Student Health Insurance

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

Schedule of benefits

Prepared exclusively for:

Policyholder:	Texas Tech HSC
Policyholder number:	686174
Student policy effective date:	08/01/2024
Plan effective date:	08/01/2024
Plan issue date:	07/23/2024
Actuarial value and metallic level:	81.44% - Gold

Underwritten by Aetna Life Insurance Company in the State of Texas

Schedule of benefits

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

How to read your schedule of benefits

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

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

How to contact us for help

We are here to answer your questions.

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

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

Important note about your cost sharing

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

You are required to pay the **policy year deductible** before **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	$500 per **policy year**	$1,000 per **policy year**
Spouse	$500 per **policy year**	$1,000 per **policy year**
Each child	$500 per **policy year**	$1,000 per **policy year**
Family	$1,500 per **policy year**	$3,000 per **policy year**

Policy year deductible waiver

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

- In-network care for *Preventive care and wellness, physician and specialist office visit, consultant office visit, Walk-in clinic visit, outpatient mental health office visit, outpatient substance abuse office visit, urgent care, and Pediatric dental care services.*
- In-network care and out-of-network care for *Preventive Immunizations up to age 6, Hospital emergency room visit, and Outpatient prescription drugs.*

Maximum out-of-pocket limits

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

Maximum out-of-pocket type	In-network coverage	Out-of-network coverage
Student	$7,900 per **policy year**	$15,800 per **policy year**
Spouse	$7,900 per **policy year**	$15,800 per **policy year**
Each child	$7,900 per **policy year**	$15,800 per **policy year**
Family	$15,800 per **policy year**	$31,600 per **policy year**

Preauthorization covered benefit penalty

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

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

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

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

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	50% (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 No **policy year deductible**, **copayment** or **coinsurance** applies for children from birth through age 6	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (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	50% (of the **recognized charge**) per visit
Pap smear or screening using liquid based cytology methods	One pap smear every 12 months for women age 18 or older	
Gynecological exam that includes a rectovaginal pelvic exam	One exam every 12 months for women over age 25 who are at risk for ovarian cancer	
Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test	One exam every 12 months for women age 18 and older	
Additional 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.	
Maximum visits per **policy year**	1 visit	

Preventive screening and counseling services

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

Description	In-network coverage	Out-of-network coverage
Obesity and/or healthy diet counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit
Obesity and/or healthy diet counseling maximum visits	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	
Misuse of alcohol and/or drugs counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit
Misuse of alcohol and/or drugs counseling maximum visits per **policy year**	5 visits	

Description	In-network coverage	Out-of-network coverage
Use of tobacco products counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit
Use of tobacco products counseling maximum visits per **policy year**	8 visits	
Sexually transmitted infection counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit
Sexually transmitted infection counseling maximum visits per **policy year**	2 visits	
Genetic risk counseling for breast and ovarian cancer office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit
Genetic risk counseling for breast and ovarian cancer age and frequency limitations	Not subject to any age or frequency limitations	

Routine cancer screenings

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

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	50% (of the **recognized charge**) per visit
Mammogram maximums	1 mammogram every 12 months for covered persons age 35 and older. When diagnostic imaging is used to evaluate a breast abnormality or where there is a personal history of breast cancer or dense breast tissue it is not subject to any age or frequency limitations.	

Description	In-network coverage	Out-of-network coverage
Prostate specific antigen (PSA) test maximums	1 PSA test every 12 months for covered persons age 50 and over 1 PSA test every 12 months for covered persons age 40 and older with a family history of prostate cancer, or other risk factor	
Additional 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 care

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

Description	In-network coverage	Out-of-network coverage
Preventive care services only	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit

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

Comprehensive lactation support and counseling services

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	50% (of the **recognized charge**) per visit
Lactation counseling services maximum visits per **policy year** either in a group or individual setting	6 visits	

Important note:
Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section.

Breast feeding durable medical equipment

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	50% (of the **recognized charge**) per item

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

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	50% (of the **recognized charge**) per visit
Contraceptive counseling services maximum visits per **policy year** either in a group or individual setting	2 visits	

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

Contraceptives (prescription drugs and devices)

Description	In-network coverage	Out-of-network coverage
Female contraceptive **prescription drugs** and devices provided, administered, or removed, by a **provider** during an office visit	100% (of the **negotiated charge**) per item No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per item

Female voluntary sterilization

Description	In-network coverage	Out-of-network coverage
Inpatient **provider** services	100% (of the **negotiated charge**) No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**)
Outpatient **provider** services	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (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**, **teledentistry** or **telehealth** consultations)	$50 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	50% (of the **recognized charge**) per visit

Allergy testing and treatment

Description	In-network coverage	Out-of-network coverage
Allergy testing performed at a **physician** or **specialist** office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Allergy injections treatment performed at a **physician** or **specialist** office	75% (of the **negotiated charge**) per visit	50% (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)	75% (of the **negotiated charge**)	50% (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)	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

In-hospital non-surgical physician services

Description	In-network coverage	Out-of-network coverage
In-**hospital** non-surgical **physician** services	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Consultant services (non-surgical and non-preventive)

Description	In-network coverage	Out-of-network coverage
Office hours visits (non-surgical and non-preventive care by a consultant, includes **telemedicine**, **teledentistry** or **telehealth** consultations)	$50 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	50% (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 No **policy year deductible** applies	50% (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	75% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission

Preadmission testing

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

Anesthesia and related facility charges for a dental procedure

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

Description	In-network coverage	Out-of-network coverage
Anesthesia and related facility charges for a dental procedure	75% (of the **negotiated charge**)	50% (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	75% (of the **negotiated charge**)	50% (of the **recognized charge**)

Home health care

Each session of up to 60 minutes is equal to one visit

Description	In-network coverage	Out-of-network coverage
Home health care	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Home health care maximum visits per **policy year**	60	

Hospice care

Description	In-network coverage	Out-of-network coverage
Inpatient facility (**room and board** and other miscellaneous services and supplies)	75% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission
Outpatient	75% (of the **negotiated charge**) per visit	50% (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	75% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission
Maximum days of confinement per **policy year**	25	

4. Emergency services and urgent care

Emergency services

Description	In-network coverage	Out-of-network coverage
Hospital emergency room	$200 **copayment** then the plan pays 75% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	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

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 No **policy year deductible** applies	50% (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.
Dental benefits are subject to the medical plan's **policy year deductibles** and **maximum out-of-pocket limits** as explained on the schedule of benefits. The reimbursement percentage, **copayment**, or **deductible** for services rendered by a **non-contracting dental provider** will be reimbursed the same as a **contracting dental provider**.

Description	Contracting dental provider coverage	Non-contracting dental provider coverage
Type A services The reimbursement percentage, **copayment**, **deductible** or no charge amount, for services rendered by a **non-contracting dental provider** will be reimbursed the same as a **contracting dental provider**	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	100% (of the **recognized charge**) per visit No **copayment** or **policy year deductible** applies
Type B services The reimbursement percentage, **copayment**, **deductible** or no charge amount, for services rendered by a **non-contracting dental provider** will be reimbursed the same as a **contracting dental provider**	50% (of the **negotiated charge**) per visit No **policy year deductible** applies	50% (of the **recognized charge**) per visit No **policy year deductible** applies
Type C services The reimbursement percentage, **copayment**, **deductible** or no charge amount, for services rendered by a **non-contracting dental provider** will be reimbursed the same as a **contracting dental provider**	50% (of the **negotiated charge**) per visit No **policy year deductible** applies	50% (of the **recognized charge**) per visit No **policy year deductible** applies
Orthodontic services The reimbursement percentage, **copayment**, **deductible** or no charge amount, for services rendered by a **non-contracting dental provider** will be reimbursed the same as a **contracting dental provider**	50% (of the **negotiated charge**) per visit No **policy year deductible** applies	50% (of the **recognized charge**) per visit No **policy year deductible** applies
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.

Diagnostic and preventive care (type A services)

Visits and images

- Periodic oral evaluation, established patient (limited to: 2 visits per year)
- Comprehensive oral evaluation (limited to: 2 visits per year)
- Comprehensive periodontal evaluation, new or established patient (limited to: 2 visits per year)
- Problem-focused examination (limited to: 2 visits per year)
- Detailed and extensive oral evaluation – problem focused, by report (limited to: 2 visits per year)
- Prophylaxis (cleaning) (limited to: 2 treatments per year)
- Topical application of fluoride (limited to: 2 courses of treatment per year)
- Topical fluoride varnish (limited to: 2 per year)
- Sealants, per tooth (limited to: 1 application every 3 years for permanent molars only)
- Preventive resin restorations in a moderate to high caries risk patient-permanent tooth (limited to: 1 application every 3 years for permanent molars only)
- Bitewing images (limited to: 2 sets per year)
- Intraoral comprehensive image series, including bitewings if **medically necessary** (limited to: 1 set every 3 years)
- Panoramic radiographic images (limited to: 1 every 3 years)
- Vertical bitewing images (limited to: 2 sets per year)
- Periapical images
- 2D Cephalometric radiographic image
- Intraoral tomosynthesis-comprehensive series of radiographic images (limited to: 1 set every 3 years)
- Intraoral tomosynthesis-bitewing radiographic images (limited to: 2 sets per year)
- Intraoral tomosynthesis-periapical radiographic images
- Intraoral tomosynthesis-comprehensive series of radiographic images-image capture only (limited to: 1 set every 3 years)
- Intraoral tomosynthesis-bitewing radiographic images-image capture only (limited to: 2 sets per year)
- Intraoral tomosynthesis-periapical radiographic images-image capture only
- 2D Oral/facial photographic images
- Interpretation of diagnostic image
- Intra-oral, occlusal view, maxillary or mandibular
- Resin infiltration lesion, 1 per tooth every 3 years
- Diagnostic models
- Emergency palliative treatment per visit

Space maintainers

- Fixed unilateral
- Fixed-bilateral, upper
- Fixed bilateral, lower
- Removable (unilateral)
- Removable-bilateral upper
- Removable-bilateral lower
- Re-cementation of space maintainer
- Removal of fixed space maintainer

Basic restorative care (type B services)

Visits and images

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Consultation (by other than the treating provider)
- Therapeutic drug injection, by report
- Infiltration of sustained release therapeutic drug – per quadrant (Eligible in conjunction with impacted wisdom tooth removal)

Images and pathology

- Extra-oral first 2D projection radiographic image
- Extra-oral posterior dental radiographic image
- Extra-oral posterior dental radiographic image - image

