Student Health Insurance

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

Schedule of benefits

Prepared exclusively for:

Policyholder:	University of Maryland College Park
Policyholder number:	252649
Student policy effective date:	08/01/2025
Plan effective date:	08/01/2025
Plan issue date:	10/17/2025
Actuarial value and metallic level:	91.19% - Platinum

Underwritten by Aetna Life Insurance Company in the State of Maryland

Important notices:

Except for the treatment of an **emergency medical condition**, covered students are encouraged to use the **University of Maryland Health Center** before seeking off-campus treatment. Benefits will be payable in accordance with the coverage provisions shown below.

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:
  - "**Select care** coverage," we mean you get care from **select care providers**.
  - "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 satisfying 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 **select care providers**, **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:
Except that **select care** and in-network preventive care services as required by ACA or COMAR 31.11.06.03-1 are covered at 0 cost share (no **deductible**, **copayment** or **coinsurance**), 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.

Surprise bill important note:
Balance billing services provided based on incorrect Provider network information:
If you are furnished, by a non-participating provider, an item or service that would otherwise be covered if provided by a participating provider, and you relied on a database, provider directory, or information regarding the provider's network status provided by us through a telephone or electronic, web-based, or internet-based means which incorrectly indicated that the provider was a participating provider for the furnishing of such item or service, then the following apply:

- The copayment amount, coinsurance percentage and/or other cost-sharing requirement for such item or service furnished by a non-participating provider is the same as the copayment amount, coinsurance percentage and/or other cost-sharing requirement listed in the contract for the item or service when provided by a participating provider; and
- Any cost-sharing payments made with respect to the item or service will be counted toward any applicable in-network deductible and in-network out-of-network maximum.
- You will not be liable for an amount that exceeds the cost sharing that would have applied to you if the provider was a participating provider.

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 satisfy the **policy year deductible** first. Then you pay your **copayment** and then you satisfy your **coinsurance**. Your **copayment** does not apply towards any **policy year deductible**.

You are required to satisfy 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 satisfy 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	Select care coverage	In-network coverage	Out-of-network coverage
Student	None	$250 per **policy year**	$500 per **policy year**
Spouse	None	$250 per **policy year**	$500 per **policy year**
Each child	None	$250 per **policy year**	$500 per **policy year**
Family	None	$500 per **policy year**	$600 per **policy year**

Policy year deductible waiver

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

- Any service identified as "no policy year deductible applies" in the schedule of benefits

Maximum out-of-pocket limits

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

Maximum out-of-pocket type	Select care coverage	In-network coverage	Out-of-network coverage
Student	$1,500 per **policy year**		$3,500 per **policy year**
Spouse	$1,500 per **policy year**		$3,500 per **policy year**
Each child	$1,500 per **policy year**		$3,500 per **policy year**
Family	$3,000 per **policy year**		$5,000 per **policy year**

Precertification covered benefit penalty

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

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

- A $500 benefit penalty will be applied separately to each type of **eligible health service.** The penalty will not exceed the cost of the **eligible health services**

The additional percentage or dollar amount of the **recognized charge** which you may pay as a penalty for failure to obtain **precertification** is not a **covered 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	Select care coverage	In-network coverage	Out-of-network coverage
Routine physical exam	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
Routine physical exam limits for **covered persons** through age 21: maximum age and visit limits per **policy year**	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.		
Routine physical exam limits for **covered persons** age 22 and over: maximum visits per **policy year**	1 visit		

Preventive care immunizations

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

Description	Select care coverage	In-network coverage	Out-of-network coverage
Preventive care immunizations	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
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 in the *How to contact us for help* section.		

Well woman preventive visits

Routine gynecological exams (including Pap smears)

Description	Select care coverage	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	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
Well woman routine gynecological exam maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.		

Preventive screening and counseling services

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

Description	Select care coverage	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	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
Misuse of alcohol and/or drugs counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
Use of tobacco products counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
Sexually transmitted infection counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies

Description	Select care coverage	In-network coverage	Out-of-network coverage
Genetic risk counseling for breast and ovarian cancer office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
Maximums	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Reasonable medical management techniques will be used to determine the frequency, method, treatment, or setting for an item or service.		

Routine cancer screenings

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

Description	Select care coverage	In-network coverage	Out-of-network coverage
Routine cancer screenings Breast cancer screening is not subject to **deductible**	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
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 in the *How to contact us for help* section.		

Routine prostate cancer screenings

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

Description	Select care coverage	In-network coverage	Out-of-network coverage
Routine prostate cancer screenings	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	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
Maximums	Review the *Routine prostate cancer screenings* section of your certificate of coverage for limitations		

Prenatal care

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

Description	Select care coverage	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	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies

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	Select care coverage	In-network coverage	Out-of-network coverage
Lactation counseling services	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
Maximums	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.		

Breast feeding durable medical equipment

Description	Select care coverage	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	100% (of the **negotiated charge**) per item No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per item No **policy year deductible** applies

Family planning services – female contraceptives

Counseling services

Description	Select care coverage	In-network coverage	Out-of-network coverage
Female contraceptive counseling services office visit	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
Maximums	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.		

Contraceptives (prescription drugs and devices)

Description	Select care coverage	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	100% (of the **negotiated charge**) per item No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per item No **policy year deductible** applies

Female voluntary sterilization

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

2. Physicians and other health professionals

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

Description	Select care coverage	In-network coverage	Out-of-network coverage
Office hours visits (non-surgical and non-preventive care by a **physician** or **specialist**)	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	$25 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
Telehealth consultation by a **physician** or **specialist**	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	$25 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies

Important note:
You will have 0 cost share (no **deductible**, **copayment** or **coinsurance**) for diagnostic breast exams when it is used to evaluate a breast abnormality seen or suspected from a prior screening examination or by other means of prior examination**,** or when it is a supplemental breast examination where no abnormality is seen or suspected from a prior examination and there is a personal or family history of breast cancer or additional factors that may increase your risk of breast cancer.

Allergy testing and treatment (including allergy serum)

Description	Select care coverage	In-network coverage	Out-of-network coverage
Physician and **specialist** services (non-surgical and non-preventive) - allergy testing and 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.	Covered according to the type of benefit and the place where the service is received.

Physician and specialist – inpatient surgical services

Description	Select care coverage	In-network coverage	Out-of-network coverage
Inpatient **surgery** performed during your **stay** in a **hospital** or birthing center by a surgeon	Not available	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Anesthetist	Not available	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Surgical assistant	Not available	80% (of the **negotiated charge**)	60% (of the **recognized charge**)

Physician and specialist – outpatient surgical services

Description	Select care coverage	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	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Anesthetist	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Surgical assistant	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

In-hospital non-surgical physician services

Description	Select care coverage	In-network coverage	Out-of-network coverage
In-**hospital** non-surgical **physician** services	Not available	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Consultant services (non-surgical and non-preventive)

Description	Select care coverage	In-network coverage	Out-of-network coverage
Office hours visits (non-surgical and non-preventive care by a consultant)	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	$25 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
Telehealth consultation by a **physician** or **specialist** consultant	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	$25 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies

Second surgical opinion

Description	Select care coverage	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.	Covered according to the type of benefit and the place where the service is received.

Surprise bill important note:

Balance billing protections for Non-emergency services performed by non-participating providers at participating facilities, including ancillary services and services for unseen urgent medical needs:
We cover items and services furnished by a non-participating provider with respect to a covered visit at a participating facility in the following manner, except when the non-participating provider has satisfied the notice and consent criteria of 45 C.F.R. §149.420 (c) through (i):

- The copayment amount, coinsurance percentage and/or other cost-sharing requirement for such items and services furnished by a non-participating provider with respect to a visit in a participating facility is the same as the copayment amount, coinsurance percentage and/or other cost-sharing requirement listed in the contract for the items and services when provided by a participating provider.
- Any cost-sharing requirements for the items and services will be calculated based on the recognized amount;
- Any cost-sharing payments made with respect to the items and services will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;
- We will make payment for the items and services directly to the non-participating provider or non-participating emergency facility. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for the services; and
- You will not be liable for an amount that exceeds your cost-sharing requirement.

