *Outpatient **prescription drugs** Contraceptives (birth control)* section.

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

Diabetic supplies

Eligible health services include but are not limited to the following:

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

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

Immunizations

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

Obesity drugs
Eligible health services include **prescription drugs** used only for the purpose of weight loss. These are sometimes called anti-obesity agents.

You must be diagnosed by your **provider**, including a physical exam and outpatient diagnostic lab work, with morbid obesity.

Over-the-counter (OTC) drugs
Eligible health services include certain OTC medications when you have a **prescription** from your **provider**. You can see a list of covered OTC drugs by logging in to your **Aetna** website. **Eligible health services** include preventive care drugs and supplements described in the *Preventive care drugs* section of the *Preventive care* section.

Pharmacy consultation services
State licensed pharmacists are allowed to prescribe certain **prescription drugs**.

Eligible health services include consultation services by your state licensed pharmacist to:
- Determine the **medical necessity** of a specific **prescription drug** for your **illness** or condition
- Prescribe specific **medically necessary prescription drugs**

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

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 medication side effects

Sexual enhancement or dysfunction prescription drugs
Eligible health services include **prescription drugs** for the treatment of sexual dysfunction or enhancement. For the most up-to-date information on covered **prescription drugs** and doses, contact us.

Tobacco cessation prescription and OTC drugs
Eligible health services include FDA approved **prescription** and OTC drugs to help stop the use of tobacco products. You must receive a **prescription** from your **provider** and submit the **prescription** to the **pharmacy** for processing.

Outpatient prescription drug exclusions
The following are not **eligible health services**:
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- **Cosmetic** drugs including medication and preparations used for **cosmetic** purposes, except as medically necessary for gender affirming treatment
- Devices, products and appliances unless listed as an **eligible health service**
- Dietary supplements, except as described in the *Eligible health services and exclusions -Nutritional Support* section
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided

- Which do not require a **prescription** by law, even if a **prescription** is written, unless we have approved a medical exception or unless it is for the coverage of an FDA approved, FDA granted or FDA cleared OTC contraceptive drug, device or other product.
- Not approved by the FDA or not proven safe or effective
- Provided under your medical plan while inpatient at a healthcare facility
- Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
- That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the **covered person** meets one or more clinical criteria detailed in our **precertification** and clinical policies or except as provided under the *Eligible health services and exclusions - Gender affirming treatment* section

- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as an **eligible health service**
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except for**:**
  - Implantable drugs and associated devices used to treat **mental health conditions** or **substance use disorders** or as specifically stated in the schedule of benefits or the certificate
  - Implantable infusion pumps to treat diabetes
  - Contraceptive implants
- **Infertility**:
  - **Prescription drugs** used primarily for the treatment of **infertility**
- Injectables including:
  - Any charges for the administration or injection of **prescription drugs**
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting with the exception of Depo Provera and other **injectable drugs** for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription drugs**:
  - That are ordered by a **dentist** or prescribed by an oral surgeon in relation to the removal of teeth or **prescription drugs** for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- A manufacturer's product when a **therapeutic equivalent** drug, supply or equipment as defined by the FDA, is on the plan's **drug guide**, except when **medically necessary**
- Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide,** except for FDA approved contraceptive drugs, devices and products. or when a different dosage or form is **medically necessary**.

Where your schedule of benefits fits in

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

Your outpatient **prescription drug** costs are based on:

- The type of **prescription drug** you are prescribed
- Where you fill your **prescription**

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

How your copayment works

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

Your cost share will not be more than the retail drug price. The amount you pay for the **prescription** drug will apply to your **maximum out-of-pocket limit** and **deductible** if you have one.

What your plan doesn't cover – general exclusions

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

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

General exclusions

The following are not **eligible health services** under your plan except as described in:

- The *Eligible health services and exclusions* section of this certificate of coverage or
- A rider or amendment issued to you for use with this certificate of coverage

Armed forces

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

Beyond legal authority

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

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 and exclusions - Clinical trial therapies (experimental or investigational)* section

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.

  This exclusion does not apply to:
- **Surgery** after an **accidenta**l **injury** when performed as soon as medically feasible. (**Injuries** that occur during medical treatments are not considered **accidental injuries** even if unplanned or unexpected.)
- Coverage that may be provided under the *Eligible health services and exclusions - Gender affirming treatment* section.