Oral surgery

- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants (primary tooth)
  - Coronectomy - intentional partial tooth removal, impacted teeth only
  - Removal of residual tooth roots (cutting procedure)
  - Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth
  - Exposure of an unerupted tooth
- Impacted teeth
  - Removal of tooth (soft tissue)
- Removal of impacted teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (completely bony)
  - Removal of tooth (completely bony with unusual surgical complications)
  - Incision and drainage of abscess
- Other surgical procedures
  - Alveoloplasty, in conjunction with extractions -- four or more teeth or tooth spaces – per quadrant
  - Alveoloplasty, in conjunction with extractions – 1 to 3 teeth or tooth spaces – per quadrant
  - Alveoloplasty, not in conjunction with extraction -- four or more teeth or tooth spaces – per quadrant
  - Alveoloplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces – per quadrant
  - Excision of hyperplastic tissue – per arch
  - Excision of periocoronal gingiva
  - Removal of lateral exostosis (maxilla or mandible)
  - Tooth re-implantation and/or stabilization
  - Transplantation of tooth or tooth bud
  - Oroantral fistula closure
- Placement of devise to facilitate eruption of impacted tooth
- Frenectomy (frenulectomy) buccal/labial
- Suture of small wound, up to 5 cm

Periodontics

- Occlusal adjustment (other than with an appliance or by restoration)
- Peridontal scaling and root planing, per quadrant-4 or more teeth (limited to 4 separate quadrants every 2 years)
- Peridontal scaling and root planing – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
- Periodontal maintenance procedures following active therapy (limited to 4 in 12 months combined with prophylaxis after completion of active periodontal therapy)
- Collection and application of autologous blood product

Endodontics

- Pulp capping
- Pulpotomy
- Pulpal therapy
- Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp; does not include final restoration)

Restorative dentistry

Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges (multiple restorations in 1 surface are considered as a single restoration)

- Amalgam restorations
- Protective restoration
- Resin-based composite restorations (other than for molars)
- Pins
- Pin retention – per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
  - Prefabricated stainless steel
  - Prefabricated resin crown (excluding temporary crowns)
  - Interim therapeutic restoration-primary teeth
  - Prefabricated porcelain/ceramic crown –primary teeth
- Re-cement or re-bond
  - Inlay
  - Crown
  - Fixed partial bridge
  - Fabricated –prefabricated post and core
  - Implant/abutment supported crown
  - Implant/abutment supported fixed partial denture
  - Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant

Prosthodontics

- Dentures and partials
  - Office reline
  - Laboratory relines
  - Special tissue conditioning, per denture
  - Rebase, per denture
  - Adjustment to denture (more than 6 months after installation)
- Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth

- Adding teeth to existing partial denture
    - Each tooth
    - Each clasp
- Repairs: bridges; partial bridges

General anesthesia, intravenous sedation and drugs

- Only when **medically necessary** and only when provided in conjunction with a covered dental surgical procedure
    - Evaluation for moderate sedation, deep sedation or general anesthesia
    - Deep sedation/general anesthesia-first 15 minutes
    - Deep sedation/general anesthesia-each 15 minute increment
    - Intravenous moderate (conscious) sedation/analgesia-first 15 minutes
    - Intravenous conscious sedation/analgesia-each subsequent 15 minute increment

Major restorative care (type C services)

Periodontics

- Osseous surgery, including flap and closure, 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Osseous surgery, including flap and closure, per quadrant (limited to 1 per quadrant every 3 years)
- Pedicle soft tissue graft procedures
- Bone replacement graft, first site in quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy, 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure – per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Clinical crown lengthening
- Autogenous connective tissue graft procedures (including donor site surgery)
- Non-autogenous connective soft tissue allograft
- Free soft tissue graft procedures implant, or edentulous tooth position in same graft
- Full mouth debridement to enable a comprehensive periodontal evaluation (limited to 1 treatment per lifetime)

Endodontics

- Apexification/recalcification
- Apicoectomy
- Root canal therapy including **medically necessary** images:
    - Anterior tooth
    - Premolar tooth
    - Molar tooth
- Retreatment of previous root canal therapy including **medically necessary** images:
    - Anterior tooth
    - Premolar tooth
    - Molar tooth
- Root amputation
- Hemisection (including any root removal)

Restorative

- Inlays, onlays, labial veneers and crowns are covered only as a treatment for decay or acute traumatic injury and only when the teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge
- Inlays/onlays (limited to 1 per tooth every 5 years)
- Veneers, non-cosmetic (limited to 1 per tooth every 5 years)
- Crowns (limited to 1 per tooth every 5 years)
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain/ceramic substrate
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - ¾ cast metallic or porcelain/ceramic
  - Titanium
  - Post and core
  - Core build-up
- Repair
  - Replace all teeth and acrylic on cast metal framework – upper/lower
  - Crowns, inlays, onlays, veneers

Prosthodontics

- Installation of dentures and bridges is covered only if needed to replace teeth that were not abutments to a denture or bridge less than 5 years old
- Replacement of existing bridges or dentures (limited to 1 every 5 years)
- Bridge abutments (see inlays and crowns) (limited to 1 per tooth every 5 years)
- Pontics (limited to 1 per tooth every 5 years)
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
  - Titanium
  - Removable bridge (unilateral) (limited to 1 every 5 years)
- One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics (limited to 1 every 5 years)
- Retainer – cast metal for resin bonded fixed prosthesis (limited to 1 every 5 years)
- Retainer – porcelain/ceramic for resin bonded fixed prosthesis (limited to 1 every 5 years)
- Dentures and partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
- Complete upper denture (limited to 1 every 5 years)
- Complete lower denture (limited to 1 every 5 years)
- Immediate upper denture (limited to 1 every 5 years)
- Immediate lower denture (limited to 1 every 5 years)
- Immediate partial upper or lower, resin base, including any conventional clasps, rests and teeth (limited to 1 every 5 years)

- Immediate upper/lower partial denture, flexible base, including any clasps, rests and teeth (limited to 1 every 5 years)
- Immediate partial upper or lower, cast metal base with resin saddles, including any conventional clasps, rests and teeth (limited to 1 every 5 years)
- Partial upper or lower, resin base – including any conventional clasps, rests and teeth (limited to 1 every 5 years)
- Partial upper or lower, cast metal base with resin saddles – including any conventional clasps, rests and teeth (limited to 1 every 5 years)
- Implants – only if determined as a dental necessity (limited to 1 per tooth every 5 years)
- Implant supported complete denture, partial denture (limited to 1 every 5 years)
- Surgical placement of interium implant body
- Surgical placement of transosteal implant
- Implant maintenance procedures
- Custom abutment (limited to 1 every 5 years)
- Bone graft at time of implant placement (limited to 1 every 5 years)
- Repair implant prosthesis (limited to 1 every 5 years)
- Repair implant abutment (limited to 1 every 5 years)
- Replacement of semi-precision or precision attachment (limited to 1 every 5 years)
- Debridement/osseous contouring of a peri-implant defect (limited to 1 every 5 years)
- Surgical removal of Implant body (limited to 1 every 5 years)
- Implant index (limited to 1 every 5 years
- Connecting bar
- Stress breakers
- Removable appliance therapy
- Fixed appliance therapy
- Interim partial denture (stayplate), anterior only
- Occlusal guard (Occlusal guard adjustment not eligible within first 6 months after placement of appliance)

Orthodontic services

- **Medically necessary** orthodontic treatment (includes removal of appliances, construction and placement of retainer)
- Limited orthodontic treatment of the primary, transitional and adolescent dentition
- Comprehensive orthodontic treatment of the transitional and adolescent dentition
- Periodic orthodontic treatment visit (as part of contract)
- Pre-orthodontic treatment visit

6. Specific conditions

Birthing center (facility charges)

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

Diabetic services and supplies (including equipment and training)

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

Voluntary sterilization for males

Description	In-network coverage	Out-of-network coverage
Inpatient **physician** or **specialist** surgical services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient **physician** or **specialist** surgical services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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	75% (of the **negotiated charge**)	75% (of the **recognized charge**)

Accidental injury to sound natural teeth

Description	In-network coverage	Out-of-network coverage
Accidental injury to **sound natural teeth**	75% (of the **negotiated charge**)	75% (of the **recognized charge**)

Dermatological treatment

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

Maternity care

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

Well newborn nursery care

Description	In-network coverage	Out-of-network coverage
Well newborn nursery care in a **hospital** or birthing center	75% (of the **negotiated charge**) No **policy year deductible** applies	75% (of the **recognized charge**) No **policy year deductible** applies

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

Gender affirming treatment

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

Autism spectrum disorder

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

Description	In-network coverage	Out-of-network coverage
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Services for children with developmental delays		
Services for children with developmental delays	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Behavioral health

Mental health treatment – inpatient

Description	In-network coverage	Out-of-network coverage
Inpatient **hospital mental health disorders** treatment (**room and board** and other miscellaneous **hospital** services and supplies) Inpatient **residential treatment facility mental health disorders** treatment (**room and board** and other miscellaneous **residential treatment facility** services and supplies) Subject to **semi-private room rate** unless **intensive care unit** is required **Mental health disorder room and board** intensive care	75% (of the **negotiated charge**) per admission Coverage is provided under the same terms, conditions as any other **illness**.	50% (of the **recognized charge**) per admission Coverage is provided under the same terms, conditions as any other **illness**.

Mental health treatment – outpatient

Description	In-network coverage	Out-of-network coverage
Outpatient **mental health disorders** office visits to a **physician** or **behavioral health provider** (Includes **telemedicine** or **telehealth** consultations)	$50 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**. No **policy year deductible** applies	50% (of the **recognized charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**.

Description	In-network coverage	Out-of-network coverage
Other outpatient **mental health disorders** treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive outpatient program	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Important note:
All mental health treatment coverage is provided under the same terms and conditions as any other **illness.**

Substance related disorders treatment – inpatient

Description	In-network coverage	Out-of-network coverage
Inpatient **hospital substance related disorders detoxification** (**room and board** and other miscellaneous **hospital** services and supplies) Inpatient **hospital substance related disorders** rehabilitation (**room and board** and other miscellaneous **hospital** services and supplies) Inpatient **residential treatment facility substance related disorders** (**room and board** and other miscellaneous **residential treatment facility** services and supplies) Subject to **semi-private room rate** unless **intensive care unit** is required **Substance related disorders room and board** intensive care	75% (of the **negotiated charge**) per admission Coverage is provided under the same terms, conditions as any other **illness**.	50% (of the **recognized charge**) per admission Coverage is provided under the same terms, conditions as any other **illness**.

Substance related disorders treatment – outpatient
Detoxification and rehabilitation

Description	In-network coverage	Out-of-network coverage
Outpatient **substance related disorders** office visits to a **physician** or **behavioral health provider** (Includes **telemedicine** or **telehealth** consultations)	$50 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**. No **policy year deductible** applies	50% (of the **recognized charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**.
Other outpatient **substance related disorder** services Partial hospitalization treatment Intensive outpatient program	75% (of the **negotiated charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**.	50% (of the **recognized charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**.