The above bulleted provisions are not applicable when the non-participating provider has satisfied the notice

and consent criteria of 45 C.F.R. §149.420 (c) through (i), including providing notice to you of the estimated charges for the items and services and that the provider is a non-participating provider, and obtaining consent form you to be treated and balanced billed by the non-participating provider. The notice and consent criteria of 45 C.F.R. §149.420 (c) through (i) do not apply to non-participating providers and the following below items and services furnished by non-participating providers will always be subject to the above five provisions with respect to:

- Covered services rendered by an on-call physician or a hospital based physician who has obtained assignment of benefits from you.
- Ancillary services
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-participating provider satisfied the notice and consent criteria.

Alternatives to physician office visits

Walk-in clinic visits (non-emergency visit)

Description	Select care coverage	In-network coverage	Out-of-network coverage
Walk-in clinic (non-emergency visit)	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	$25 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies

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	Select care coverage	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	Not available	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

Surprise bill important note:

Balance billing protections for Non-emergency services performed by non-participating providers at participating facilities, including ancillary services and services for unseen urgent medical needs:
We cover items and services furnished by a non-participating provider with respect to a covered visit at a participating facility in the following manner, except when the non-participating provider has satisfied the notice and consent criteria of 45 C.F.R. §149.420 (c) through (i):

- The copayment amount, coinsurance percentage and/or other cost-sharing requirement for such items and services furnished by a non-participating provider with respect to a visit in a participating facility is the same as the copayment amount, coinsurance percentage and/or other cost-sharing requirement listed in the contract for the items and services when provided by a participating provider.
- Any cost-sharing requirements for the items and services will be calculated based on the recognized amount;
- Any cost-sharing payments made with respect to the items and services will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;
- We will make payment for the items and services directly to the non-participating provider or non-participating emergency facility. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for the services; and
- You will not be liable for an amount that exceeds your cost-sharing requirement.

The above bulleted provisions are not applicable when the non-participating provider has satisfied the notice and consent criteria of 45 C.F.R. §149.420 (c) through (i), including providing notice to you of the estimated charges for the items and services and that the provider is a non-participating provider, and obtaining consent form you to be treated and balanced billed by the non-participating provider. The notice and consent criteria of 45 C.F.R. §149.420 (c) through (i) do not apply to non-participating providers with respect to:

- Covered services rendered by an on-call physician or a hospital based physician who has obtained assignment of benefits from you.
- Ancillary services
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item

or service is furnished, regardless of whether the non-participating provider satisfied the notice and consent criteria; and such items and services furnished by non-participating providers will always be subject to the bullets listed in the first paragraph.

Preadmission testing

Description	Select care coverage	In-network coverage	Out-of-network coverage
Preadmission testing	Not available	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	Select care coverage	In-network coverage	Out-of-network coverage
Anesthesia and related facility charges for a dental procedure	Not available	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Alternatives to hospital stays

Outpatient surgery (facility charges)

Description	Select care coverage	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	100% (of the **negotiated charge**) No **policy year deductible** applies	80% (of the **negotiated charge**)	60% (of the **recognized charge**)

Home health care

Description	Select care coverage	In-network coverage	Out-of-network coverage
Home health care	Not available	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Hospice care

Description	Select care coverage	In-network coverage	Out-of-network coverage
Inpatient facility (**room and board** and other miscellaneous services and supplies)	Not available	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission
Outpatient	Not available	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

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

Outpatient private duty nursing

Up to 8 hours equals one shift

Description	Select care coverage	In-network coverage	Out-of-network coverage
Outpatient private duty nursing	Not available	8% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Skilled nursing facility

Description	Select care coverage	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	Not available	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

Patient-centered medical homes

Description	Select care coverage	In-network coverage	Out-of-network coverage
Patient-centered medical homes	Not available	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.

Case management program

Description	Select care coverage	In-network coverage	Out-of-network coverage
Case management program	Not available	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.

4. Emergency services and urgent care

Emergency services

Description	Select care coverage	In-network coverage	Out-of-network coverage
Emergency room	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	$100 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	Paid the same as **select care** coverage and in-network coverage
Non-emergency care in an emergency room	Not covered	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 1-800-878-1938 and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.
- A separate emergency room **copayment** will apply for each visit to an emergency room. If you are admitted to a **hospital** as an inpatient right after a visit to an emergency room, your emergency room **copayment** will be waived and your inpatient **copayment** will apply.
- **Covered benefits** that are applied to the emergency room **copayment** cannot be applied to any other **copayment** under the plan. Likewise, a **copayment** that applies to other **covered benefits** under the plan cannot be applied to the emergency room **copayment**.
- Separate **copayment** amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These **copayment** amounts may be different from the emergency room **copayment**. They are based on the specific service given to you.
- Services given to you in the emergency room that are not part of the emergency room benefit may be subject to **copayment** amounts.

Surprise bill important note:
Balance billing protections for emergency services:

- The copayment amount, coinsurance percentage and/or other cost-sharing requirement for emergency services provided by a non-participating provider or non-participating emergency facility is the same as the copayment amount, coinsurance percentage and/or other cost-sharing requirement listed in the contract for emergency services provided by a participating provider or participating emergency facility.
- Any cost-sharing payments made with respect to emergency services provided by a non-participating provider or non-participating emergency facility will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;
- If emergency services provided by a non-participating provider or non-participating emergency facility, any cost-sharing requirement will be calculated on the recognized amount;
- If emergency services provided by a non-participating provider or non-participating emergency facility, we will make payment for the covered emergency services directly to the non-participating provider or non-participating emergency facility. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for the services; and
- You will not be liable for an amount that exceeds your cost-sharing requirement.

Urgent care

Description	Select care coverage	In-network coverage	Out-of-network coverage
Urgent medical care provided by an urgent care **provider**	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	$50 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	$50 **copayment** then the plan pays 100% (of the balance of the **recognized charge**) per visit No **policy year deductible** applies
Non-urgent use of urgent care **provider**	Not covered	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.

Description	Select care coverage	In-network coverage	Out-of-network coverage
Type A services	Not available	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	80% (of the **recognized charge**) per visit
Type B services	Not available	70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Type C services	Not available	50% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Orthodontic services	Not available	50% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Dental emergency services	Not available	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), include the following:

Visits and images

- Periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry
- Periodic oral examination, per provider or location (limited to 2 per year)
- Oral exam for patients under 3 years old (limited to 2 per provider or location)
- Comprehensive oral evaluation
- Oral hygiene instructions, per provider or location (limited to 2 per year)
- Caries risk assessment, per provider or location (limited to 2 per year)
- Routine comprehensive or recall examination, per provider or location (limited to 2 visits per year)
- Problem-focused examination
- Prophylaxis (cleaning) (limited to: 2 treatments per year per person)
- Topical application of fluoride (limited to two courses of treatment per year)
- Topical application of fluoride varnish
- Sealants, per tooth (limited to one application every 36 months for permanent molars and premolars)
- Preventive resin restoration (limited to one application per tooth every 36 months for permanent molars only)
- Bitewing images, per provider or location (limited to 2 sets per year)
- Intraoral periapical images
- X-rays intraoral occlusal film
- Extraoral-first film
- Intraoral-bitewing radiographic image-image capture only

- Intraoral-occlusal radiographic image-image capture only
- Intraoral-complete series of radiographic images-image capture only (limited to 1 set every 36 months)
- Comprehensive image series, including bitewings per provider or location (limited to 1 set every 36 months)
- Panoramic radiographic image per provider or location (limited to 1 set every 36 months)
- Vertical bitewing images (limited to 2 sets per year)
- Cephalometric radiographic image
- Sialography
- Temporomandibular joint arthrogram, including injection
- Other temporomandibular joint films
- Pulp vitality tests
- Assessment of patient (limited to 2 per year)
- Home/extended care facility call, as if the visit was rendered in the Dentist's office
- Biopsy and accession of tissue examination of oral tissue
- Emergency palliative treatment, per visit
- Consultation, provided by dentist or physician other than the requesting provider

Space maintainers

- Fixed (unilateral) per quadrant No limit
- Fixed (bilateral)-upper No limit
- Fixed (bilateral)-lower No limit
- Removable (unilateral) per quadrant No limit
- Removable (bilateral)-upper No limit
- Removable (bilateral)-lower No limit
- Re-cement or re-bond bilateral space maintainer-upper
- Re-cement or re-bond bilateral space maintainer-lower
- Re-cement or re-bond unilateral space maintainer-per quadrant
- Removal of fixed unilateral space maintainer-per quadrant
- Removal of fixed bilateral space maintainer-upper
- Removal of fixed bilateral space maintainer-lower