Court-ordered testing

- Court-ordered testing or care unless **medically necessary**

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

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

This exclusion does not apply to:

- **Medically necessary** treatment of **mental health disorders** and **substance use disorders**
- Assistance with activities of daily living that are provided as part of **eligible health services** under **Hospice care** when given as part of a **home health care program**, **hospice care program**, inpatient **skilled nursing facility** care or inpatient **hospital** care

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.

Educational services
Services that are non-medical and are not **medically necessary** to treat **mental health conditions** or **substance use disorders** are:

- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services and exclusions – Diabetic services and supplies (including equipment and training)* or *Preventive care and wellness* sections.
  Excluded education and training or retraining services or testing are:
  - Special education

- Remedial education
- Job training
- Job hardening programs

- Educational services, any services, schooling related or similar, including therapeutic programs, within a school setting.

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 and exclusions – Other services* section.

Facility charges
For care, services or supplies provided in:

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

Gene-based, cellular and other innovative therapies (GCIT)
The following are not **eligible health services** unless you receive prior written approval from us:

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**.
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the *Medical necessity and precertification requirements* section.

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

This exclusion does not apply to gender affirming treatment or bone growth stimulation devices.

Incidental surgeries

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

Judgment or settlement

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

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

This exclusion does not apply to disposable supplies that must be covered as or in connection with durable medical equipment, hospice care, ostomy and urological supplies, and outpatient prescription drugs

Other primary payer

- Payment for a portion of the charge that **Medicare** or another party pays for as the primary payer

Personal care, comfort or convenience items

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

Private duty nursing

School health services

- Services and supplies normally provided without charge by the **policyholder's**:
  - **School health services**
  - Infirmary
  - **Hospital**
  - **Pharmacy** or

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

Services not permitted by law

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

Services provided by a family member

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

Sinus surgery

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

Strength and performance

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

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

This exclusion does not apply to services to treat a **mental health condition** or **substance use disorder**

Telemedicine

- Services given by **providers** that are not contracted with **Aetna** to provide **telemedicine** services

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

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

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

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

Out-of-network providers

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

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

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

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

- You join the plan and the **provider** you have now is not in the network
- You are already covered under another **Aetna** plan and your **provider** stops being in our network
- The **provider**'s terms of participation change, resulting in a termination of in-network status with respect to a **provider**

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

This does not apply to terminations of the provider contracts for failure to meet applicable quality standards or for fraud.

Care will continue during a transitional period that will vary based on your condition.

If you have this condition	**The length of transitional period is**
Acute condition	As long as the condition lasts
Serious chronic condition	No more than 12 months. Usually until you complete a period of treatment and your **physician** can safely transfer your care to another **physician**.
Pregnancy	All three trimesters of pregnancy and the immediate post-partum period
Maternal **mental health condition** (a **mental health condition** that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery)	Up to 12 months after diagnosis or after pregnancy ends, whichever occurs later
Terminal illness	As long as the person lives
Care of a child under 3 years	Up to 12 months
An already scheduled **surgery** or other procedure	Within 180 days of you joining the **Aetna** plan or your **provider** leaving the network

We will notify you of your right to elect continued transitional care from the **provider** if their termination leads to a change in network status. If you request to keep going to your current **provider**, we will tell you how long you can continue to see the **provider**.

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

What the plan pays and what you pay

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

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

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

The general rule

When you get **eligible health services**:

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

And then

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

And then

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

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

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

Important exception – when your plan pays all

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

Important exceptions – when you pay all

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

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

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

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

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

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

Instead:

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

And then

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

And then

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

And then

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

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

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

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

Where your schedule of benefits fits in

How your policy year deductible works

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

How your copayment works

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

How your maximum out-of-pocket limit works

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

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

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

These procedures apply to claims involving **out-of-network providers**.

Submit a claim

- You should notify and request a claim form from the **policyholder**
- We will send you a claim form within 15 days of your request
- The claim form will provide instructions on how to complete and where to send the form
- If you are unable to complete a claim form, you may send us:
  - A description of services
  - A bill of charges
  - Any medical documentation you received from your **provider**

Proof of loss (claim)

- Proof of loss is a completed claim form and any additional information required by us
- You or your **provider** must send us notice and proof within 12 months of the date you received services, unless you are legally unable to notify us

Benefit payment

- Written proof must be provided for all benefits
- If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss
- Benefits will be paid as soon as the necessary proof to support the claim is received but no later than 30 business days after receipt.

Types of claims and communicating our claim decisions

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

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

Urgent care claim

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

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

Pre-service claim
A pre-service claim is a claim that involves services you have not yet received.