Important note:
All mental health treatment coverage is provided under the same terms and conditions as any other **illness.**

Oral and maxillofacial treatment (mouth, jaws, and teeth)

Description	In-network coverage	Out-of-network coverage
Oral and maxillofacial treatment (mouth, jaws, and teeth)	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

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.

Infertility Services

Basic infertility

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

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Description	In-network coverage	Out-of-network coverage
Diagnostic complex imaging services performed in the outpatient department of a **hospital** or other facility	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

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	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Diagnostic radiological services performed in a **physician's** office, the outpatient department of a **hospital** or other facility	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Diagnostic follow-up care related to newborn hearing screening

Description	In-network coverage	Out-of-network coverage
Diagnostic follow-up care related to newborn hearing screening	75% (of the **negotiated charge**) per visit No **policy year deductible** applies	50% (of the **recognized charge**) per visit No **policy year deductible** applies

Cardiovascular disease testing

Description	In-network coverage	Out-of-network coverage
Cardiovascular disease testing	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Maximum visits per **policy year**	1 screening every 5 years Limited to: Men age 45 and over but less than 76 and women age 55 and over but less than 76	

Chemotherapy

Description	In-network coverage	Out-of-network coverage
Chemotherapy	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Oral anti-cancer **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.

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.	Covered according to the type of benefit and the place where the service is received.

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	75% (of the **negotiated charge**) per visit	50% (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	75% (of the **negotiated charge**) per visit	50% (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	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Pulmonary rehabilitation

Description	In-network coverage	Out-of-network coverage
Pulmonary rehabilitation	75% (of the **negotiated charge**) per visit	50% (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	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Maximum visits per **policy year**	Unlimited	

Acquired brain injury

Description	In-network coverage	Out-of-network coverage
Acquired brain **injury**	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Speech or hearing loss or impairment

Description	In-network coverage	Out-of-network coverage
Speech or hearing loss or impairment	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Chiropractic services

A visit is equal to no more than 1 hour of therapy

Description	In-network coverage	Out-of-network coverage
Chiropractic services	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Maximum visits per **policy year**	35	

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

Alzheimer's disease

Description	In-network coverage	Out-of-network coverage
Alzheimer's disease	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Ambulance service

Description	In-network coverage	Out-of-network coverage
Emergency ground, air, and water **ambulance** (Includes non-emergency **ambulance**)	$200 **copayment** then the plan pays 75% (of the balance of the **negotiated charge**) per trip No **policy year deductible** applies	Paid the same as in-network coverage

Important note:
Services received by an out-of-network air ambulance provider will be covered the same as services received by an **in-network provider**, regardless of emergency status. This includes applying cost shares towards the in-network **deductible** and **out-of-pocket maximum.** An out-of-network air ambulance provider cannot balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirements, such as **deductibles**, **copayments** and **coinsurance**, except for those services not covered in your plan.

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	75% (of the **negotiated charge**) per item	50% (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	75% (of the **negotiated charge**) per item	50% (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
Cranial prosthetics (Medical wigs)	75% (of the **negotiated charge**) per item	50% (of the **recognized charge**) per item
Prosthetic devices	75% (of the **negotiated charge**) per item	50% (of the **recognized charge**) per item

Hearing aids and cochlear implants and related services

Description	In-network coverage	Out-of-network coverage
Hearing aids and cochlear implants and related services	75% (of the **negotiated charge**) per item	50% (of the **recognized charge**) per item
Hearing aids maximum per ear	One per ear every three years	
Replacement of cochlear implant external speech processor and controller components	One per ear every three years	

Hearing exams

Description	In-network coverage	Out-of-network coverage
Hearing exams	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Hearing exam maximum	1 hearing exam every **policy year**	

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, optometrist, therapeutic optometrist, or any other **providers** acting within the scope of their license	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	50% (of the **recognized charge**) per visit
Maximum visits per **policy year**	1 visit	

Pediatric comprehensive low vision evaluations

Description	In-network coverage	Out-of-network coverage
Performed by a legally qualified ophthalmologist, optometrist, therapeutic optometrist, or any other **providers** acting within the scope of their license	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum	One comprehensive low vision evaluation every **policy year**	

Pediatric vision care services and supplies

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	50% (of the **recognized charge**) per visit
Maximum contact lens fitting visits per **policy year**	1 visit	

Description	In-network coverage	Out-of-network coverage
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	100% (of the **negotiated charge**) per item No **policy year deductible** applies	50% (of the **recognized charge**) per item
Maximum number of eyeglass frames per **policy year**	One set of eyeglass frames	
Maximum number of **prescription** lenses per **policy year**	One pair of **prescription** lenses	
Maximum number of **prescription** contact lenses per **policy year** (includes non-conventional **prescription** contact lenses and aphakic lenses prescribed after cataract **surgery**)	Daily disposable: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per **policy year**	One optical device	

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

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

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, therapeutic optometrist, or any other **providers** acting within the scope of their license	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Maximum visits per **policy year**	1 visit	

Adult vision care services and supplies

Description	In-network coverage	Out-of-network coverage
Office visit for fitting of contact lenses	75% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Maximum contact lens fitting visits per **policy year**	1 visit	
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	75% (of the **negotiated charge**) per item	50% (of the **recognized charge**) per item
Maximum number of eyeglass frames per **policy year**	One set of eyeglass frames	
Maximum number of **prescription** lenses per **policy year**	One pair of **prescription** lenses	
Maximum number of **prescription** contact lenses per **policy year** (includes non-conventional **prescription** contact lenses and aphakic lenses prescribed after cataract **surgery**)	Daily disposable: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable: one set	
Non-conventional **prescription** contact lenses and aphakic lenses prescribed after cataract **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.

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.

All other outpatient services and supplies

Description	In-network coverage	Out-of-network coverage
All other outpatient services and supplies for which cost-sharing is not otherwise shown in this schedule of benefits	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.

9. Outpatient prescription drugs

Plan features

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

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

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

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

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

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

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

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

Preferred generic prescription drugs

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	$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 60% (of the balance of the **recognized charge**) No **policy year deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$60 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$60 **copayment** per supply then the plan pays 60% (of the balance of the **recognized charge**) No **policy year deductible** applies

Non-preferred generic prescription drugs

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	$100 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$100 **copayment** per supply then the plan pays 60% (of the balance of the **recognized charge**) No **policy year deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$300 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$300 **copayment** per supply then the plan pays 60% (of the balance of the **recognized charge**) No **policy year deductible** applies

Preferred brand-name prescription drugs

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	$60 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$60 **copayment** per supply then the plan pays 60% (of the balance of the **recognized charge**) No **policy year deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$180 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$180 **copayment** per supply then the plan pays 60% (of the balance of the **recognized charge**) No **policy year deductible** applies

Non-preferred brand-name prescription drugs

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	$100 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$100 **copayment** per supply then the plan pays 60% (of the balance of the **recognized charge**) No **policy year deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$300 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$300 **copayment** per supply then the plan pays 60% (of the balance of the **recognized charge**) No **policy year deductible** applies

Diabetic insulin

Description	In-network coverage	Out-of-network coverage
30 day supply at **retail pharmacy**	Paid according to the type of drug per the schedule of benefits above	Paid according to the type of drug per the schedule of benefits above
91 day supply at **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits above	Paid according to the type of drug per the schedule of benefits above

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

Important note:
When an emergency refill of diabetes supplies is provided, the emergency refill of insulin may not exceed a 30-day supply. The quantity of an emergency refill of insulin-related equipment or supplies may not exceed the lesser of a 30 day supply or the smallest available package.

Specialty drugs

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **specialty pharmacy**	$200 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$200 **copayment** per supply then the plan pays 60% (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** or **mail order pharmacy** You may receive up to a 3 month supply of the covered contraceptive drug when you obtain the drug for the first time	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** or **mail order pharmacy** You may receive up to a 3 month supply of the covered contraceptive drug when you obtain the drug for the first time	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above

Preventive care drugs and supplements

Description	In-network coverage	Out-of-network coverage
Preventive care drugs and supplements filled at a **retail pharmacy** or **mail order 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

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

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

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

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

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

General coverage provisions

This section provides detailed explanations about these features:

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

Policy year deductible provisions

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

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**.

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

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

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

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

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.

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

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 or your **covered dependents** have paid for **eligible health services** during the **policy year** meets the individual **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 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

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

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

- All costs for non-covered services
- **Preauthorization** penalties because you did not get a service or supply **preauthorized**

Calculations; determination of recognized charge; determination of benefits provisions

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

Student Health Insurance

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

Certificate of Coverage

Prepared exclusively for:

Policyholder:	Texas Tech HSC
Policyholder number:	686174
Student policy effective date:	08/01/24
Plan effective date:	08/01/24
Plan issue date:	07/23/24

Important note:
You have the right to an adequate network of preferred providers (known as "network providers"). If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

You have the right, in most cases, to obtain estimates in advance from out-of-network providers of what they will charge for their services and from your insurer of what it will pay for the services.

You may obtain a current directory of preferred providers at the following website: www.aetna.com or by calling Aetna Member Services at the toll-free number on your ID card for assistance in finding available preferred providers.

If you are treated by a provider or facility that is not a preferred provider, you may be billed for anything not paid by the insurer unless balance billing is prohibited.

If directory information is materially inaccurate and you rely on it, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

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.

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.

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.

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

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

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

Paying for eligible health services– sharing the expense

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

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

Disagreements

We know that people sometimes see things differently.

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

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

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

Your in-network coverage helps you:

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

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

School health services

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

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

You don't have to access care through **school health services**. You may go directly to **in-network providers** for **eligible health services**.
For more information about **in-network providers** and the role of **school health services**, see the *Who provides the care* section.

Aetna's network of providers

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

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

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

The section above told you how your plan works while you are covered for in-network coverage. You also have coverage when you want to get your care from **providers** who are not part of the **Aetna** network.

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

Your out-of-network coverage:

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

You will find details on:

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

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
  - The estimated charges for the items and services
  - Notice that the **provider** is an **out-of-network provider**
- Out-of-network air **ambulance** services

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

Ancillary services mean any professional services including:

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

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

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**

- **Residential treatment facilities**
- Diagnostic, laboratory, and imaging centers
- Rehabilitation facilities
- Other therapeutic health settings

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

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

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

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

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

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

How to contact us for help

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

- Calling our Member Services at the toll-free number 1-877-480-4161
- 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

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

Your ID card

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

Remember, only you 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

Who is eligible?

All registered domestic undergraduate students enrolled in seven (7) or more credit hours, (three (3) or more credit hours during the summer) and all registered domestic graduate students enrolled in four (4) or more credit hours, interns, fellows and students working on their dissertation or thesis are eligible to enroll in this insurance plan on a voluntary basis. All registered international students on non-immigrant visas enrolled in one (1) or more credit hours are required to purchase the Student Health Insurance plan, and are automatically enrolled in the plan, unless evidence of coverage is provided that meets the Texas Tech HSC international student requirements.