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)

Images, pathology and prescription drugs

- Extra-oral, occlusal view, maxillary or mandibular

Oral surgery

- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants primary teeth
  - Surgical removal of erupted tooth/root tip
- Impacted teeth
  - Removal of tooth (soft tissue)
- Other surgical procedures
  - Alveoplasty, in conjunction with extractions – per quadrant
  - Alveoplasty, in conjunction with extractions – 1 to 3 teeth or tooth spaces – per quadrant
  - Alveoplasty, not in conjunction with extraction – per quadrant

- Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces – per quadrant
- Excision of hyperplastic tissue
- Removal of exostosis
- Removal of torus palatinus
- Removal of torus mandibularis
- Transplantation of tooth or tooth bud
- Closure of oral fistula of maxillary sinus
- Oroantral fistula closure
- Partial ostectomy/sequestrectomy for removal of non-vital bone
- Frenectomy
- Tooth implantation and/or stabilization
- Root amputation (resection)
- Surgical exposure of root surface for anterior tooth, premolar tooth, or molar tooth without apicoectomy or repair of root resorption
- Excision of periocoronal gingiva

Periodontics

- Periodontal scaling and root planing, 4+ teeth (limited to 4 separate quadrants per 2 years)
- Periodontal scaling and root planing – 1 to 3 teeth per quadrant (limited to 4 separate quadrants per 2 years)
- Periodontal maintenance procedures following active therapy (limited to 2 per 12 months)
- Gingivectomy or gingivoplasty, 4 or more contiguous teeth or tooth bounded spaces per quadrant (limited to 1 per quadrant every 2 years)
- Gingivectomy or gingivoplasty, 1 to 3 contiguous teeth or tooth bounded spaces per quadrant (limited to 1 per quadrant every 2 years)
- Gingival flap procedure, including root planing-for 4 or more contiguous teeth or tooth bounded spaces per quadrant (limited to 1 per quadrant every 2 years)
- Gingival flap procedure, including root planing – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant (limited to 1 per quadrants every 2 years)
- Provisional splinting
- Full mouth debridement (limited to 1 every 2 years)
- Localized delivery of antimicrobial agents
- Occlusal adjustment
- Anatomical crown exposure
- Clinical crown lengthening
- Unscheduled dressing change

Endodontics

- Pulp capping
- Pulpotomy
- Pulpal debridement
- Pulpal therapy anterior and posterior
- Endodontic Therapy
- Root canal therapy including medically necessary images
  - Anterior tooth
  - Premolar tooth
- Retreatment of previous root canal therapy
  - Anterior tooth
  - Premolar tooth
- Apexification/recalcification

- Apicoectomy
- Retrograde filling per root
- Root amputation per root
- Intentional re-implantation
- Hemisection
- Periradicular surgery without apicoectomy
- Intentional re-implantation (including necessary splinting)

Restorative dentistry

Does not include inlays, crowns (other than prefabricated stainless steel or resin) and bridges (multiple restorations in 1 surface are considered as a single restoration). Please see coverage under Type C Services for these services.

- Amalgam restorations
- Protective restoration
- Resin-based composite restorations
- 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-primary tooth
  - Prefabricated stainless steel-permanent tooth
  - Prefabricated steel with resin window
  - Prefabricated resin (excluding temporary crowns)
  - Prefabricated esthetic coated stainless steel -primary tooth
- Adjustment of maxillofacial prosthesis
- Re-cementation
  - Inlay/onlay
  - Crown
  - Fixed partial denture
- Post removal

Major restorative care (type C services), include the following:

Oral Surgery

- Impacted teeth
  - Removal of impacted tooth – partially bony impacted
  - Removal of impacted tooth – fully bony impacted
  - Removal of tooth – complication
- Vestibuloplasty
- Surgical repositioning of tooth
  - Incision and drainage of abscess
  - Removal odontogenic cyst or tumor
  - Removal of nonodontogenic cyst or tumor

Periodontics

- Osseous surgery (including flap and closure) 1 to 3 teeth contiguous teeth or tooth bounded spaces per quadrant (limited to 1 per quadrant every 24 months)
- Osseous surgery (including flap and closure) four or more contiguous teeth or tooth bounded spaces per quadrant (limited to 1 per quadrant every 24 months)
- Soft tissue graft procedures

Endodontics

- Endodontic therapy
- Root canal therapy including **medically necessary** images:
  - Molar tooth
- Retreatment of previous root canal therapy:
  - Molar tooth
- Pulp regeneration
- Gross pulp debridement

Restorative

- Labial veneers (limited to 1 per tooth per patient per 60 months)
- Inlays/onlays - metal and/or porcelain/ceramic (limited to 1 per tooth per patient per 60 months)
- Crowns:
  - Resin-based composite crown anterior
  - Resin with noble metal (limited to 1 per tooth per patient per 60 months)
  - Crown - resin with base metal (limited to 1 per tooth per patient per 60 months)
  - Crown - porcelain/ceramic (limited to 1 per tooth per patient per 60 months)
  - Crown - porcelain fused to high noble metal (limited to 1 per tooth per patient per 60 months)
  - Crown - porcelain fused to noble metal (limited to 1 per tooth per patient per 60 months)
  - Crown - porcelain fused to base metal (limited to 1 per tooth per patient per 60 months)
  - Crown - base metal (full cast) (limited to 1 per tooth per patient per 60 months)
  - Crown - high noble metal (full cast) (limited to 1 per tooth per patient per 60 months)
  - Crown - ¾ cast metallic or porcelain/ceramic (limited to 1 per tooth per patient per 60 months)
  - Crown - porcelain fused to titanium and titanium alloys (limited to 1 per tooth per patient per 60 months)
  - Crown - high noble metal (¾ cast) (limited to 1 per tooth per patient per 60 months)
  - Crown - predominantly base metal (¾ cast) (limited to 1 per tooth per patient per 60 months)
  - Crown - noble metal (¾ cast) (limited to 1 per tooth per patient per 60 months)
  - Crown - noble metal (full cast) (limited to 1 per tooth per patient per 60 months)
  - Crown - titanium (limited to 1 per tooth per patient per 60 months)
  - Labial veneer (laminate) - chair (limited to 1 per tooth per patient per 60 months)
  - Labial veneer (resin laminate) - laboratory (limited to 1 per tooth per patient per 60 months)
  - Labial veneer (porc laminate) - laboratory (limited to 1 per tooth per patient per 60 months)
- Post and core
- Core build-up (See crowns - metal and/or porcelain/ceramic crowns and crown build-ups, limited to 1 per tooth per patient per 60 months)

Prosthodontics

- 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
- 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)

- 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.)
  - Office reline
  - Laboratory reline
  - 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
- Complete upper denture/partial (limited to 1 every 5 years)
- Complete lower denture/partial (limited to 1 every 5 years)
- Immediate upper denture/partial (limited to 1 every 5 years)
- Immediate lower denture/partial (limited to 1 every 5 years)
- Overdenture
  - Complete upper
  - Complete lower
  - Partial upper
  - Partial lower
- 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)
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Maintenance and cleaning of maxillofacial prosthesis
- Occlusal guard
- Occlusal guard adjustment
- Repairs of occlusal guards
- Repairs: crowns and bridges – repairs necessitated by restorative material failure
- Adjustment to complete dentures-maxillary/mandibular (limited to adjustments made after 6 months of installation)
- Fabrication of athletic mouth guard (limited to 1 per 12 months)

General anesthesia and intravenous sedation

Only when **medically necessary** and only when provided in conjunction with a covered dental surgical procedure

- General anesthesia
- General anesthesia – each subsequent 15 minute increment
- Intravenous sedation
- Intravenous sedation –each subsequent 15 minute increment
- Non-intravenous conscious sedation
- Application of desensitizing medicament
- Nitrous oxide/analgesia

Orthodontic services, include the following

Limited to severe dysfunctional, handicapping malocclusions

- Medically necessary orthodontic treatment including retention
- Replacement of retainer
- Re-cementing/re-bonding fixed retainer, including reattachment
- Repair of orthodontic appliance
- Cephalometric radiographic image-image capture only

6. Specific conditions

Abortion care

Description	Select care coverage	In-network coverage	Out-of-network coverage
Inpatient **physician** or **specialist** surgical services	Not available	100% (of the **negotiated charge**) No **policy year deductible** applies	100% (of the **recognized charge**) No **policy year deductible** applies
Outpatient **physician** or **specialist** surgical services	Not available	100% (of the **negotiated charge**) No **policy year deductible** applies	100% (of the **recognized charge**) No **policy year deductible** applies

Birthing center (facility charges)

Description	Select care coverage	In-network coverage	Out-of-network coverage
Inpatient (**room and board** and other miscellaneous services and supplies) See *Maternity care* for home visit information	Not available	Paid at the same cost-sharing as **hospital** care.	Paid at the same cost-sharing as **hospital** care.