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

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

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

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

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

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination	72 hours	5 business days	30 business days	Urgent request: 24 hours Non-urgent request: 5 business days
Extension	None	15 days	15 days	Not applicable
Our additional information request to you	24 hours	15 days	30 days	Not applicable
Your response to our additional information request	48 hours	45 days	45 days	Not applicable

Important note for concurrent care urgent requests:
We have to receive the request at least 24 hours before the previously approved health care services end.

Adverse benefit determinations

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

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

The difference between a complaint and an appeal

A Complaint

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

An Appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us by calling Member Services at the toll-free number on your ID card.

Appeals of adverse benefit determinations

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

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

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

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

Urgent care or pre-service claim appeals

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

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

Timeframes for deciding appeals

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

Claim type	Decision timeframe	Extensions
Urgent care claim	36 hours	None
Pre-service claim	5 business days	None
Post-service claim	30 business days	None
Concurrent care claim	As appropriate to type of claim	As appropriate to type of claim

After 30 days or after three days for an urgent care claim, you can request an independent medical review (IMR) from the California Department of Insurance within 6 months of either date.

Independent medical review (IMR) managed by the California Department of Insurance

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

You have a right to an IMR 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

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

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

You must submit the Request for External Review Form:

- To the:
  California Department of Insurance, Consumer Services Division
  300 Spring Street, South Tower
  Los Angeles, CA 90013
  1-800-927-HELP (4357), TDD: 1-800-482-4TDD (4833)
  www.insurance.ca.gov
  https://www.insurance.ca.gov/01-consumers/110-health/60-resources/01-imr/index.cfm
- Within 6 months of the date you received the decision from us. (The date may be extended by the Commissioner of Insurance)
- And you must include a copy of the notice from us and all other important information that supports your request

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

The California Department of Insurance will:

- Contact the ERO that will conduct the review of your claim
- The ERO will:
  - Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
  - Consider appropriate credible information that you sent
  - Follow our contractual documents and your plan of benefits
  - Send notification of the decision within 30 calendar days of the date the California Department of Insurance receives your request form and all the necessary information

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

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

For initial adverse determinations
Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function or
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment)

For final adverse determinations
Your **provider** tells us that a delay in your receiving health care services would:

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

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.

Recordkeeping

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

Fees and expenses

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

Coordination of benefits (COB)

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

Key terms

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

Allowable expense means:

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

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

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

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

Here's how COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage
- When this is your secondary plan:
  - We calculate payment as if the primary plan does not exist. Then we reduce our payment based on any amount the primary plan paid.
  - We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable submitted expenses.
  - Each family member has a separate benefit reserve for each **policy year**. The benefit reserve balance is:
    - The amount that the secondary plan saved due to COB
    - Used to cover any unpaid allowable expenses
    - Erased at the end of the year

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. A plan that does not contain a COB provision is always the primary plan.

COB rule	Primary plan	Secondary plan
Covered under this plan as a student or dependent	Plan covering you as a student	Plan covering you as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the **calendar year** (Birthday rule)	Plan of parent whose birthday is later in the **calendar year**
Child – parents separated, divorced, or not living together	• Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent's plan if there is no court order	• Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent's plan
Child – covered by individuals who are not parents (i.e., stepparent or grandparent)	Same rule as parent	Same rule as parent
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

How COB works with Medicare

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

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

- Age
- Disability
- ALS / Lou Gehrig's disease or
- End stage renal disease (ESRD)

When you have **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before **Medicare** pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after **Medicare** or after an amount that **Medicare** would have paid had you been covered.

Who pays first?

- **Medicare** pays first when you have **Medicare** because of:
  - Age
  - Disability
  - ALS / Lou Gehrig's disease

- When you have **Medicare** because of ESRD:
  - We pay first for the first 3 months unless you take a self-dialysis course.
  - If you take a self-dialysis course, there is no **Medicare** waiting period and **Medicare** becomes primary payer on the first of the month of dialysis.
  - If a transplant takes place within the 3-month waiting period, **Medicare** becomes primary payer on the first of the month in which the transplant takes place.

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

This plan is secondary to **Medicare** in all other circumstances.

How are benefits paid?

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

Other health coverage updates – contact information

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

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

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

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

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

When coverage ends

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

When will your coverage end?