Medicare eligibility

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

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

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

When you can join the plan

As a student you can enroll yourself and your dependents:

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

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

When you can join the continuation of coverage plan

For continuation of coverage plans, you must:

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

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

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

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

If you choose a plan that 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
- Your domestic partner who meets the rules set by the **policyholder** and requirements under state law
- Your dependent children – your own or those of your spouse, or domestic partner
  - The children must be under 26 years of age, and they include:
    - Biological children
    - Stepchildren
    - Legally adopted children
    - A child legally placed with you for adoption (including a foster child)*
    - A grandchild who, at the time of application, is your dependent for federal tax purposes
    - Children you are responsible for under a qualified medical or dental support order or court-order (whether or not the child resides with you and whether or not the child resides inside the service area)

  * Your adopted child may be enrolled as shown in the *When you can join the plan* section at your option, after the date:
    - You become a party in a suit for adoption, or
    - The adoption becomes final

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 *How can you extend coverage for your disabled child beyond the plan age limits?* under the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

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

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

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

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

Adding new dependents

You can add 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
- 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, domestic partner adopt, or that is placed with you for adoption is covered on your plan for the first 31 days after you become party in a suit to adopt the child or the adoption or the placement is complete.

- To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption, after you become party in a suit to adopt the child, or after placement for adoption.
- You must still enroll the child within 31 days of the adoption, you become party in a suit to adopt the child 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, the child for whom you became a party in a suit to adopt, or the child placed with you for adoption, you become party in a suit to adopt the child 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, the child for whom you became a party in a suit to adopt, or the 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

You can enroll in these situations:

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

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

Effective date of coverage

Enrollment

Student coverage

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

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

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

Dependent coverage

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

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

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

Late enrollment

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

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

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

Medical necessity and preauthorization requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible health services.** See the *Eligible health services 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 preauthorizes** the **eligible health service** when required

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

Medically necessary; medical necessity

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

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

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.

Preauthorization

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

Preauthorization for medical services and supplies

In-network care

Your in-network **physician** is responsible for obtaining any necessary **preauthorization** before you get the care. If your in-network **physician** doesn't get a required **preauthorization**, you will only have to pay your applicable **deductible** and/or **copayment**/**coinsurance**. If your in-network **physician** requests **preauthorization** and we refuse it, you can still get the care but the plan won't pay for it. You will find details on requirements in the *What the plan pays and what you pay - Important exceptions – when you pay all* section.

Out-of-network care

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

Preauthorization call

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

Type of care	Timeframe
Non-emergency admission	Call at least 3 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 preauthorization decisions

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

Inpatient and outpatient preauthorization

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

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

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

What if you don't obtain the required preauthorization?

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

- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits *Preauthorization 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 preauthorization?
Preauthorization is required for the following types of services and supplies:

Inpatient –

- Gender affirming treatment
- Gene-based, cellular and other innovative therapies (GCIT)
- **Stays** in a **hospice facility**
- **Stays** in a **hospital**
- **Stays** in a rehabilitation facility
- **Stays** in a **residential treatment facility** for treatment of **mental health disorders** and **substance related disorders**
- **Stays** in a **skilled nursing facility**

Outpatient –

- Certain **prescription drugs** and devices
- Gender affirming treatment
- Gene-based, cellular and other innovative therapies (GCIT)
- Home health care
- **Hospice care**
- Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
- Non-emergency transportation by airplane
- Private duty nursing services

*For a current listing of the **prescription drugs** and medical **injectable drugs** that require **preauthorization**, contact Member Services by calling the toll-free number in the How to contact us for help section or by logging in to the **Aetna** website at https://www.aetnastudenthealth.com.*

A **preauthorization** may not be required for some services if your **provider** meets the requirements of prior **preauthorization** approvals. Please contact your **physician** or us for additional information.

Your **provider** may request a renewal of an existing **preauthorization** within 60 days of the expiration date of the preauthorization. We will notify you of our decision before the expiration of the existing **preauthorization**.

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

Preauthorization for prescription drugs and devices
Certain **prescription drugs** and devices are covered under the medical plan when they are given to you by your **provider** or health care facility. The following **preauthorization** information applies to these **prescription drugs** and devices.

For certain **prescription drugs** and devices, your **provider** needs to get approval from us before we will cover the **prescription drug** or device. The requirement for getting approval in advance guides appropriate use of certain **prescription drugs** and devices and makes sure they are **medically necessary**. For the most up-to-date information, call Member Services at the toll-free number in the *How to contact us for help* section or log in to your **Aetna** website at https://www.aetna.com.

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

Step therapy
Step therapy is a type of **preauthorization** 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. Step therapy will not apply to **prescription drugs** used for the treatment of:

- stage-four advanced, metastatic cancer or associated conditions
- diagnosis of a serious mental illness if you are age 18 or older.

For the most up-to-date information about **step therapy prescription drugs**, call Member Services at the toll-free number on your ID card in the *How to contact us for help* section 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

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.

See the *When you disagree – claim decisions and appeals procedures* section for more information on your appeals rights in these situations.

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.

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

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

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

- Diagnostic testing for the treatment or diagnosis of a medical condition will not be covered under the preventive care and wellness benefit. See the *Specific therapies and tests* section for information on diagnostic testing. Except for diagnostic mammograms, you will pay the cost sharing specific to **eligible health services** for diagnostic testing and treatment.

- 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.

- To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or by calling the toll-free number in the *How to contact us for help* section. This information can also be found at the https://www.healthcare.gov website.

Routine physical exams

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

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
  - Screening for gestational diabetes for women
  - High-risk Human Papillomavirus (HPV) DNA testing for women
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial **hospital** checkup and the administration of the newborn screening tests as required by applicable Texas law including the cost of a newborn screening test kit in the amount provided by the Department of State Health Services

Preventive care immunizations

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

Immunizations for children from birth to age 18
Eligible health services include:

- Diphtheria, tetanus, pertussis
- Haemophilus influenza type b
- Hepatitis A
- Hepatitis B
- Human papillomavirus
- Inactivated poliovirus
- Influenza
- Measles, mumps, rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella
- Any other immunization that is required for children by law

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 exam office visit to your **physician**, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes Pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.
- Exam for the early detection of ovarian and cervical cancer, including:
  - A CA 125 blood test
  - Pap smear screening or screening using liquid-based cytology methods
  - Any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer

Preventive screening and counseling services

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

Here is more detail about those benefits:

- **Obesity and/or healthy diet counseling**
  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**
  Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment

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

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

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

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

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms (All forms of low-dose mammography, including digital mammography and breast tomosynthesis)
- CA 125 blood test for ovarian cancer
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies (includes:
  - Pre-procedure **specialist** consultant
  - Bowel preparation medications
  - Anesthesia
  - Removal of polyps performed during a screening procedure
  - Pathology exam on any removed polyps)
  - Follow-up colonoscopy if the findings are abnormal
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

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

Prenatal care

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

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

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

Important note:
You should review the benefit under *Eligible health services 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) and counseling services during pregnancy or at any time following delivery for breast-feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support **provider**.

Breast feeding durable medical equipment

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

Breast pump
Eligible health services include:

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

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

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

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

Family planning services –contraceptives

Eligible health services include family planning services such as:

Counseling services

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

Contraceptives

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

Voluntary sterilization

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

Important note:
See the following sections for more information:

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

The following are not covered under this benefit:

- Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a **provider**

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, teledentistry** or **telehealth**

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

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

The following are not covered under this benefit:

- Allergy sera and extracts administered via injection

Physician and specialist – inpatient surgical services

Eligible health services include the services of:

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

When your **surgery** requires 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**, **teledentistry** or **telehealth.**

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

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

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, including the cost of the blood or blood product
- Radiation therapy
- Inhalation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a **hospital**

Preadmission testing

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

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

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

Anesthesia and related facility charges for a dental procedure

Eligible health services include:

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

for your dental procedure.

Your provider must certify that the dental care cannot be performed in the dentist's office due to a physical, mental, or medical condition.

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

Alternatives to hospital stays

Outpatient surgery (facility charges)

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

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

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

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

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, furnishing of medical equipment and supplies (other than drugs or medicines) or are short-term speech, physical or occupational therapy
- **Home health aide** services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker

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

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

The following are not covered under this benefit:

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

Hospice care

Eligible health services include inpatient and outpatient **hospice care** when given as part of a **hospice care program.**

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

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

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

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

The following are not covered under this benefit:

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

Skilled nursing facility

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

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

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

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

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

Important note:
Even if you receive **eligible health services** at a health care facility that is an **in-network provider**, not all services may be in network. Other services you receive may be from an **out-of-network provider**. **Providers** that may not be an **in-network provider** include anesthesiologists, radiologists, pathologists, and assistant surgeons. We will reimburse the **out-of-network provider** at the usual and customary rate or at an agreed rate. Please contact Member Services if you receive a bill from the **out-of-network provider**. We will work to resolve the outstanding balance so that all you pay is the appropriate **network deductible**, **coinsurance**, or **copayments** under your plan.

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

The types of services that are eligible for coverage include:

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

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

You will be credited for:

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

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 based on the usual and customary rate or at an agreed rate. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.

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

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

For follow-up care, you are covered when:

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

In case of a medical emergency

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

Non-emergency condition

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

The following are not covered under this benefit:

- Non-emergency services in a **hospital** emergency room facility freestanding emergency medical care facility or comparable emergency 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** or **school health services.** If your **physician** or **school health services** is not reasonably available to provide services, you may access urgent care from an **urgent care facility**.

Non-urgent care

If you go to an **urgent care facility** for what is not an **urgent condition,** the plan will not cover your expenses. See the 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 found in the *Pediatric dental care* section of the schedule of benefits. You can get those services in an in person setting or by way of **teledentistry** from a **contracting dental provider**.

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 a **non-contracting dental provider**.

If you have a **dental emergency**, you should consider calling your **contracting dental provider** who may be more familiar with your dental needs. Services given for other than the temporary relief of the **dental emergency** by a **non-contracting dental provider** can cost you more. To get the maximum level of benefits, services should be provided by your **contracting dental provider**.