Diabetic services and supplies and treatment (including equipment and training)

Description	Select care coverage	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.	Covered according to the type of benefit and the place where the service is received.
Diabetes test strips	100% (of the **negotiated charge**) No **policy year deductible** applies	100% (of the **negotiated charge**) No **policy year deductible** applies	100% (of the **recognized charge**) No **policy year deductible** applies

Voluntary sterilization for males

Description	Select care coverage	In-network coverage	Out-of-network coverage
Inpatient **physician** or **specialist** surgical services	Not available	100% (of the **negotiated charge**) No **policy year deductible** applies	100% (of the **recognized charge**) No **policy year deductible** applies
Outpatient **physician** or **specialist** surgical services	Not available	100% (of the **negotiated charge**) No **policy year deductible** applies	100% (of the **recognized charge**) No **policy year deductible** applies

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

Description	Select care coverage	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.	Covered according to the type of benefit and the place where the service is received.

Impacted wisdom teeth

For persons beyond the age as covered under the *Pediatric dental care* provision

Description	Select care coverage	In-network coverage	Out-of-network coverage
Impacted wisdom teeth	100% (of the **negotiated charge**) No **policy year deductible** applies	80% (of the **negotiated charge**)	80% (of the **recognized charge**)

Accidental injury to sound natural teeth

Description	Select care coverage	In-network coverage	Out-of-network coverage
Accidental injury to **sound natural teeth**	100% (of the **negotiated charge**) No **policy year deductible** applies	80% (of the **negotiated charge**)	80% (of the **recognized charge**)

Dermatological treatment

Description	Select care coverage	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.	Covered according to the type of benefit and the place where the service is received.

Maternity care

Description	Select care coverage	In-network coverage	Out-of-network coverage
Maternity care (includes delivery and postpartum care services in a **hospital** or birthing center)	Not available	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.
Postpartum home visits See the certificate of coverage for visit limits	Not available	100% (of the **negotiated charge)** per visit No **policy year deductible** applies	100% (of the **recognized charge)** per visit No **policy year deductible** applies

Well newborn nursery care

Description	Select care coverage	In-network coverage	Out-of-network coverage
Well newborn nursery care in a **hospital** or birthing center	Not available	80% (of the **negotiated charge**) No **policy year deductible** applies	60% (of the **recognized charge**) No **policy year deductible** applies

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

Gender affirming treatment

Description	Select care coverage	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.	Covered according to the type of benefit and the place where the service is received.

Gender affirming treatment additional services

Description	Select care coverage	In-network coverage	Out-of-network coverage
Reduction thyroid chondroplasty (tracheal shave)	Not available	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.
Electrolysis, laser hair removal	Not available	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.
Voice and communication therapy, voice lessons	Not available	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.
Blepharoplasty	Not available	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.
Brow lift	Not available	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.
Cheek implants	Not available	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.
Chin implants	Not available	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	Select care coverage	In-network coverage	Out-of-network coverage
Facial bone reduction or augmentation	Not available	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.
Forehead lift	Not available	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.
Lip enhancement or reduction	Not available	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.
Rhinoplasty or nose implants	Not available	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.
Rhytidectomy (face lift, facial liposuction, neck tightening)	Not available	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.
Voice modification **surgery**, laryngoplasty	Not available	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	Select care coverage	In-network coverage	Out-of-network coverage
Autism spectrum disorder	Not available	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Applied behavior analysis	Not available	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	Select care coverage	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	Not available	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

Mental health treatment – outpatient

Description	Select care coverage	In-network coverage	Out-of-network coverage
Outpatient **mental health disorders** office visits to a **physician** or **behavioral health provider** (Includes **telehealth** consultations)	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	$25 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
Other outpatient **mental health disorders** treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive outpatient program	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Substance related disorders treatment – inpatient

Description	Select care coverage	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	Not available	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

Substance related disorders treatment – outpatient

Detoxification and rehabilitation

Description	Select care coverage	In-network coverage	Out-of-network coverage
Outpatient **substance related disorders** office visits to a **physician** or **behavioral health provider** (Includes **telehealth** consultations)	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	$25 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
Other outpatient **substance related disorder** services Partial hospitalization treatment Intensive outpatient program	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Obesity surgery

Description	Select care coverage	In-network coverage	Out-of-network coverage
Obesity **surgery** – inpatient and outpatient facility and **physician** services	Not available	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Reconstructive surgery and supplies

Description	Select care coverage	In-network coverage	Out-of-network coverage
Reconstructive **surgery** and supplies (includes reconstructive breast **surgery**)	Not available	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	Select care coverage	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	Not available	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	Not available	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Transplant services – travel and lodging

Description	Select care coverage	In-network coverage (IOE facility)	Out-of-network coverage (Includes **providers** who are otherwise part of **Aetna's** network but are non-IOE **providers**)
Transplant services – travel and lodging	Not available	Covered	Covered

Infertility Services

Basic infertility

Description	Select care coverage	In-network coverage	Out-of-network coverage
Treatment of basic **infertility**	Not available	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.

Limited infertility services

Description	Select care coverage	In-network coverage	Out-of-network coverage
Inpatient and outpatient care	Not available	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	Not available	Outpatient in-vitro services up to 3 attempts	

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Description	Select care coverage	In-network coverage	Out-of-network coverage
Diagnostic complex imaging services performed in the outpatient department of a **hospital** or other facility	100% (of the **negotiated charge**) No **policy year deductible** applies	80% (of the **negotiated charge**)	60% (of the **recognized charge**)

Diagnostic lab work and radiological services

Description	Select care coverage	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	100% (of the **negotiated charge**) No **policy year deductible** applies	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Diagnostic radiological services performed in a **physician's** office, the outpatient department of a **hospital** or other facility	100% (of the **negotiated charge**) No **policy year deductible** applies	80% (of the **negotiated charge**)	60% (of the **recognized charge**)

Surprise bill important note:

Balance billing protections for Non-emergency services performed by non-participating providers at participating facilities, including ancillary services and services for unseen urgent medical needs:
We cover items and services furnished by a non-participating provider with respect to a covered visit at a participating facility in the following manner, except when the non-participating provider has satisfied the notice and consent criteria of 45 C.F.R. §149.420 (c) through (i):

- The copayment amount, coinsurance percentage and/or other cost-sharing requirement for such items and services furnished by a non-participating provider with respect to a visit in a participating facility is the same as the copayment amount, coinsurance percentage and/or other cost-sharing requirement listed in the contract for the items and services when provided by a participating provider.
- Any cost-sharing requirements for the items and services will be calculated based on the recognized amount;
- Any cost-sharing payments made with respect to the items and services will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;
- We will make payment for the items and services directly to the non-participating provider or non-participating emergency facility. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for the services; and
- You will not be liable for an amount that exceeds your cost-sharing requirement.

The above bulleted provisions are not applicable when the non-participating provider has satisfied the notice and consent criteria of 45 C.F.R. §149.420 (c) through (i), including providing notice to you of the estimated charges for the items and services and that the provider is a non-participating provider, and obtaining

consent form you to be treated and balanced billed by the non-participating provider. The notice and consent criteria of 45 C.F.R. §149.420 (c) through (i) do not apply to non-participating providers with respect to:

- Covered services rendered by an on-call physician or a hospital based physician who has obtained assignment of benefits from you.
- Ancillary services
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-participating provider satisfied the notice and consent criteria; and such items and services furnished by non-participating providers will always be subject to the bullets listed in the first paragraph.

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 section when it is used to evaluate a breast abnormality seen or suspected from a prior screening examination or by other means of prior examination, or when it is a supplemental examination where no abnormality is seen or suspected from a prior examination and there is a personal or family history of breast cancer or additional factors that may increase your risk of breast cancer.
- Cost share will be no more than the cost share for breast cancer screening and diagnosis for diagnostic ultrasound, magnetic resonance imaging, computed tomography and image-guided biopsy for recommended follow-up diagnostic imaging to assist in the diagnosis of lung cancer when recommended by the U.S. Preventative Services Task Force.