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

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

Withdrawal from classes – leave of absence

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

Withdrawal from classes – other than leave of absence

- If you withdraw from classes within 31 days after the policy effective date, you will be considered ineligible for coverage. Your coverage will be terminated retroactively, and any **premium** paid will be refunded.
- If you withdraw from classes more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which **premium** payment has been received. No **premium** will be refunded.
- If you withdraw from classes to enter the armed forces of any country, your coverage will end as of the date of such entry. We will refund your **premium**, on a pro-rata basis, if you submit a written request within 90 days from the date you withdraw.

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 date of the child's 26th birthday.
- Your dependent is no longer eligible for coverage.
- The date dependents are no longer an eligible class.
- You do not make the required **premium** contribution toward the cost of dependents' coverage.
- Your coverage ends for any of the reasons listed above.
- For your spouse, the date the marriage ends in divorce or annulment.
- For your domestic partner or civil union partner, the date the domestic partnership or civil union ends. You should provide the **policyholder** a completed and signed Declaration of Termination of Domestic Partnership.

What happens to your dependent coverage if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

Why would we suspend paying claims or end your coverage?

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

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

We may immediately end your and your dependents coverage if:

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

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

Special coverage options after your plan coverage ends

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

Continuation of coverage for other reasons

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

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

You are "totally disabled" if you cannot engage in most normal activities of a healthy person of the same age and gender.

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

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

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

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

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

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

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

How can you extend coverage after graduation when you are injured or ill?
If your coverage ends because you are graduating, your coverage may be extended for an **injury** or **illness** that started while you were covered under the **student policy**. Benefits are extended only for the services or supplies to treat that **illness** or **injury**.

You may extend coverage but not beyond 24 weeks from:

- The date of the **accident** or
- The date of the first treatment of the **illness**

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

No change in the student health policy will be valid until:

- Approved by our authorized officer
- Endorsed onto or attached to the student health policy.

No agent has authority to change the student health policy or to waive any of its provisions.

Administrative provisions

How you and we will interpret this certificate of coverage

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

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

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

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

Coverage and services

Your coverage can change

Your coverage is defined by the **student policy**. This document may have amendments or riders too. Under certain circumstances, we or the **policyholder** or the law may change your plan according to requirements of the **student policy**.

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

Legal action

You must 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 60 days after we receive written submission of claim.

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

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 before we learned of it. All statements made by you or the policyholder will be deemed representations and not warranties.

Intentional deception of a material fact under the terms of coverage
If we learn that you defrauded us or you intentionally misrepresented material facts within the first 24 months of your effective date, 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 managed by the California Department of Insurance

Some other money issues

Assignment of benefits
When you see an **in-network provider** they will usually bill us directly. When you see an **out-of-network provider,** we may choose to pay you or to pay the **provider** directly. When you assign your benefits to your out-of-network provider, you are not required to pay the full amount and we will pay the **provider** directly.

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

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

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

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

To help us get paid back, you are doing four things now:

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

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 licensed or certified to provide diagnostic and/or therapeutic services for **mental health conditions** and **substance use disorders** under the laws of the jurisdiction where the individual practices. This includes:

- A person that is licensed under Division 2, Healing Arts, (beginning with Section 500), of the Business & Professions Code
- An associate marriage and family therapist or marriage and family therapist trainee functioning in accordance with Section 4980.43.3 of the Business and Professions Code
- A qualified autism service provider or qualified autism service professional certified by a national entity
- An associate clinical social worker functioning in accordance with Section 4996.23.2 of the Business and Professions Code
- An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
- A registered psychologist as described in Section 2909.5 of the Business and Professions Code or psychological assistant as described in Section 2913 of the Business and Professions Code
- A psychology trainee or person supervised under the direction of a licensed psychologist
- A 988 center or mobile crisis team

Body mass index
This is a degree of obesity and is calculated by dividing your weight in kilograms by your height in meters squared.

Brand-name prescription drug
An FDA-approved **prescription drug** marketed with a specific name or trademark name by the company that manufactures it, usually by the company which develops and patents it.

Calendar year
A period of 12 months beginning January 1st and ending on December 31st.

Clinical related injury
As used within the *Blood and body fluid exposure* **covered benefit**, this is any **incident** which exposes you, acting as a student in a clinical capacity, to an **illness** that requires testing and treatment. Incident means unintended:

- Needlestick pricks
- Exposure to blood and body fluid
- Exposure to highly contagious pathogens

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

Copayments
The specific dollar amount or percentage you have to pay for a health care service listed in the schedule of benefits.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance. It does not include coverage provided under the *Eligible health services and exclusions - Gender affirming treatment* section.