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

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

Orthodontic treatment

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

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

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

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

Replacements

The plan's "replacement rule" applies to:

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

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

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

Missing teeth that are not replaced

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

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

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

Getting an advance claim review

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

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

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

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

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

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

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

Pediatric dental care exclusions

The following are not covered under this benefit:

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

6. Specific conditions

Birthing center (facility charges)

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

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

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

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

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

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 and insulin analog preparations
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Hypodermic needles and syringes used for the treatment of diabetes
  - Injection aids, including devices used to assist with insulin injection and needleless systems
  - Diabetic test agents
  - Lancets/lancing devices
  - Test strips, including visual reading – blood glucose, ketone and urine
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Injectable glucagons
  - Glucagon emergency kits
  - Biohazard disposal containers
- Equipment
  - External and implantable insulin pumps and pump supplies, including associated appurtenances:
    - Insulin infusion devices
    - Batteries
    - Skin preparation items
    - Adhesive supplies
    - Infusion sets
    - Insulin cartridges
    - Durable and disposable devices to assist in the injection of insulin

    - Other required disposable supplies
    - Repairs and necessary maintenance of insulin pumps if not covered by manufacturer's warranty or purchase agreement
    - Rental fees for pumps during repair and maintenance
  - Blood glucose meters without special features, unless required due to blindness
  - Podiatric appliances, including therapeutic shoes to prevent complications of diabetes
- Training
  - Self-management training provided by a health care **provider** certified in diabetes self-management training

"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.

All supplies, including medications, equipment for controlling diabetes shall be dispensed as written unless substitution is approved by your physician who issues the written order.

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

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 **health care facility** after a vaginal delivery
- 96 hours of inpatient care in a **health care facility** 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

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

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

Well newborn nursery care

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

Eligible health services include certain services and supplies for gender affirming treatment.

Important note:
Visit https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html for detailed information about this benefit, including eligibility and **medical necessity** requirements. You can also call *Member Services* at the toll-free number in the *How to contact us for help* section.

Alzheimer's disease

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

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

Autism spectrum disorder

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

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

We will cover screenings for autism spectrum disorder.

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

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

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

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

As used here, "generally recognized services" can include:

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

Services for children with developmental delays

Eligible health services for a child with developmental delays include:

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

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

If the child is **homebound**, therapy services may be provided in the child's home.

Behavioral health

Mental health treatment

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

- **Inpatient room and board** at the **semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Other services and supplies related to your condition that are provided during your **stay** in a general medical **hospital**, **psychiatric hospital**, crisis stabilization unit, or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a general medical **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** or **telehealth** consultations)
  - Individual, group and family therapies for the treatment of mental health
  - Other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - Observation
    - Peer counseling support by a peer support specialist (including **telemedicine** or **telehealth** consultation)
      - A peer support specialist serves as a role model, mentor, coach, and advocate. Peer support must be supervised by a **behavioral health provider**.

Eligible health services will be covered under the same terms and conditions as medical and surgical benefits for any other physical illness.

Substance related disorders treatment

Eligible health services include the treatment of **substance related 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 **telemedicine** or **telehealth** consultations)
  - Individual, group and family therapies for the treatment of **substance related disorders**

- Other outpatient **substance related disorders** treatment such as:
  - Outpatient **detoxification**
  - Partial hospitalization treatment provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
  - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
  - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
    - Your **physician** orders them
    - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
    - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness**, or disease
  - Ambulatory **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
  - Observation
  - Peer counseling support by a peer support specialist (including **telemedicine** or **telehealth** 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 note:
Your **student policy** covers **telemedicine** or **telehealth** for **mental health disorders** and **substance related disorders**. All in-person **physician** or **behavioral health provider** office visits that are **covered benefits** are also covered if you use **telemedicine or telehealth** provided by a **physician** or **behavioral health provider** instead.

Eligible health services will be covered under the same terms and conditions as medical and surgical benefits for any other physical illness.

Reconstructive surgery and supplies

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

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

- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.
- Your **surgery** corrects a craniofacial abnormality. This includes an abnormal structure that is caused by developmental deformities, congenital defects, trauma, tumors, infections or disease. The **surgery** will be covered if the purpose of the surgery is to:
  - Improve function
  - Attempt to create a normal appearance

Transplant services

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

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy for FDA-approved treatments
- 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 they will not be **eligible health services**.

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.

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.**

Infertility services exclusions

The following are not covered under the **infertility** services benefit:

- All **infertility** services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- **Infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.
- 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.

Eligible health services also include biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of your condition when the following requirements are met:

- Evidence-based
- Scientifically valid based on the medical and scientific evidence
- Informs a patient's outcome and a **provider's** clinical decision
- Predominately addresses the acute or chronic issue for which the test is being ordered, except that a test may include some information that cannot be immediately used in the formulation of a clinical decision
- Provided in a manner that will not disrupt your care or limits the number of biopsies or biospecimen samples

Important note:
Your cost share for diagnostic imaging using mammography, ultrasound imaging, or magnetic resonance imaging will be the same as mammograms performed for routine cancer screenings as described in the *Preventive care and wellness* section when it is used to evaluate a breast abnormality, including abnormalities detected by you, or where there is a personal history of breast cancer or dense breast tissue.

This diagnostic imaging is not subject to any age limitations.

Diagnostic follow-up care related to newborn hearing screening

Eligible health services include necessary diagnostic follow-up care related to the newborn hearing screening test from birth through 24 months of age.

Cardiovascular disease testing

Eligible health services include certain lab tests for the early detection of cardiovascular disease when a covered person has:

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

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

- Computed tomography (CT) scanning
- Ultrasonography

Important note:
If an **out-of-network provider** performs a covered diagnostic complex imaging, lab work or radiological service in connection with an **eligible health service** performed by a **network provider, w**e will reimburse the **out-of-network provider** at the usual and customary rate or at an agreed rate. Please contact Member Services if you receive a bill from the **out-of-network provider**. We will work to resolve the outstanding balance so that all you pay is the appropriate **network deductible**, **coinsurance**, or **copayments** under your plan.

Chemotherapy

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

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

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:
The amount you will pay for GCIT **eligible health services** depends on where you get the care. Your cost share will be lower when you get GCIT **eligible health services** from the facility/**provider** we designate. **Eligible health services** received from a GCIT-designated facility/**provider** are subject to the in-network **copayment**, **coinsurance**, **deductible**, maximum out-of-pocket and limits, unless otherwise stated in this certificate and the schedule of benefits.

You may also get GCIT **eligible health services** from a non-designated facility/**provider**, but your cost share will be higher. **Eligible health services** from a non-designated GCIT facility/**provider** are subject to the out-of-network **copayment**, **coinsurance**, **deductible**, maximum out-of-pocket and limits, unless otherwise stated in this certificate and the schedule of benefits. 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.

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 in the *How to contact us for help* section or by logging in to your **Aetna** website at https://www.aetnastudenthealth.com.

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

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

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

The following are not covered under this benefit:

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

Outpatient radiation therapy

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 in the *How to contact us for help* section or by logging in to your **Aetna** website at https://www.aetnastudenthealth.com to determine if coverage is under the outpatient **prescription drug** benefit of this certificate of coverage.

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

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

Outpatient respiratory therapy

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

Transfusion or kidney dialysis of blood

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

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

Short-term cardiac and pulmonary rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

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

Short-term rehabilitation and habilitation therapy services

Short-term rehabilitation therapy services

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

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

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

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

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute **illness**, **injury** or **surgical procedure**, except as described in the *Speech or hearing loss or impairment* section

- 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**, except as described in the *Speech or hearing loss or impairment* section 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.

Inpatient and outpatient treatment for acquired brain injury

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

- Physical function
- Sensory processing
- Cognition
- Psychosocial behavior

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

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

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

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

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

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

Short-term habilitation therapy services

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

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

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

Speech or hearing loss or impairment

Eligible health services include the care and treatment of loss or impairment of speech or hearing by a **provider**.

Outpatient physical, occupational, and speech habilitation therapy

Eligible health services include:

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

Chiropractic services

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

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

Diagnostic testing for learning disabilities

Eligible health services include diagnostic testing for:

- Attention deficit disorder
- Attention deficit hyperactive disorder
- Dyslexia

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

8. Other services

Ambulance service

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

For **emergency services**:

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

For non-emergency services:

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

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

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

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 or **terminal illnesses** and all of the following conditions are met:

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

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

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

Clinical trials (routine patient costs)

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

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

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:

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

We:

- Assume no responsibility
- Make no express or implied warranties

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

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

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

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

The following are not covered under this benefit:

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

Nutritional support

Eligible health services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease or disorder of amino and organic acids. This includes coverage for amino acid based elemental formula.

We will cover these items to the same extent that the plan covers drugs that are available only on the orders of a physician.

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.

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

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 the initial orthotic device and subsequent replacement that your **physician** orders and administers.

We will cover the same type devices that are covered by Medicare when they are **preauthorized**. Your **provider** will tell us which device best fits your need.

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

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

Coverage Includes:

- Repairing or replacing the original device. Examples of these are:
  - 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
- Instruction and other services (such as attachment or insertion) so you can properly use the device

The following are not covered under this benefit**:**

- Services covered under any other benefit
- Repair and replacement due to loss, misuse, abuse or theft

Osteoporosis (non-preventive care)

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

- A postmenopausal woman not receiving estrogen replacement therapy
- An individual with:
  - Vertebral abnormalities
  - Primary hyperparathyroidism
  - A history of bone fractures
- An individual who is:
  - Receiving long-term glucocorticoid therapy
  - Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

Prosthetic devices

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

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

Prosthetic device means:

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

Coverage includes:

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

The following are not covered under this benefit:

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

Hearing aids, cochlear implants and related services

Eligible health services include hearing aids or cochlear implants and the following related services and supplies:

- Fitting and dispensing services and ear molds necessary to maintain optimal fit of hearing aids
- Treatment related to hearing aids and cochlear implants, including:
  - Habilitation and rehabilitation necessary for educational gain
  - For cochlear implants, an external speech processor and controller
- Internal replacement of cochlear implants as **medically necessary** or audio-logically necessary

Eligible health services also 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
  - Any other **provider** acting within the scope of their license
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select and adjust or fit a hearing aid

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

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

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

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 36 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 or other **provider** not acting within the scope of their license

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 except for complications of diabetes. See the *Diabetic services and supplies (including equipment and training)* section
  - 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, teledentistry** or **telehealth** consultations when provided by a **physician**, **specialist**, **behavioral health provider telemedicine, teledentistry** or **telehealth provider** acting within the scope of their license.

Vision care

Pediatric vision care

Routine vision exams

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

Vision care services and supplies

Eligible health services include:

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

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

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, optometrist, therapeutic optometrist, or any other **providers** acting within the scope of their license. The exam will include refraction and glaucoma testing.

Vision care services and supplies

Eligible health services include:

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

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:

Adult vision care

- 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 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.

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

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

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

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

Partial fill dispensing for certain prescription drugs

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

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

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

How to access in-network pharmacies

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

Pharmacy types

Retail pharmacy

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

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

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

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

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**.

Prescriptions can be filled at an in-network **mail order pharmacy**.

Specialty pharmacy

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

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

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

How to access out-of-network pharmacies

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

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

Other covered services

Anti-cancer drugs taken by mouth

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.