Chemotherapy

Description	Select care coverage	In-network coverage	Out-of-network coverage
Chemotherapy	Not available	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

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

Description	Select care coverage	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	Not available	Covered according to the type of benefit and the place where the service is received.	Not covered

Outpatient infusion therapy

Description	Select care coverage	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	Not available	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	Select care coverage	In-network coverage	Out-of-network coverage
Outpatient radiation therapy	Not available	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Specialty prescription drugs

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

Description	Select care coverage	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.	Covered according to the type of benefit and the place where the service is received.

Outpatient respiratory therapy

Description	Select care coverage	In-network coverage	Out-of-network coverage
Respiratory therapy	Not available	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Transfusion or kidney dialysis of blood

Description	Select care coverage	In-network coverage	Out-of-network coverage
Transfusion or kidney dialysis of blood	Not available	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	Select care coverage	In-network coverage	Out-of-network coverage
Cardiac rehabilitation	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	$25 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies

Pulmonary rehabilitation

Description	Select care coverage	In-network coverage	Out-of-network coverage
Pulmonary rehabilitation	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	$25 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies

Rehabilitation and habilitation therapy services

Description	Select care coverage	In-network coverage	Out-of-network coverage
Outpatient physical, occupational, speech, and cognitive therapies Combined for rehabilitation services and habilitation therapy services There is no age limit except for certain habilitative services. See the Habilitation therapy services section in the certificate of coverage for details.	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	$25 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies

Chiropractic services

Description	Select care coverage	In-network coverage	Out-of-network coverage
Chiropractic services	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	$25 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies

Diagnostic testing for learning disabilities

Description	Select care coverage	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.	Covered according to the type of benefit and the place where the service is received.

8. Other services

Acupuncture

Description	Select care coverage	In-network coverage	Out-of-network coverage
Acupuncture	Not available	$25 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies

Ambulance services

Description	Select care coverage	In-network coverage	Out-of-network coverage
Emergency ground **ambulance**	100% (of the **negotiated charge**) per trip No **policy year deductible** applies	$100 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per trip No **policy year deductible** applies	Paid the same as in-network coverage
Emergency air or water **ambulance**	100% (of the **negotiated charge**) per trip No **policy year deductible** applies	$100 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per trip No **policy year deductible** applies	Paid the same as in-network coverage
Non-emergency **ambulance**	100% (of the **negotiated charge**) per trip No **policy year deductible** applies	80% (of the **negotiated charge**) per trip	60% (of the **recognized charge**) per trip

Surprise bill important note:

Balance billing for non-participating providers-air ambulance services:

When services are received from a non-participating provider of an air ambulance services:

- The copayment amount, coinsurance percentage and/or other cost-sharing requirement for the air ambulance service is the same as the copayment amount, coinsurance percentage and/or other cost-sharing requirement listed in the contract for air ambulance services when provided by a participating provider of ambulance services.
- Any cost-sharing requirement will be calculated based on the lesser of the qualifying payment amount or the billed amount for the services;
- Any cost-sharing payments made with respect to the air ambulance service will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;
- We will make payment for the air ambulance services directly to the non-participating provider of ambulance services. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for air ambulance services; and
- You will not be liable for an amount that exceeds your cost-sharing requirement.

Clinical trials

Description	Select care coverage	In-network coverage	Out-of-network coverage
Experimental or investigational therapy	Not available	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Routine patient costs	Not available	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	Select care coverage	In-network coverage	Out-of-network coverage
Durable medical equipment	100% (of the **negotiated charge**) per item No **policy year deductible** applies	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item

Professional nutritional counseling and medical nutrition therapy

Description	Select care coverage	In-network coverage	Out-of-network coverage
Professional nutritional counseling and medical nutrition therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum visits per **policy year**	Unlimited		

Enteral formulas and nutritional supplements

Description	Select care coverage	In-network coverage	Out-of-network coverage
Enteral formulas and nutritional supplements	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Orthotic devices

Description	Select care coverage	In-network coverage	Out-of-network coverage
Orthotic devices	100% (of the **negotiated charge**) per item No **policy year deductible** applies	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item

Prostheses

Description	Select care coverage	In-network coverage	Out-of-network coverage
Prostheses	100% (of the **negotiated charge**) per item No **policy year deductible** applies	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Cranial prosthetics (Medical wigs)	100% (of the **negotiated charge**) per item No **policy year deductible** applies	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item

Hearing aids

Description	Select care coverage	In-network coverage	Out-of-network coverage
Hearing aids	100% (of the **negotiated charge**) per item No **policy year deductible** applies	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Hearing aids maximum per ear	One hearing aid per hearing impaired ear every 36 month consecutive period		

Hearing exams

Description	Select care coverage	In-network coverage	Out-of-network coverage
Hearing exams	Not available	$25 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit No **policy year deductible** applies
Hearing exam maximum	Not available	1 hearing exam every **policy year**	

Podiatric (foot care) treatment

Description	Select care coverage	In-network coverage	Out-of-network coverage
Physician and **specialist** non-routine foot care treatment	Not available	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 and dilation)

Description	Select care coverage	In-network coverage	Out-of-network coverage
Performed by a legally qualified ophthalmologist or optometrist	Not available	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit
Maximum visits per **policy year**	Not available	1 visit	

Low vision services

Description	Select care coverage	In-network coverage	Out-of-network coverage
Performed by a legally qualified ophthalmologist or optometrist	Not available	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit
Maximum	Not available	One comprehensive low vision evaluation every 5 years and 4 follow-up visits in any 5 year period	

Pediatric vision care services and supplies

Description	Select care coverage	In-network coverage	Out-of-network coverage
Office visit for fitting of contact lenses	Not available	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	80% (of the **recognized charge**) per visit
Maximum contact lens fitting visits per **policy year**	Not available	1 visit	

Description	Select care coverage	In-network coverage	Out-of-network coverage
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	Not available	100% (of the **negotiated charge**) per item No **policy year deductible** applies	80% (of the **recognized charge**) per item
Maximum number of eyeglass frames per **policy year**	Not available	One set of eyeglass frames	
Maximum number of **prescription** lenses per **policy year**	Not available	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**)	Not available	Daily disposable: up to 12 month supply Extended wear disposable: up to 12 month supply Non-disposable: one set	
Low vision prescribed optical devices	Not available	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**	Not available	One optical device	

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

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

9. Outpatient prescription drugs

Plan features

Outpatient **prescription drug** benefits are subject to the medical plan's **policy year deductibles** and **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 **copayment** will not apply to risk reducing breast cancer **prescription drugs** filled at a **retail** or **mail order select care**, **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

Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, see the *How to contact us for help* section.

Policy year deductible and copayment waiver for contraceptives

The **policy year deductible** and the **copayment** will not apply to female contraceptive methods when obtained at a **select care pharmacy**, **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 therapeutically equivalent **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 **copayment** continue to apply to **prescription drugs** that have a generic equivalent, biosimilar or generic alternative available within the same **therapeutic drug class** obtained at a **select care pharmacy** or **in-network pharmacy** unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

We cover a 12-month supply of **prescription** contraceptives for a single dispensing.

Important note:
Review the *How to access out-of-network pharmacies* section of the certificate of coverage for more information on how these **pharmacies** are subject to higher out-of-pocket costs.