Covered benefits
Eligible health services that meet the requirements for coverage under the terms of this plan, including:

- They are **medically necessary**
- You received **precertification**, if required

Covered dependent
A person who is insured under the **student policy** as a dependent of a **covered student**.

Covered person
A **covered student** or a **covered dependent** of a **covered student** for whom all of the following applies:

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

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

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

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

Dental emergency
Any dental condition that:

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

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

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

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

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

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

Directory
The list of **in-network providers** for your plan. The most up-to-date **directory** for your plan appears at https://www.aetnastudenthealth.com. When searching from our online **provider directory**, you need to make sure that you are searching for **providers** that participate in your specific plan. **In-network providers** may only be considered for certain **Aetna** plans. When searching for **in-network dental providers**, you need to make sure you are searching under Pediatric Dental plan.

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

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

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

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

Eligible health services
The health care services and supplies and outpatient **prescription drugs** listed in the *Eligible health services and exclusions* section and not carved out or limited in the *General exclusions* 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

An acute, severe medical condition that would lead a prudent layperson to reasonably believe that the condition, **illness**, or **injury** is of a severe nature. And that if you don't get immediate medical care it could result in:

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

Emergency services

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

Experimental or investigational

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

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

Generic prescription drug

An FDA-approved drug that must be the **therapeutic equivalent**, as defined by the FDA, to the brand-name product.

Health professional

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, **physicians**, nurses, **dental providers**, vision care **providers**, and physical therapists. For **mental health conditions** and **substance use disorders**, it includes a **behavioral health provider**.

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 care

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

Hospice care agency

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

Hospice care program

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

Hospice facility

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

Hospital

An institution licensed as a **hospital** by applicable law and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can stay overnight for care. Or than can be treated and leave the same day. All **hospitals** must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

Hospital stay

This is your **stay** of 18 or more hours in a row as a resident bed patient in a **hospital**.

Illness or illnesses
Poor health resulting from disease of the body or mind.

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

In-network pharmacy
A **retail pharmacy**, **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**.

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
- For an individual or their partner who has been clinically diagnosed with gender dysphoria

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

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

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

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

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.

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 (services or supplies other than for a mental health condition and substance use disorder)
Health care services or supplies that prevent, evaluate, diagnose or treat an **illness**, **injury**, disease or its symptoms, and that are all of the following:

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

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and
- Following the standards set forth in our clinical policies and applying clinical judgment

Medically necessary, medical necessity (for mental health conditions or substance use disorders services or supplies)
Health care services or products provided to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness or injury, condition or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms that are:

- In accordance with generally accepted standards of **mental health conditions** and **substance use disorder** care
- Clinically appropriate, in terms of type, frequency, extent, site and duration
- Not primarily for the economic benefit for us or the convenience of the patient, **physician**, or other health care **provider**

Generally accepted standards of **mental health conditions** and **substance use disorder** care means standards of care and clinical practice that are generally recognized by health care **providers** practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of **mental health condition** and **substance use disorder** care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

All **medical necessity** determinations of a **covered person** diagnosed with a **mental health condition** or a s**ubstance use disorder** including, but not limited to determinations concerning:

- Service intensity
- Level of care placement
- Continued stay
- Transfer or discharge

will be made in accordance with generally accepted standards of **mental health conditions** and **substance use disorder** care, including the use of the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

This includes the following Nonprofit Specialty Guidelines:

- Primary **substance use disorder** diagnosis in adolescents and adults ages 13 and older: The ASAM Criteria developed by the American Society of Addiction Medicine
- Primary **mental health condition** diagnosis in adults ages 19 and older: Level of Care Utilization System (LOCUS) developed by the American Association for Community Psychiatry (AACP)
- Primary **mental health condition** diagnosis in children ages 6-18: Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) developed by AACP and the American Academy of Child & Adolescent Psychiatry (AACAP)
- Primary **mental health condition** diagnosis in children ages 5 and younger: Early Childhood Service Intensity Instrument (ECSII) developed by AACAP

In making determinations of medical necessity for gender affirming treatment we use the most recent version of the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People developed by the World Professional Association for Transgender Health (WPATH).

Important note:
We use the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty except when the relevant criteria and guidelines are not applicable. In that case we rely on clinical policy bulletins we have developed and maintained that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **experimental or investigational**. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact us. See the *How to contact us for help* section.

For gender affirming treatment and behavioral health services, we use the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty to determine **medical necessity** in accordance with state law.