Coverage for oral anti-cancer **prescription drugs** will not be less favorable than for intravenously or injected anti-cancer medications covered as a medical benefit rather than as a **prescription drug** benefit. Also, the cost sharing for anti-cancer **prescription drugs** will not exceed the **coinsurance** or **copayment** applicable to a chemotherapy visit or cancer treatment visit. Your **prescriber** or your pharmacist may need to get approval from us before we will agree to cover the drug for you. For more information see the *Medical necessity and preauthorization* requirements section.

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

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

Preventive contraceptives important note:
You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **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 including visual reading, for blood glucose, ketones, urine
- Insulin and insulin analogs
- Prescriptive and nonprescriptive oral agents for controlling blood sugar levels
- Glucagon emergency kits

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.

Nutritional supplements
Eligible health services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids. This includes coverage for amino -acid based elemental formula.

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

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

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

Preventive care drugs and supplements
Eligible health services include preventive care drugs and supplements, including 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

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**:

- Abortion drugs used for elective termination of pregnancy except when the pregnancy aggravates, causes or results in a life-threatening physical condition that a **physician** believes places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless termination of the pregnancy occurs
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- **Cosmetic** drugs including medication and preparations used for **cosmetic** purposes
- Devices, products and appliances unless listed as an **eligible health service**
- Dietary supplements including medical foods
- 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
  - That are therapeutically the same or an alternative to a covered **prescription drug**, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility

- Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
- That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as an **eligible health service**
- That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the **covered person** meets one or more clinical criteria detailed in our **preauthorization** and clinical policies

- Duplicative drug therapy; 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 as specifically stated in the schedule of benefits or the certificate
- **Infertility**:
  - **Prescription drugs** used primarily for the treatment of **infertility**, except for drugs used for fertility preservation
- Injectables including:
  - Any charges for the administration or injection of **prescription drugs** except as described in the *Diabetic services and supplies (including equipment and training)* section
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting with the exception of Depo Provera and other **injectable drugs** for contraception
- 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
- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

Where your schedule of benefits fits in

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

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

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

How your copayment works

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

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

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

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

Abortion

- Services and supplies provided for an abortion except when the pregnancy aggravates, causes or results in a life-threatening physical condition that a **physician** believes places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless the abortion is performed

Abortion drugs

- Drugs used for elective termination of pregnancy except when the pregnancy aggravates, causes or results in a life-threatening physical condition that a **physician** believes places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless termination of the pregnancy occurs

Acupuncture

- Acupuncture
- Acupressure

Air or space travel

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

  This exclusion does not apply if:
  - You are traveling solely as a fare-paying passenger
  - You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
  - You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
    - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved
    - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the **policyholder** performing duties for the **policyholder**

Alternative health care

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

Armed forces

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

Behavioral health treatment

- Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:
  - **Stay** in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
  - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation
  - Sexual deviations and disorders except as described in the *Eligible health services and exclusions* section
  - Tobacco use disorders except as described in the *Eligible health services and exclusions – Preventive care and wellness* section

Beyond legal authority

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

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

Examples of these are:

- The provision of donated blood to the **hospital**, other than blood derived clotting factors
- The service of blood donors, including yourself, apheresis or plasmapheresis
- The blood you donate for your own use, excluding administration and processing expenses and except where described in the *Eligible health services and exclusions – Transplant services* section

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**, 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
- For behavioral health (mental health treatment and **substance related disorders** treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function
    - Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults

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

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

Educational services

Examples of these services are:

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

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

Felony

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

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

The following are not **eligible health services** unless you receive prior written approval from us:

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

Incidental surgeries

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

Jaw joint disorder

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

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

Judgment or settlement

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

Maintenance care

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

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Syringes, except for treatment of diabetes
  - Blood or urine testing supplies, except for treatment of diabetes
  - Other home test kits
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Medicare

- Services and supplies available under **Medicare**, if you are enrolled in **Medicare** Part B, or if you are not enrolled in **Medicare** Part B because you refused it, dropped it, or did not make a proper request for it

Non-U.S. citizen

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

Obesity (bariatric) surgery and services

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity** except as described in the *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:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric **surgery**
  - **Surgical procedures,** medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Other primary payer

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

Outpatient prescription or non-prescription drugs and medicines

- Outpatient **prescription drugs** or non-prescription drugs and medicines provided by the **policyholder**
- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient **prescription drug** plan

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 outpatient

Riot

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

Routine exams

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

School health services

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

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

  the **policyholder**.

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

Sexual dysfunction and enhancement

- Any treatment, **prescription drug**, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - **Surgery**, **prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Not eligible for coverage are **prescription drugs** in 60 day supplies

Sinus surgery

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

Specialty prescription drugs

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

Sports

- Any services or supplies given by **providers** as a result from play or practice of collegiate or intercollegiate sports, not including intercollegiate club sports and intramurals

Strength and performance

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

Students in mental health field

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

Telemedicine, teledentistry or telehealth

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

Therapies and tests

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

Tobacco cessation

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

Treatment in a federal, state, or governmental entity

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

Voluntary sterilization

- Reversal of voluntary sterilization procedures, including related follow-up care

Wilderness treatment programs

See *Educational services* within this section

Work related illness or injuries

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

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**. This section also tells you about the role of **school health services**.

School health services

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

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

Important note:
If we agree to your request to see an **out-of-network provider**, you may receive a bill for services from the **out-of-network provider**, as we paid them at the usual and customary rate or at an agreed rate. We will work with the **provider** so that all you pay is your appropriate network level cost-sharing.

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

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

Out-of-network providers

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

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

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

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

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

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

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

	If you have a terminal illness and your provider stops participation with Aetna
Request for approval	Your **provider** should call us for approval to continue any care. You can call Member Services at the toll-free number on the back of your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period for up to nine (9) months. This date is based on the date the **provider** terminated their participation with **Aetna**.
How claim is paid	Your claim will be paid at not less than the **negotiated charge** during the transitional period.
	If you are pregnant and have entered your second trimester and your provider stops participation with Aetna
Request for approval	Your **provider** should call us for approval to continue any care. You can call Member Services at the toll-free number on the back of your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period through delivery, including the time required for postpartum care directly related to the delivery. This includes a post-delivery checkup within six weeks.
How claim is paid	Your claim will be paid at not less than the **negotiated charge** during the transitional period.

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 preauthorization requirements* section.

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

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

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**

Important note:
Although health care services may be or have been provided to you at a health care facility that is a member of the provider network used by your health benefit plan, other professional services may be or have been provided at or through the facility by physicians and other health care practitioners who are not members of that network. You may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by your health benefit plan unless balance billing for those services is prohibited.

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** that are not surprise bill claims. All surprise bill claims will be paid in 30 days.

Submit a claim

- You should notify and request a claim form from the **policyholder**
- The claim form will provide instructions on how to complete and where to send the form
- We must receive your claim within 20 days (or as soon as reasonably possible) after you get a covered medical service.
- You can send the claim to us or to one of our authorized agents. We will send you a claim form within 15 days after we receive your notice of a claim. If we do not send you a claim form within those 15 days, you will automatically be considered to have met the proof of loss requirements. See the *Proof of loss* section below.
- 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
- We must receive written proof of loss from you within 90 days after your loss occurs. If you couldn't reasonably provide this proof within 90 days, we will still accept your claim. But you must provide the proof as soon as possible, but no later than one year after the 90 days ends (unless you were legally incapacitated).

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
- We will pay benefits to you or your assignee. After we receive your timely proof of loss, we will pay claims within 60 days after we receive the proof of loss. Please see the *Proof of loss* section above for more information

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.

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

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

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

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

We will not reduce or deny coverage for services that we have already approved. During the concurrent claim extension period, you are still responsible for your share of the costs, such as **copayments**, **coinsurance** and **deductibles** that apply to the service or supply. If your request for extended services is not approved after your adverse determination appeal, and we uphold our decision to reduce or terminate such services you will be responsible for all of the expenses for the service or supply received during the continuation period.

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

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

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
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.

*If we approve the care and services, we will send you a letter no later than 2 business days after we receive the request. The *Adverse determinations* section explains how and when we tell you about an adverse determination.

Adverse determinations

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

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

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

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

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

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

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 in the *How to contact us for help* section 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.

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

An Appeal

You can ask us to re-review an adverse determination if you are not satisfied with or disagree with the adverse determination. This is called an appeal. You can appeal to us by calling Member Services at the toll-free number in the *How to contact us for help* section.

Appeals of adverse determinations

You can appeal our adverse determination. We will assign your appeal to someone who was not involved in making the original decision.

You can appeal by sending a written appeal to the address on the notice of adverse determination or by calling Member Services at the toll-free number in the *How to contact us for help* section. For a written appeal, you need to include:

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

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 in the *How to contact us for help* section. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

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

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

Expedited internal appeal

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

Timeframes for deciding appeals of adverse determinations

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. We may tell you about our decision orally or in writing. If we tell you orally, we will also send you a letter within 3 calendar days after the oral notice.

Claim type	Decision timeframe	Extensions
Urgent care claim	36 hours	None
Pre-service claim	15 days	None
Post-service claim	30 days	None
Concurrent care claim	As appropriate to type of claim	As appropriate to type of claim

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

Exhaustion of appeals process

In most situations you must complete the appeal process with us before you can

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

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

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

- You have a life-threatening condition. You can have your appeal reviewed through the independent review process.
- If you are receiving **prescription drugs** or intravenous infusion treatment and we deny them. You can have your appeal reviewed through the independent review process.
- Your request for a **step therapy** exception was denied. You can have your appeal reviewed through the independent review process.

Independent review

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

You have a right to Independent review only if:

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

You may also request Independent 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 Independent review, we will say that in the notice of adverse determination we send you. That notice also will describe the Independent review process. It will include a copy of the Request for Independent Review form.

You must submit the Request for Independent Review Form:

- To **Aetna** Within 4 months of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

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

Aetna will:
Contact the IRO that will conduct the review of your claim If your request is based on exigent circumstances your request will be sent as soon as possible. An “exigent circumstance” means when you are:

- Experiencing a health condition that may seriously jeopardize your life, health or ability to regain maximum function
- Undergoing a current course of treatment using a non-formulary drug
-
- The IRO will:
  - Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
  - Consider appropriate credible information that you sent
  - Follow our contractual documents and your plan of benefits
  - Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

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

How long will it take to get an IRO decision?

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

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

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

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)
- The adverse determination concerns an admission, availability of care, continued **stay** or health care service for which you received **emergency services**, but have not been discharged from a facility
    - A request for step therapy exceptions
    - A request for intravenous infusions you are currently receiving

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. or within 24 hours if your request is for an exigent circumstance.

Fees and expenses

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

Coordination of benefits (COB)

The Coordination of benefits ("COB") provision applies when a person has 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). "Plan" is defined below in the *Key terms* section.