Preferred generic prescription drugs (including specialty drugs)

Description	Select care coverage	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	100% (of the **negotiated charge**) No **policy year deductible** applies	$20 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$20 **copayment** per supply then the plan pays 100% (of the balance of the **recognized charge**) No **policy year deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail or mail order pharmacy**	100% (of the **negotiated charge**) No **policy year deductible** applies	$50 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$50 **copayment** per supply then the plan pays 100% (of the balance of the **recognized charge**) No **policy year deductible** applies

Non-preferred generic prescription drugs (including specialty drugs)

Description	Select care coverage	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	100% (of the **negotiated charge**) No **policy year deductible** applies	$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 100% (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 **retail** or **mail order pharmacy**	100% (of the **negotiated charge**) No **policy year deductible** applies	$150 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$150 **copayment** per supply then the plan pays 100% (of the balance of the **recognized charge**) No **policy year deductible** applies

Preferred brand-name prescription drugs (including specialty drugs)

Description	Select care coverage	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	100% (of the **negotiated charge**) No **policy year deductible** applies	$40 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$40 **copayment** per supply then the plan pays 100% (of the balance of the **recognized charge**) No **policy year deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail** or **mail order pharmacy**	100% (of the **negotiated charge**) No **policy year deductible** applies	$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 100% (of the balance of the **recognized charge**) No **policy year deductible** applies

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

Description	Select care coverage	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	100% (of the **negotiated charge**) No **policy year deductible** applies	$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 100% (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 **retail** or **mail order pharmacy**	100% (of the **negotiated charge**) No **policy year deductible** applies	$150 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$150 **copayment** per supply then the plan pays 100% (of the balance of the **recognized charge**) No **policy year deductible** applies

Diabetic supplies, drugs and insulin

Description	Select care coverage	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
More than a 30 day supply but less than a 91 day supply filled at a **retail** or **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	Paid according to the type of drug per the schedule of benefits, above

Diabetic supplies, drugs, and insulin important note:
Your cost share per 30 day supply of a covered diabetic **prescription** filled at a **select care** or **in-network pharmacy** will not exceed:

- $25 for preferred **prescription** insulin

No **policy year deductible** applies for preferred insulin.

Prescription drugs to treat diabetes, HIV, or AIDS

Description	Select care coverage	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	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	Paid according to the type of drug per the schedule of benefits above

Important note:
The **copayment** or **coinsurance** for a covered **prescription drug** to treat diabetes, HIV, or AIDS will not exceed $150 for a 30 day supply.

Anti-cancer drugs taken by mouth

Description	Select care coverage	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 **negotiated charge**) No **policy year deductible** applies	100% (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 **specialty pharmacy** or a **retail pharmacy**	100% (of the **negotiated charge**) No **policy year deductible** applies	100% (of the **negotiated charge**) No **policy year deductible** applies	100% (of the **recognized charge**) No **policy year deductible** applies

Contraceptives (birth control)

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

Description	Select care coverage	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**	100% (of the **negotiated charge**) No **policy year deductible** applies	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**	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	Paid according to the type of drug per the schedule of benefits, above

Preventive care drugs and supplements

Description	Select care coverage	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	100% (of the **negotiated charge**) per **prescription** or refill No **copayment** or **policy year deductible** applies	100% (of the **recognized charge**) per **prescription** or refill No **copayment** or **policy year deductible** applies
Preventive care drugs and supplements maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.		

Risk reducing breast cancer prescription drugs

Description	Select care coverage	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	100% (of the **negotiated charge**) per **prescription** or refill No **copayment** or **policy year deductible** applies	100% (of the **recognized charge**) per **prescription** or refill No **copayment** or **policy year deductible** applies
Risk reducing breast cancer **prescription drugs** maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered risk reducing breast cancer **prescription drugs**, contact Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.		

Tobacco cessation prescription and over-the-counter drugs

Description	Select care coverage	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	100% (of the **negotiated charge**) per **prescription** or refill No **copayment** or **policy year deductible** applies	100% (of the **recognized charge**) per prescription or refill No **policy year deductible** applies
Tobacco cessation **prescription drugs** and OTC drugs maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.		

Outpatient prescription drugs important note:

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

General coverage provisions

This section provides detailed explanations about these features:

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

Policy year deductible provisions

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

The **select care**, 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 incur 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 incur 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** incur for **select care**, 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** incur for **eligible health services** reaches this family **policy year deductible**, this plan will begin to pay for **eligible health services** 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 costs** 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

Select care coverage and In-network coverage

This is a specified dollar amount or percentage that must be paid by you when you receive **eligible health services** from a **select care provider** or **in-network provider**. If **Aetna** compensates **select care providers** and **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 **select care** and in-network **maximum out-of-pocket limit**. **Eligible health services** applied to the **select care** and 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

Select care and In-network care

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

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

- All costs for non-covered services

Out-of-network care

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

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

- Charges, expenses or costs in excess of the **recognized charge**
- All costs for non-covered services
- **Precertification** penalties because you did not get a service or supply **precertified**

Calculations; determination of recognized charge; determination of benefits provisions

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

Student Health Insurance

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

Certificate of Coverage

Prepared exclusively for:

Policyholder:	University of Maryland College Park
Policyholder number:	252649
Student policy effective date:	08/01/25
Plan effective date:	08/01/25
Plan issue date:	10/17/25

Underwritten by Aetna Life Insurance Company
151 Farmington Ave, Hartford, CT 06156

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

Welcome

Thank you for choosing **Aetna®**.

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

This certificate of coverage will tell you about your **covered 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* section.
- They are not carved out in the *What your plan doesn't cover – general exclusions* section.
- They are not beyond any limits in the schedule of benefits.

Paying for eligible health services– the general requirements

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

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

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

Paying for eligible health services– sharing the expense

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

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

Disagreements

We know that people sometimes see things differently.

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

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

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

Your **select care** and in-network coverage helps you:

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

Generally your **select care** coverage will pay only when you get care from a **select care 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 **select care** or **in-network providers** for **eligible health services**. Your plan often will pay a bigger share for **eligible health services** that you get through **school health services**.

For more information about **select care** and **in-network providers** and the role of **school health services**, see the *Who provides the care* section.

Select care providers

Select care providers are identified by the **policyholder** for your plan.
School health services is a **select care provider** for your plan.

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.

You do not need **precertification** to get a service or supply from an **out-of-network provider** for **emergency services** and emergency ambulance services. **Eligible health services** that you get from an **out-of-network provider** for these services and supplies are paid at the **select care** and 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 **select care** and in-network coverage. You also have coverage when:

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

You will find details on:

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

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 in a notice and obtained consent (notice and consent criteria enumerated in 45 CFR §149.420(c) through (i)) from you to be treated and balanced bulled by the **out-of-network provider**:
  - The estimated charges for the items and services
  - The **provider** is an **out-of-network provider**
- Out-of-network air ambulance services

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. Please see the Schedule of benefits for more information on cost shares.

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.

Surprise bill Important note-Glossary:
The following definitions meet all Maryland requirements and pertain to the Surprise bill section only.

Air ambulance: transportation by a fixed wing aircraft certified as a fixed wing ambulance or a rotary wing (helicopter) certified as a rotary wing ambulance and such services and supplies may be **medically necessary**.

Ancillary services:

- Items and services furnished by a non-participating provider in a participating facility related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- Items or services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Items and services provided by a non-participating provider if there is no participating provider who can furnish such items or services at such facility

Authorized representative: an individual authorized under State law to provide consent on behalf of a patient, provided that the individual is not a provider affiliated with the facility or employee of the facility, unless such provider or employee is a family member of the patient.
Continuing care patient: an individual who, with respect to a provider or facility:

- Is undergoing a course of treatment for serious and complex condition from the provider or facility
- Is undergoing a course of institutional or inpatient care from the provider or facility
- Is scheduled to undergo non-elective **surgery** from the provider, including receipt of postoperative care from such provider or facility with respect to such **surgery**;
- Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility
- Is or was determined to be terminally ill and has a medical prognosis of a life expectancy of 6 months or less and is receiving treatment for such **illness** from such provider or facility.

Emergency facility: an emergency department of a **hospital**, or an independent freestanding emergency department where **emergency services** are provided. "Emergency facility" includes a **hospital**, regardless of the department of the **hospital**, in which items or services with respect to **emergency services** are provided by a non-participating provider or non-participating emergency facility; after the individual is stabilized; and as

part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which other **emergency services** are furnished.
Independent freestanding emergency department: a health facility that is geographically separate and distinct and licensed separately from a **hospital** under applicable State law; and provides any **emergency services**.

Non-participating emergency facility: an emergency facility that has not contracted directly with us or indirectly, such as through an entity contracting on behalf of us to provide health care services to our enrollees.

Non-participating provider: a physician or other health care provider that has not contracted directly with us or an entity contracting on behalf of us to provide health care services to our enrollees.

Other health care provider: any person who is licensed or certified under applicable State law to provide health care services and is acting within the scope of practice of the provider's license or certification, but does not include a provider of air ambulance services.