Medicare

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

Mental health condition

A **mental health condition** is a condition that falls under any of the diagnostic categories listed in the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)* or that is listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's I*nternational Statistical Classification of Diseases and Related Health Problems (ICD).*

Changes in terminology, organization, or classification of **mental health conditions** in future versions of the DSM or ICD will not affect the conditions covered as long as a condition is commonly understood to be a **mental health condition** by health care **providers** practicing in relevant clinical specialties.

Morbid obesity/Morbidly obese

This means the **body mass index** is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea or
- Diabetes

Negotiated charge

Health coverage

This is either:

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

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

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

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

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

Some of these arrangements are called:

- Value-based contracting
- Risk sharing

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

Prescription drug coverage from an in-network pharmacy

In-network pharmacy

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

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

Non-preferred drug

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

Out-of-network dental provider

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

Out-of-network pharmacy

A **pharmacy** that is not an **in-network pharmacy**, or National Advantage Program (NAP) **provider** and does not appear in the **directory** for your plan.

Out-of-network provider

A **provider** who is not an **in-network provider** or National Advantage Program (NAP) **provider** and does not appear in the **directory** for your plan**.**

Pharmacy
An establishment where **prescription drugs** are legally dispensed. This includes an in-network **retail pharmacy**, **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. For mental health conditions and substance use disorders, it includes a **behavioral health provider**.

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.

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

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

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

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

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

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

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

Psychiatric hospital
An institution licensed or certified as a **psychiatric hospital** by applicable laws to provide a program for the diagnosis, evaluation, and treatment of a **mental health condition** (including **substance use disorders**).

Recognized charge
The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The **recognized charge** depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Service or supply	**Recognized charge is based on:**
Professional services and other services or supplies not mentioned below	105% of the **Medicare** allowed rate
Services of **hospitals** and other facilities	140% of the **Medicare** allowed rate
Prescription drugs	100% of the average wholesale price (AWP)
Dental expenses	80% of the prevailing charge rate
Important note: If the **provider** bills less than the amount calculated using the method above, the **recognized charge** is what the **provider** bills.	

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP **provider**. NAP **providers** are **out-of-network providers** and third-party vendors that have contracts with us but are not **in-network providers**.

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
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the **provider**

Our reimbursement policies are based on our review of:

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

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

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

R.N.
A registered nurse.

Residential treatment facility
A facility that provides **mental health condition** services or **substance use disorder** services and meets the following requirements:

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

Residential treatment facility (substance use disorders)

An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for **substance use disorder** 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 use disorder** 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**

In addition to the above requirements, for substance use **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**.

Room and board

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

Semi-private room rate

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

Service area

The specific geographic area that is the service area for this student plan. Your service area includes all counties

Skilled nursing facility

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

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

- Is:
  - Credentialed by us, or
  - Certified by Medicare, or
  - Accredited by The Joint Commission (TJC) or The Committee on Accreditation of Rehabilitation Facilities (CARF)

Skilled nursing facilities also include rehabilitation **hospital**s, 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 health conditions** or **substance use disorders**.

Skilled nursing services
Services provided by an **R**.**N**. or **L.P.N.** within the scope of his or her license.

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

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

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

Specialty prescription drug
An FDA-approved **prescription drug** that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:
- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

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

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

Student policy
The **student policy** consists of several documents taken together. The list of documents can be found in the *Entire student policy* section of this certificate of coverage.

Substance use disorder
A **substance use disorder** is a condition that falls under any of the diagnostic categories listed in the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or that is listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* (ICD).

Changes in terminology, organization, or classification of **substance use disorders** in future versions of the DSM or ICD will not affect the conditions covered as long as a condition is commonly understood to be a **substance use disorder** by **providers** practicing in relevant clinical specialties.

Surgery center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all **Medicare** accreditation standards (even if it does not participate in **Medicare**).

Surgery, surgeries or surgical procedures
The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution or
- Otherwise physically changing body tissues and organs

Telemedicine
A consultation between you and a **physician**, **specialist**, **behavioral health provider**, or **telemedicine provider** who is performing a clinical medical or behavioral health service by means of electronic communication.

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

Terminal illness
A medical prognosis that you are not likely to live more than 6-24 months.

Therapeutic equivalent

A **therapeutic equivalent** drug is one that can be substituted with the full expectation that the substituted drug will produce the same clinical effect and safety profile as the prescribed drug. Drugs are considered to be therapeutically equivalent only if they meet these criteria:

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

Urgent admission

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

Urgent care facility

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

Urgent condition

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

Walk-in clinic

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near, or within a:

- Drug store
- **Pharmacy**
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- **Hospital**
- Outpatient department of a **hospital**
- **Physician's** office
- **Urgent care facility**

Discount programs

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third-party service providers”. These third-party service **providers** may pay us so that they can offer you their services.