The order of benefit determination rules tell you the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms. Payment is made without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

Key terms

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

Plan:
A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

• A plan includes:	• Group blanket or franchise accident and health insurance policies, excluding disability income protection coverage • Individual and group health maintenance organization evidences of coverage • Individual accident and health insurance policies • Individual and group preferred provider benefit plans and exclusive provider benefit plans • Group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care • Medical care components of individual and group long-term care contracts • Limited benefit coverage that is not issued to supplement individual or group in-force policies • Uninsured arrangements of group or group-type coverage • The medical benefits coverage in automobile insurance contracts • Medicare or other governmental benefits as permitted by law

• A plan does not include:	• Disability income protection coverage • The Texas Health Insurance Pool • Workers' compensation insurance coverage • **Hospital** confinement indemnity coverage or other fixed indemnity coverage • Specified disease coverage • Supplemental benefit coverage • Specified accident coverage • School accident-type coverages that cover students for accidents only, including athletic injuries, either on "24-hour" or a "to and from school" basis • Benefits provided in Long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and **custodial care** or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services • Medicare supplement policies • A state plan under Medicaid • A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan • Other nongovernmental plan • An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable **deductible**

Each plan for coverage is a separate plan, if a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This plan:
This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans

• How this plan coordinates with like benefits:	Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.
• The order of benefit determination rules for this plan:	The order of benefit determination rules determines whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. • When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits • When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100% of the total allowable expense

Allowable expense:
Allowable expense is a health medical eye care, vision, or dental care expense, including **deductibles,** coinsurance and **copayments**, that is covered at least in part by any plan covering the person.

• Allowable expense for benefits provided in the form of services:	When a plan provides benefits in the form of services the reasonable cash value of each service will be considered an allowable expense and a benefit paid.
• Expenses that are not allowable expenses:	An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a **provider** or **physician** by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense. Some expenses and services are not allowable expenses. Here are some examples: • The difference between the cost of a semi-private **hospital** room and a private **hospital** room is not an allowable expense, unless one of the plans provides coverage for private **hospital** room expenses. • If a person is covered by two or more plans that don't have a **negotiated charge** and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule

	reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for specific benefit is not an allowable expense. • If a person is covered by two or more plans that provide benefits or services on the basis of **negotiated charges,** an amount in excess of the highest of the **negotiated charges** is not an allowable expense. • If a person is covered by one plan that does not have **negotiated charges** and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides it benefits or services based on **negotiated charges**, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care **provider** or **physician** has contracted with the secondary plan to provide the benefit or service for a specific **negotiated charge** or payment amount that is different that the primary plan's payment arrangement and if the health care **provider** or **physician** contract permits, the **negotiated charge** or payment must be the allowable expense used by the secondary plan to determine its benefits. • The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, **preauthorization** of admissions, and **network provider** and **physician** arrangements.

Allowed amount:
Allowed amount is the amount of a billed charge that a carrier determines to be covered for services by an **out-of-network provider.** The amount includes both the carrier's payment and any applicable **deductible, copayment,** or coinsurance amounts for which the insured is responsible.

Closed panel plan:
Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care **providers** and **physicians** that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care **providers** and **physicians**, except in cases of emergency or referral by a panel member.

Custodial parent:
Custodial parent is the parent with the right to designate the primary residence of a child by court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the **calendar year**, excluding any temporary visitation.

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Allowed amount is the amount of a billed charge that a carrier determines to be covered for services by an **out-of-network provider.** The amount includes both the carrier's payment and any applicable **deductible, copayment,** or coinsurance amounts for which the insured is responsible.

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Order of benefit determination rules

When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- The primary plan pays according to its terms of coverage and without regard to the benefits under any other plan

- A plan does not have a COB provision is always primary unless the provisions of both plans state that the complying plan is primary, except:
  - Coverage that you have because of membership in a group that is designed to supplement part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are:
    - Major medical coverages that are superimposed over base plan **hospital** and **surgical** benefits
    - Insurance type coverages that are written in connection with a closed panel to provide **out-of-network** benefits.

- A plan may consider the benefits paid by another plan in calculating payment of its benefits only when it is secondary to that other plan.

- If the primary plan is closed panel plan and the secondary plan is not, the secondary plan must pay benefits as if it were the primary plan when a covered person uses an **out-of-network provider** or **physician** except for **emergency services** or authorized **referrals** that are paid or provided by the primary plan.

• When multiple contracts providing coordinated coverage are treated as a single plan, this applies only to the plan as a whole. Coordination among the component contract is governed by the terms of the contracts. If more than one carrier pays or provided benefits under the plan, the carrier designated ad primary within the plan must be responsible for the plan's compliance with these rules.
• If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of the secondary plan.

Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.
Contact us if you have questions or want more information.

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

Effect on the benefits of this plan

- When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan:
    - Will calculate the benefits it would have paid in the absence of other health care coverage. The calculated amount will be applied to any allowable expense under its plan that is unpaid by the primary plan.
    - May reduce its payment so that the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim.
    - Must credit to its plan **deductible** any amounts it would have credited to its **deductible** in the absence of other health care coverage.
- If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with federal and state laws concerning confidential information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give us any facts it needs to apply those rules and determine benefits.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid. Or, we may recover from any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of the benefits provided in the form of services.

Other health coverage updates – contact information

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

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

Right to receive and release needed information

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

Right to pay another carrier

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

Right of recovery

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

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

When coverage ends

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

When will your coverage end?

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

- This plan is discontinued
- The **student policy** ends
- You are no longer eligible for coverage
- The last day for which any required **premium** contribution has been paid
- The date you are no longer in an eligible class
- We end your coverage for one of the reasons shown in this 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.

When will your continuation of coverage plan end?

Your coverage and your dependent's coverage under the continuation of coverage plan will end when:

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

See the *Continuation of coverage for other reasons* section to learn how you can extend your coverage.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- For a dependent child, on the first **premium** due date following the child's 26th birthday.
- Your dependent is no longer eligible for coverage.
- The date dependents are no longer an eligible class.
- You do not make the required **premium** contribution toward the cost of dependents' coverage.
- Your coverage ends for any of the reasons listed above.
- For your spouse, the date the marriage ends in divorce or annulment.
- They are covered under a continuation of coverage plan and it ends. Coverage for dependents ends on the date the continuation of coverage plan ends.

In addition, coverage for your domestic partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners.
- The date the domestic partnership ends. For domestic partnerships, you should provide the **policyholder** a completed and signed Declaration of Termination of Domestic Partnership.

What happens to your 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

We may immediately end your and your dependents coverage if:

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

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

We will not end your coverage based on your health care status or needs, we also will not end your coverage because you used your rights under the *Complaints, claim decisions, and appeal procedures* section.

Special coverage options after your plan coverage ends

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

Continuation of coverage plan

If your or your dependent's coverage under the **student policy** will end, you can elect to continue coverage under the **student policy** if:

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

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

Continuation of coverage – State of Texas

Continuation privilege for certain dependents

There are events that may cause your dependents to lose coverage. For some events, certain dependents are eligible to continue their coverage for a time. Here are the events, eligible dependents and time periods:

Qualifying event causing loss of coverage:	Covered persons eligible for continued coverage:	Length of continued coverage (starts from the day you lose current coverage):
• Death of **covered student** • Divorce	• Dependent who has been covered under the plan for at least one year • An infant under one year of age	3 years

When do I receive state continuation information?

The chart below lists who must give notice, the type of notice required, and the time period to give the notice.

Notice	Requirement	Deadline
You or your covered spouse	Send written notice to your **policyholder**	Within 15 days of the qualifying event
Your **policyholder**	• Will provide you with an enrollment form to continue coverage • The amount of **premium** to be charged (in the case of the **covered student's** death)	Immediately after they receive notification
You or your covered spouse	Complete the enrollment form to continue coverage	Within 60 days of the qualifying event.

You must send the completed enrollment form from within 60 day of the qualifying event. If you don't, you will lose the right to continue coverage. We will cover your dependent during this period as long as the premiums and administrative charges are paid.

Continuation of coverage for other reasons

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

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

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

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

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

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

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

You have the right to extend coverage for your disabled **covered dependent** child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly on you for support

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

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

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

Your disabled child's coverage will end:

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

General provisions – other things you should know

Entire student policy

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

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

Administrative provisions

How you and we will interpret this certificate of coverage

We prepared this certificate of coverage according to federal laws and state laws that apply. You and we will interpret it according to these laws.

How we administer this plan

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

Who's responsible to you

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

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

Coverage and services

Your coverage can change

Your coverage is defined by the **student policy**. This document may have amendments or riders too. Under certain circumstances, we or the **policyholder** or the law may change your plan according to requirements of the **student policy**. When an emergency or epidemic is declared, we may modify or waive **preauthorization**, **prescription** quantity limits or your cost share if you are affected. Only **Aetna** may waive a requirement of your plan. No other person – including the **policyholder** or **provider** – can do this. Any modifications made will be no less favorable than the current plan requirements.

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

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

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

Legal action

You are encouraged to complete the appeal process before you take any legal action against us for any expense or bill. See the *When you disagree - claim decisions and appeals procedures* section. You cannot take any action until 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 after the effective date of this certificate.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage as follows:

- We will give you 30 days advanced written notice of any rescission of coverage
- You have the right to an **Aetna** appeal
- You have the right to a third-party review conducted by an independent external review organization
    - We won't rescind your coverage due to an intentional deception if the deception happened more than 2 years after the effective date of this certificate.
    - In the absence of fraud, any statement made on your application for coverage is considered a representation and not a warranty. We will only use a statement during a dispute if it is shared with you and your beneficiary, or the person making the claim.

Some other money issues

Assignment of benefits

When you see an **in-network provider** they will usually bill us directly. When you see an **out-of-network provider,** we may choose to pay you or to pay the **provider** directly to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** under this **student policy.** This may include:

- The benefits due
- The right to receive payments or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this **student policy**

To request assignment you must complete an assignment form. The assignment form is available from the **policyholder**. The completed form must be sent to us for consent.

Notice of claim

You must give us written notice of claim within 20 days (or as soon as reasonably possible) after you have incurred expenses for **eligible health services**. You can send the claim to us or to one of our authorized agents. We will send you a claim form within 15 days after we receive your notice of a claim. If we do not send you a claim form within those 15 days, you will automatically be considered to have met the proof of loss requirements. See the *Proof of loss* section below.

Proof of loss

You must submit written proof of loss you within 90 days after your loss occurs. If you couldn't reasonably provide this proof within 90 days, we will still accept your claim. But you must provide the proof as soon as possible, but no later than one year after the 90 days ends (unless you were legally incapacitated).