Out-of-network rate: with respect to an item or service furnished by a non-participating provider, non-participating emergency facility, or non-participating provider of air ambulance services:

- In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the plan/carrier, non-participating provider/ non-participating emergency facility, and item/service, the amount that the State approves under the All-Payer Model Agreement for the item or service. For certain items or services billed by Maryland hospitals, this is the amount for the item or service approved by the Health Services Cost Review Commission (HSCRC).
- If there is no such All-Payer Model Agreement applicable to the item or service, but a specified State law is in effect and applicable, the amount for the item or service determined in accordance with such specified State law. Under specified Maryland law, for an on-call physician or a **hospital** based physician who has obtained an assignment of benefits from the enrollee, this is the amount required by §14-205.2 of the Insurance Article.
- If there is no such All-Payer Model Agreement or specified State law applicable to the item or service, an amount agreed upon by us and the non-participating provider or non-participating emergency facility.
- If none of the three conditions above apply, an amount determined by a certified independent dispute resolution (IDR) entity under the IDR process described in section 2799A-1(c) or 2799A-2(b) of the federal Public Health Service Act, as applicable.

Participating emergency facility: an emergency facility that has contracted directly with us or an entity contracting on behalf of us to provide health care services to our enrollees. A single case agreement between an emergency facility and us that is used to address unique situations in which an enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating facility: a health care facility that has contracted directly with us or an entity contracting on behalf of us to provide health care services to our enrollees. A single case agreement between a health care facility and us that is used to address unique situations in which an enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Additionally, for purposes of this definition and in the context of non-**emergency services**, "health care facility" is limited to a **hospital** (as defined in section 1861(e) of the Social Security Act); a **hospital** outpatient department; a critical access **hospital** (as defined in section 1861(mm)(1) of the Social Security Act); and an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Participating provider: a physician or other health care provider that has contracted directly with us or an entity contracting on behalf of us to provide health care services to our enrollees.

Qualifying payment amount: the amount calculated using the methodology described in 45 C.F.R. §149.140(c), which is based on the median contracted rate for all plans offered by the carrier in the same insurance market for the same or similar item or services that is: provided by a provider in the same or similar specialty or facility of the same or similar facility type; and provided in the geographic region in which the item or service is furnished. The median contracted rate is subject to additional adjustments specified in federal regulations.

Recognized amount: an amount for an item or service furnished by a non-participating provider or non-participating emergency facility, determined as follows:

- In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the plan/carrier, non-participating provider/ non-participating emergency facility, and item/service, the amount that the State approves under the All-Payer Model Agreement for the item or service. For certain items or services billed by Maryland hospitals, this is the amount for the item or service approved by the Health Services Cost Review Commission (HSCRC).
- If there is no such All-Payer Model Agreement applicable to the item or service, in a state that has in effect a specified State law, the amount for the item or service determined in accordance with such specified State law. Under specified Maryland law, for an on-call physician or a **hospital** based physician who has obtained an assignment of benefits from the enrollee, this is the amount required by §14-205.2 of the Insurance Article.
- If neither an All-Payer Model Agreement or a specified State law apply to the item or service, the lesser of: the amount billed by the non-participating provider or non-participating emergency facility, or the qualifying payment amount.

Serious or complex condition: for an acute **illness**, or condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or in the case of a chronic **illness** or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

To Stabilize: for an **emergency medical condition**, means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Treating provider: a physician or other health care provider who has evaluated the individual.

Visit: the instance of going to or staying at a health care facility, and, with respect to items and services furnished to an individual at a health care facility, includes, in addition to items and services furnished by a provider at the facility, equipment and devices, **telehealth** services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.

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 1-800-878-1938
- 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 Domestic Undergraduate students enrolled in six (6) or more credit hours and all International Undergraduate students enrolled at UMD are required to purchase this plan, unless proof of comparable coverage is provided.
- All students enrolled full-time in a master's or doctoral program at the University of Maryland, College Park campus must have health insurance coverage. Full-time students are those who are enrolled for at least 48 units for the semester or 36 units for a 12-week term. Full-time graduate students will be automatically enrolled in the Student Health Insurance Annual Plan, unless proof of comparable coverage is provided in a waiver request.
- Part-time students, non-degree-seeking students and students enrolled in certificate programs, exclusively online programs, and/or programs at the Shady Grove campus are encouraged, but not required, to have health insurance, unless the student's immigration status requires insurance.

Medicare eligibility

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

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

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

When you can join the plan

As a student you can enroll yourself and your dependents:

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

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

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

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

- Your legal spouse that resides with you
- Your domestic partner who meets the 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 child for whom guardianship is granted by court or testamentary appointment, other than a temporary guardianship of less than 12 months
    - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
    - Grandchildren in your court-ordered custody

A dependent does not include:

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

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

Adding new dependents

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

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

- Birth
- Adoption or placement for adoption
- Marriage
- Domestic partnership
- Legal guardianship
- Court or administrative order
- Upon the death of a spouse, a dependent child previously covered by the spouse's plan

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

Newborn child, including a grandchild in court ordered custody

- Your newborn child is covered on your health plan from the moment of birth.
- If coverage requires the payment of an additional **premium** for a dependent, to keep your newborn covered under your plan we must receive your completed enrollment information within the 31 day period.
- 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, including an adopted grandchild
A child that you, or you and your spouse, or domestic partner adopt, or that is placed with you for adoption is covered on your plan starting on the date of the adoption or the date the placement is complete, whichever is earlier.

- If coverage requires the payment of an additional premium for a dependent, to keep your adopted child or child legally placed with you for adoption covered under your plan we must receive your completed enrollment information within the 31 day period.
- If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
- If your coverage ends during this 31 day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31 day period has not ended.

A child under guardianship
A child for whom guardianship is granted by court or testamentary appointment, other than a temporary guardianship of less than 12 months, is covered from the date of appointment.

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

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

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

Notification of change in status

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

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

Special times you and your dependents can join the plan

You can enroll in these situations:

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

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

Effective date of coverage

Enrollment

Student coverage

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

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

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

Dependent coverage

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

Late enrollment

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

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

Medical necessity and precertification requirements

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 *What your plan doesn't cover - general exclusions* sections plus the schedule of benefits.

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

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

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

Medically necessary; medical necessity

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

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

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

Precertification

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

Precertification for medical services and supplies

Select care and In-network care

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

Out-of-network care

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

Also, for any **precertification** benefit penalty that is applied, see the schedule of benefits *Precertification covered benefit penalty* section.

Precertification call

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

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

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

Written notification of precertification decisions

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

Inpatient and outpatient precertification

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

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

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

What if you don't obtain the required precertification?

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

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

What types of services and supplies require precertification?
Precertification is required for inpatient **stays** and certain outpatient services and supplies.

Your **select care provider** or in-network **physician** should contact us for a list of **select care** and in-network services that require **precertification**.

Precertification is required for the following out of network services and supplies:

Inpatient –

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

Outpatient –

- Complex imaging
- **Cosmetic** and reconstructive **surgery**
- 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)
- Limited infertility services
- Non-emergency transportation by airplane
- Obesity (bariatric) **surgery**
- Outpatient back **surgery** not performed in a **physician's** office
- Private duty nursing services
- Sleep studies
- Wrist **surgery**]

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

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

For certain drugs covered under your medical plan or **prescription drug** plan, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**.

We will honor a prior authorization for the prescription drug and you will not need to obtain a new certification for a prescription drug if:

- You change Aetna plans and the prescription drug is also covered under the new plan
- The dosage on the approved drug changes and the changes are consistent with the FDA labeled dosages

We will not issue an adverse decision on a reauthorization for the same prescription drug or request additional documentation from the prescriber for the reauthorization request if:

- The prescription drug is an immune globulin (human) as defined in 21 C.F.R. §640.100 or used for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical manual of Mental Disorders published by the American Psychiatric Association
- We previously approved a prior authorization for your prescription drug
- You have been treated with the prescription drug without interruption since the initial approval of the prior authorization and
- Your prescriber attests, based on the prescriber's professional judgement, the prescription drug continues to be necessary to effectively treat your condition

If the prescription drug being requested has been removed from the formulary or has been moved to a higher deductible, copayment, or coinsurance tier, we will provide you and your health care provider the following:

- Notice of the change at least 60 days before the change is implemented
  - The notice will include the process for requesting a medical exception. (Please see the *Requesting a medical exception* section for more information)

We shall approve a request for the prior authorization of a course of treatment, including for chronic conditions, rehabilitative services, substance use disorders, and mental health conditions, that is:

- For a period of time that is as long as necessary to avoid disruptions in care and
- Determined in accordance with applicable coverage criteria, your medical history, and the health care provider's recommendation

When you are a new member, we will not disrupt or require reauthorization for an active course of treatment for covered services for at least 90 days after the date of enrollment.