Third-party service **providers** are independent contractors. The third-party service **provider** is responsible for the goods or services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don’t pay the third-party service **providers** for the services they offer. You are responsible for paying for the discounted goods or services.

Wellness and other incentives

We may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services, and to continue your participation in the **Aetna** plan through incentives. You and your **physician** can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, including but not limited to financial wellness programs, we may provide incentives based on your participation.

Incentives may include but are not limited to:

- Modifications to **copayment**, **coinsurance**, or **policy year deductible** amounts
- **Premium** discounts or rebates
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards or
- Any combination of the above.

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon your health status.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

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.

Nondiscrimination Notice

Aetna does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, have questions about our non-discrimination policy, or have a discrimination-related concern that you would like to discuss, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: P.O. Box 14462, Lexington, KY 40512 (HMO customers: P.O. Box 24030 Fresno, CA 93779)
- Email: CRCoordinator@aetna.com

Please visit https://www.aetna.com/individuals-families/member-rights-resources/complaints-grievances-appeals.html#california for information about how to file a complaint or grievance with the California Department of Insurance or California Department of Managed Health Care (for HMO enrollees).

You can also file a discrimination complaint with the United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex by following the instructions on the Department's website: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Language accessibility statement

Interpreter services are available for free.

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-877-480-4161** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-480-4161** (TTY: **711**).

አማርኛ/Amharic

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-877-480-4161** (መስማት ለተሳናቸው: **711**).

العربية/Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-480-4161** (رقم الهاتف النصي: **711**).

Ɓàsɔ̀ɔ̀ Wùdù/Bassa

Dè dɛ nìà kɛ dyɛ́dɛ́ gbo: Ɔ jǔ kɛ́ m̀ dyi Ɓàsɔ̀ɔ̀-wùdù-po-nyɔ̀ jǔ nɨ̀, nɨ̀ à wudu kà kò dò po-poɔ̀ ɓɛ́ m̀ gbo kpáa. Ɗá **1-877-480-4161** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-877-480-4161** (TTY: **711**)。

فارسی/Farsi

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-877-480-4161** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d'une assistance gratuite dans votre langue en composant le **1-877-480-4161** (TTY: **711**).

ગુજરાતી/Gujarati

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિઃશુલ્ક ઉપલબ્ધ છે. કૉલ કરો **1-877-480-4161** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-480-4161** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-877-480-4161** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-877-480-4161** (TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-877-480-4161** (TTY: **711**). Estes serviços são oferecidos gratuitamente.

Русский/Russian

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-877-480-4161** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-480-4161** (TTY: **711**).

Urdu/اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں - (TTY: **711**) **1-877-480-4161** پر کال کریں.

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-877-480-4161** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-877-480-4161** (TTY: **711**).

Aetna Life Insurance Company

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**
  Generally, an individual is covered by the Association if the insurer was a member of the Association and the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**
  The basic coverage protections provided by the Association are as follows.

  - **Life Insurance, Annuities and Structured Settlement Annuities**
    For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

    - **Life Insurance**
      80% of death benefits but not to exceed $300,000.
      80% of cash surrender or withdrawal values but not to exceed $100,000.

    - **Annuities and Structured Settlement Annuities**
      80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000.

    The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

  - **Health Insurance**
    The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.caifega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract.
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society.
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual.
- Employer and association plans, to the extent they are self-funded or uninsured.
- A policy or contract providing any health care benefits under Medicare Part C or Part D.
- An annuity issued by an organization that is only licensed to issue charitable gift annuities.
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued.
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

Your Health Insurance Choices Are Different. You May Qualify for Free or Low-Cost Health Insurance.

Because of changes in federal law, you have different health insurance choices that may save you money.

Covered California

You can buy health insurance through Covered California. The State of California set up Covered California to help people and families, like you, find affordable health insurance. You can use Covered California if you do not have insurance through your employer, or Medicare. You can also apply for Medi-Cal through Covered California.

If you are eligible for the Medicare Program you should examine your options carefully, as delaying Medicare enrollment may result in substantial financial implications

You must apply during an open or special enrollment period, except a Medi-Cal application can be made at any time. Open enrollment begins on October 15 of every year and ends on January 31 of the following year. If you have a life change such as marriage, divorce, a new child or loss of a job, you can apply at the time the life change occurs ("special enrollment period").