Time of payment of claims

We will pay benefits to you or your assignee. After we receive your timely proof of loss, we will pay claims within 60 days after we receive the proof of loss. Please see the *Proof of loss* section above. This does not apply to surprise bill claims.

Grace period

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

Payment of premiums

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

Recovery of overpayments

We sometimes pay too much for **eligible health services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid – you or your **provider** – to return what we paid. If we don't do that, we have the right to reduce any future benefit payments by the amount we paid by mistake. We will not reduce any future dental benefit payments to a dentist who did not receive the overpayment.

When you are injured by a third party

If third party caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money for your injuries. If you have a legal right to get money from a third party for causing your injuries We are entitled to that money, up to the amount we pay for your care.

When you have a legal right to get money from one or more third parties for causing your injuries and you pursue that legal right, you are:

- 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 those third parties because of your injuries.
- You are agreeing to cooperate with us so we can get paid back in full. up to the applicable amount noted below. For example, you'll tell us within 30 days of when you seek money from those third parties for your **injury** or **illness**. You'll hold any money you receive until we are paid in full. And you'll give us the right to our portion of money you get, ahead of everyone else.
- You are agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money. Notify us by contacting us.

We will only seek money from your own uninsured/underinsured motorist or medical payments coverage (if any) if you or your immediate family member did not pay premiums for the coverage.

If you are not represented by an attorney, then we can recover the lesser of:

- One-half of the money you receive, or
- The total amount paid by us

If you are represented by an attorney, then we can recover the lessor of:

- One-half of the money you receive, less attorney's fees and costs for the recovery, or
- The total amount paid by us, less attorney's fees and costs for the recovery

How will Attorney's fees be determined?

If we do not use an attorney:

- We (and any other payors) will pay your attorney a fee agreed to between us (and other payors) and your attorney plus a pro rata share of the recovery expenses
- If no agreement exists, then the court will award your attorney a reasonable fee payable for our (and any other payors) share of the recovery not to exceed 1/3 of the recovery

If we use an attorney:

- The court will award attorney's fees to our attorney and your attorney based on the benefit accruing as a result of each attorney's service. The total attorney's fees may not exceed 1/3 of our (and any other payors) recovery.

Payor means a plan issuer that:

- Has a contractual right of subrogation, and
- Pays benefits to you or on your behalf as a result of personal injuries caused by someone else's tortious conduct

A payor includes, but is not limited to, an issuer of:

- A health benefit that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness
- A disability benefit plan
- An employee welfare benefit plan

Reimbursement to Texas Health and Human Services Commission
We will repay the actual costs of medical expenses the Texas Health and Human Services Commission pays through medical assistance for you or your dependent if you or your dependent is entitled to payment for the medical expenses.

Repayment of these medical expenses for your dependent child will be paid to the Texas Health and Human Services Commission if, when you submit proof of loss, you notify us in writing that:

- Your dependent child is covered under the financial and medical assistance service program in Texas and you either:
  - Have possession of or access to the child through a court order; or
  - Are not entitled to possession of or access to the child and are required by the court to pay child support.

You will need to ask us to make direct payment to the Texas Health and Human Services Commission.

Payment to a conservator, other than you
Sometimes a court order gives another person certain rights and duties to act on behalf of your dependent child. Such a person is called a managing or possessory conservator. We may pay that person benefits on behalf of your dependent child. To receive benefits, they must send us a written certified copy of the court order with the claim form. But they are not entitled to benefits if:

- We received a valid assignment of benefits on an unpaid medical bill
- You sent us a claim for benefits for an **eligible health service** that you paid

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 in the *How to contact us for help* section.

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.

Effect of prior coverage - transferred business

Prior coverage means:

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

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

Glossary A-M

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

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

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 disorders** and **substance related disorders** under the laws of the jurisdiction where the individual practices.

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.

Contracting dental provider
A **dental provider** listed in the **directory** for your plan.

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

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible health services that meet the requirements for coverage under the terms of this plan, including:
- They are **medically necessary**
- You received **preauthorization** 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.

Crisis stabilization unit
An institution licensed or certified by the Texas Department of Mental Health and Mental Retardation to provide a 24-hour residential program to treat a moderate to severe psychiatric crisis. The program is prescribed by a **physician** or other **health professional** to provide short-term, intensive and structured care.

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

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

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

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

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

Dentist
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
- Serious disfigurement
- In the case of a pregnant woman:
  - Serious jeopardy to the health of the fetus
  - One who is having contractions and there is inadequate time to effect a safe transfer to another **hospital** before delivery or
  - A transfer may pose a threat to the health or safety of the woman or unborn child

Emergency services
Treatment given in an **ambulance** and a **hospital**'s emergency room or an independent freestanding emergency department. or comparable emergency facility 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 with the same intended use as the brand-name product. It is considered to be as effective as the brand-name product and offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional
A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, nurses, **dental providers**, vision care **providers**, and physical therapists.

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

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

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

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

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

You are not **homebound** if:

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

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

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

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

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

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

Hospital
An institution licensed as a **hospital** by applicable law. This is a place that offers medical care. 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 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

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

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

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and
- Following the standards set forth in our clinical policies and applying clinical judgment

Important note:
We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **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.

Medicare

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

Mental health disorder

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

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

Glossary N-Z

Negotiated charge

Health coverage

This is either:

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

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

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.

Prescription drug coverage

The amount a **network provider** has agreed to accept for providing **prescription drugs** or supplies to members of your plan.

Non-contracting dental provider
A **dental provider** who is not a **contracting dental provider** and does not appear in the **directory** for your plan.

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

Out-of-network 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** and **mail order pharmacy**.

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

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

Policy year deductible
The amount you pay for **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**.

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

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

Preferred in-network pharmacy
A network **retail pharmacy** that **Aetna** has identified as a **preferred in-network pharmacy.**

Premium
The amount you or the **policyholder** are required to pay to **Aetna**.

Prescription

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

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

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

Prescription drug

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

Provider(s)

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

Psychiatric hospital

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

Recognized charge

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The **recognized charge** depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Service or supply	Recognized charge is based on:
Professional services and other services or supplies not mentioned below	105% of the **Medicare** allowed rate
Services of **hospitals** and other facilities	140% of the **Medicare** allowed rate
Prescription drugs	100% of the average wholesale price (AWP)
Dental expenses	80% of the prevailing charge rate
Prescription drugs for gene-based, cellular and other innovative therapies (GCIT)	100% of the average wholesale price (AWP)

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

  When the **recognized charge** is based on a percentage of the **Medicare** allowed rate, it is not affected by adjustments or incentives given to **providers** under **Medicare** programs.
- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.

Our reimbursement policies

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

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

Our reimbursement policies are based on our review of:

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

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

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

R.N.
A registered nurse.

Residential treatment facility
An institution specifically licensed by applicable laws to provide residential treatment programs for **mental health disorders**, **substance related disorders**, or both. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following:
For residential treatment programs treating **mental health disorders**:

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

For residential treatment programs treating **substance related disorders**:

- 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**
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For **detoxification** programs within a residential setting:

- An **R.N.** must be onsite 24 hours/day for 7 days/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.

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

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

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

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 disorders** or **substance related disorders**.

Skilled nursing services
Services provided by an **R**.**N**. or **L.P.N.** within the scope of his or her license.

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

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

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

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

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

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

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

Student policy
The **student policy** consists of several documents taken together. The list of documents can be found in the *Entire student policy* section of this certificate of coverage.

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

Surgery center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all **Medicare** accreditation standards (even if it does not participate in **Medicare**).

Surgery, surgeries or surgical procedures
The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution or
- Otherwise physically changing body tissues and organs

Teledentistry
A health care service delivered by a dentist, or a **health professional** acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or **health professional's** license or certification to a patient at a different physical location than the dentist or **health professional** using telecommunications or information technology.

Telehealth
A health service, other than a **telemedicine** medical service, delivered by a **health professional** licensed, certified or otherwise entitled to practice in the State of Texas and acting within the scope of their license, certification or entitlement to a patient at a different physical location than the **health professional** using telecommunications or information technology.

Telemedicine
A health care service delivered by a **physician** licensed, certified or otherwise entitled to practice in the State of Texas and acting within the scope of their license, certification or entitlement to a patient at a different physical location than the **health professional** using telecommunications or information technology.

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

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

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

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

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

Walk-in clinic
A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near, or within a:

- Drug store
- **Pharmacy**
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- **Hospital**
- Outpatient department of a **hospital**
- **Physician's** office
- **Urgent care facility**

Wellness and Other Incentives and 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, we may provide incentives based on your participation.

Incentives may include but are not limited to:

- Health and wellness equipment and wearable devices
- Health and wellness mobile applications
- Fitness center membership reimbursement
- Health and wellness merchandise
- Coupons for health and wellness goods and services
- Gift cards for health and wellness goods and services
- 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 a member's health status. Rather, you can obtain these benefits simply by participating in a wellness or health improvement program that we offer you. There's no charge, and you are not required to participate. You can earn benefits as long as we offer wellness and health improvement programs and you participate in them. If we decide to stop offering a wellness or health improvement program we will let you know at least 30 days in advance. If the provider of the benefit is someone other than us and they fail to give you the benefit, contact us and we will assist you in getting the benefit.

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.

Non-Discrimination

Aetna is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

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, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.

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 Wùɖù/Bassa
Dè dɛ nìà kɛ dyɛ́ɖɛ́ gbo: Ɔ jǔ kɛ́ m̀ dyi Ɓàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ jǔ nǐ, nǐ à wuɖu kà kò ɖò 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 - (**711** :TTY) **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

Texas Life, Accident, Health & Hospital Service
Insurance Guaranty Association

Important Information About Coverage Under The Texas
Life and Health Insurance
Guaranty Association
(For Insurers Declared Insolvent or Impaired on or After September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association (the "Association") administers this protection system. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association
When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at the time **(regardless of where the policyholder lived when the policy was issued).**
- Residents of other states, ONLY if the following conditions are met:
  1. The policyholder has a policy with a company domiciled in Texas;
  2. The policyholder's state of residence has a similar guaranty association; and
  3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association
Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies; up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health
Insurance Guaranty Association
515 Congress Avenue,
Suite 1875
Austin, Texas 78701
800-982-6362 or
www.txlifega.org

Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711- 2030
800-252-3439
www.tdi.texas.gov

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Aetna, Inc.

To get information or file a complaint with your insurance company or HMO:

Call: Aetna's toll-free telephone number at 1-888-416-2277
Toll-free: 1-888-416-2277
Online: www.aetna.com
Email: aetnamemberservices@aetna.com
Mail: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711- 2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Aetna, Inc.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: al numero de teléfono gratis de Aetna al 1-888-416-2277
Teléfono gratuito: 1-888-416-2277
En línea: www.aetna.com
Correo electrónico: aetnamemberservices@aetna.com
Dirección postal: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711- 2030