Through Covered California, you may also get help paying for your health insurance. You can:

- Reduce your out of pocket costs: Out-of-pocket costs are how much you pay for things like going to the doctor or hospital or getting prescription drugs.

To qualify for help paying for insurance, you must:

- Meet certain household income limits; and
- Be a U.S. citizen, U.S. national or be lawfully present in the U.S.
- In addition, other rules and requirements apply.

You can also buy coverage directly from health insurers, health plans or insurance agents during Open Enrollment and Special Enrollment periods, but the financial help is available only if you select a Covered California product.

Medi-Cal

Free or low-cost health insurance is available through Medi-Cal. Medi-Cal is California's health care program for people with low incomes. You can get Medi-Cal if:

- Your income is low; and
- You are a U. S. citizen, U.S. national or lawfully present in the U.S age 26 and older;
- Your income is low; and
- You are an adult age 19 through 25 who does not have satisfactory immigration status or is unable to establish satisfactory immigration status or to verify United States citizenship.

Your eligibility is based on your income. It is not based on how much money you have saved or if you own your own home. You do not have to be on public assistance to qualify for Medi-Cal. You can apply for Medi-Cal anytime.

You can also get Medi-Cal if you are:

- Age 21 or younger
- Age 65 or older
- Blind
- Disabled
- Pregnant
- In a skilled nursing or intermediate care home
- On refugee status for a limited time, depending how long you have been in the United States
- A parent or caretaker relative of an age eligible child
- Have been screened for breast and/or cervical cancer

Other rules or requirements may apply.

For More Information

To learn more about Covered California or Medi-Cal, visit https://www.coveredca.com/ or call 1-800-300-1506. When you apply for coverage through Covered California, you will find out if you are eligible for Medi-Cal. You can also get more information or apply for Medi-Cal by calling 1-800-430-4263, visiting www.benefitscal.org or www.beneficioscal.org (Spanish) online, or visiting your county human services office in person.

Aetna Life Insurance Company Rider

Travel and Lodging Reimbursement

Rider effective date: 08/31/2024

This rider is added to the *Eligible health services and exclusions* section of your certificate of coverage. This rider is subject to all other requirements described in your certificate, including general exclusions and defined terms.

Eligible health services and exclusions

Travel and lodging expenses

We will reimburse you for travel and lodging expenses when you need to travel at least 100 miles to access **eligible health services** because a law or regulation where you are located prohibits those **eligible health services.** The following are covered travel and lodging expenses:

- U.S. domestic travel expenses for the **covered person** and the **covered person's** travel companion in the 48 contiguous states (coach class air, bus, train or shuttle fares, taxi or ride share fares for local travel)
- Mileage costs, not to exceed amounts permitted by Internal Revenue Service guidelines
- Parking and tolls
- Lodging costs of up to $50 per night, per **covered person** or $100 per night, total, for the **covered person** and the **covered person's** travel companion, not to exceed amounts permitted by Internal Revenue Service guidelines

You must submit a travel and lodging claim form to be reimbursed.
You should contact us before travel and lodging expenses are incurred so that we can confirm travel was necessary because no **provider** within 100 miles of where you are located was available to provide the **eligible health services** due to a law or regulation that prohibits the eligible health services.

Call the toll-free number on your ID card to:

- Obtain a travel and lodging claim form
- Get assistance in locating a **provider**
- Get information about these **eligible health services** including specific eligibility requirements and limitations

We will reimburse your covered travel and lodging expenses as described in the schedule of benefits below.

See your certificate of coverage for information on **eligible health services**. Your schedule of benefits describes the **policy year deductibles**, **copayments** or **coinsurance**, if any, that apply to **eligible health services**.

Exclusions

The following are not covered travel and lodging expenses under this rider:

- Expenses for more than one travel companion Gasoline/fuel costs
- Car rentals
- Meals, groceries, hotel room service, alcohol/tobacco products
- Personal care/convenience items, (e.g. shampoo, clothing, deodorant)
- Entertainment/souvenir expenses
- Telephone calls
- Taxes
- Tips, gratuities
- Childcare expenses
- Lost wages

Schedule of benefits

This rider is subject to the requirements described in your medical plan schedule of benefits unless otherwise noted below.

Travel and lodging expenses

Description	Amount
Travel and lodging reimbursement	100% No **policy year deductible** applies
Limit per **policy year**	$3000