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

We will waive **step therapy** if any of the following conditions is met:

- The prerequisite drug is not approved by the FDA for your medical condition
- Your **provider** provides supporting medical information showing that a covered **prescription** drug
  - Was ordered for you within the past 180 days, and
  - In their professional judgement, was effective in treating your disease or condition
- A **prescription** drug approved by the FDA if:
  - The drug is used to treat your stage four advanced metastatic cancer; and
  - Use of the drug is:
    - Consistent with the FDA approved indication or The National Comprehensive Cancer Network Drugs & Biologics Compendium Indication for the treatment of your cancer, and
    - Supported by peer-reviewed medical literature

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

Requesting a medical exception
Sometimes you, someone who represents you or your **provider** may ask for a medical exception to get health care services for **prescription drugs** that are not covered under this plan or may seek to continue the same cost share when a **prescription drug** or device is moved to a higher cost share tier.

If we remove a drug from the **preferred drug guide** or move a drug or device to a higher cost share tier, we will give you and your **provider** 30 days advance notice with the information on how to request a medical exception.

You or your **provider** can contact us. You will need to provide us with the required clinical documentation. We will make a coverage determination within 72 hours after we receive your request and any information. We will tell you and your **provider** of our decision. Any exception granted is based upon an individual, case by case decision, and will not apply to other **covered persons**. If approved by us, you will receive the non-preferred benefit level and the exception will apply for the entire time of the **prescription**.

For directions on how you can submit a request for a review:

- Contact Member Services at the toll-free number 1-800-878-1938
- 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 process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-covered drug. If approved by us, the exception will apply for the entire time you have an urgent situation.

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

We will cover a **prescription drug** or device not listed in the formulary, or cover it at the same cost share when it is moved to a higher cost share tier, if your **provider** determines:

- There is no equivalent **prescription drug** or device in the formulary in a lower tier;
- An equivalent **prescription drug** or device in the formulary in a lower tier:
- Has been ineffective in treating your disease or condition; or
- Has caused or is likely to cause an adverse reaction or other harm to you; or

For a contraceptive **prescription drug** or device, the **prescription drug** or device not on the formulary is **medically necessary** for you to adhere to the appropriate use of the **prescription drug** or device.

Eligible health services

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 the *What your plan doesn't cover - General exclusions* section.
- Not beyond any limitations in the schedule of benefits.
- Not prohibited by law.

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.
- **Skilled nursing facility** is generally covered but may only be covered up to a set number of visits per year. This is a limitation.
- Your **provider** may recommend services that are considered **experimental, investigational, or unproven** services. But an **experimental, investigational, or unproven** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of **eligible health services** below.

We explain **eligible health services** in this section. You can find out about general exclusions in the *What your plan doesn't cover - 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

Eligible health services for preventive care and wellness include all 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 or as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

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

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

You are encouraged to do a health risk assessment. Aetna will then give feedback and helpful examples to improve on any risks found.

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.

Your plan does not cover immunizations that are not considered to be 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**, or **provider** specializing in OB/GYN care. This includes Pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.

Preventive screening and counseling services

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

  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 using the latest screening guidelines issued by the American Cancer Society for breast cancer screening
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies (includes:
  - Bowel preparation medications
  - Anesthesia
  - Removal of polyps performed during a screening procedure
  - Pathology exam on any removed polyps)
- Lung cancer screenings, including diagnostic imaging (diagnostic ultrasound, magnetic resonance imaging, computed tomography, and image-guided biopsy) to assist in the diagnosis of lung cancer

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

Routine prostate cancer screenings

Eligible health services include the following:

- Prostate specific antigen (PSA) tests
- Digital rectal exams

Eligible health services also include medically recognized diagnostic examination when:

- The covered member is between 40 and 75 years of age
- Used for guiding Patient management in monitoring the response to prostate cancer treatment
- Used for staging in determining the need for a bone scan for patients with prostate cancer
- The covered member is at high risk for prostate cancer

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**, or **provider** specializing in OB/GYN Care.

Important note:
You should review the benefit under *Eligible health services – 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 – female 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 will 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*

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 **telehealth**

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

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

Important note:
You will have 0 cost share (no **deductible**, **copayment** or **coinsurance**) for diagnostic breast exams when it is used to evaluate a breast abnormality seen or suspected from a prior screening examination or by other means of prior examination**,** or when it is a supplemental breast examination where no abnormality is seen or suspected from a prior examination and there is a personal or family history of breast cancer or additional factors that may increase your risk of breast cancer.

Allergy testing and treatment

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

- Allergy testing
- Allergy injections treatment
- Allergy sera and extracts administered via injection

Physician and specialist – inpatient surgical services

Eligible health services include the services of:

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

When your **surgery** requires 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**.

Physician and specialist – outpatient surgical services

Eligible health services include the services of:

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

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

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

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

In-hospital non-surgical physician services

During your **stay** in a **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 **telehealth.**

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

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

Second surgical opinion

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

Covered benefits include diagnostic lab work and radiological services ordered by the **specialist**.
We must receive a written report from a **specialist** on the second surgical opinion.

Alternatives to physician and specialist office visits

Walk-in clinic (non-emergency visit)

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

- Scheduled and unscheduled visits for **illnesses** and **injuries** that are not **emergency medical conditions**
- Preventive care immunizations administered within the scope of the clinic's license

3. Hospital and other facility care

Hospital care (facility charges)

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

- Semi-private **room and board**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge.
- Services of **physicians** employed by the **hospital**.
- Administration of blood and blood products, including all expenses for blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin.
- For mastectomy (surgical removal of all or part of a breast) or testicle removal:
  - No less than 48 hours of inpatient care in a **hospital** and a home visit after discharge if prescribed by the attending **physician**
  - If discharged early:
    - One home visit within 24 hours after discharge
    - Another home visit if prescribed by your attending **physician**

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 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.

The following conditions must be met:

- You are a child age 7 or under, or
- You are developmentally disabled, and
  - A successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition, and
  - A superior result can be expected from dental care provider under general anesthesia; or
- You are 17 or younger; and
  - Are extremely uncooperative, fearful, or uncommunicative; and
  - Delayed treatment will result in oral pain or put your dental/oral health at risk determined by your **dental provider**

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.

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

Home health care

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

- You are **homebound**
- Your **physician** orders them
- The services take the place of your needing to **stay** in a **hospital** or a **skilled nursing facility**, or needing to receive the same services outside your home
- The services are part of a **home health care plan**
- The services are **skilled nursing services**, **home health aide** services or medical social services, or are 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 R*ehabilitation services and Habilitation therapy service*s sections and the schedule of benefits.

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

Hospice care

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

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

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a **hospice care agency** or **hospice care** provided in a **hospital**
- Medical social services under the direction of a **physician** such as:
  - Assessment of your social, emotional and medical needs, and your home and family situation
  - Identification of available community resources
  - Assistance provided to you to obtain resources to meet your assessed needs
- Bereavement counseling
- **Respite care**

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

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

Outpatient private duty nursing

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

Skilled nursing facility

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**

Patient centered medical homes

Eligible health services include services through patient centered medical homes if you have a chronic condition, serious **illness** or complex health care need. For services, you will need to agree to participate in a patient centered medical home program. Coordination of care services are included in this benefit. These services include:

- Liaison services between you and the **health professional**, nurse coordinator, and case coordination team
- Creation and supervision for your care plan
- Education for you and your family about your **illness**, treatment, and self-care techniques
- Help with coordinating your care. This includes arranging for you to consult with a **specialist**, getting needed services and supplies, and help with accessing community resources

Case Management Program

Covered services include any other services approved by Aetna's case management program.

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

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

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

- You are evaluated and your condition is stabilized, regardless of the department of hospital in which the further medical examination and treatment is furnished:
  - To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer from a facility
- For a pregnancy, the woman has delivered (including the placenta)
- 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 to an available participating **provider** or facility located within a reasonable travel distance
- You have received notice and provided informed consent to continue receiving services and items from a non-participating provider. Please refer to the *Emergency services* definition under the *Glossary* section for more information on the notice and informed consent.

For follow-up care, you are covered when:

- Your **select care provider** or 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 or independent freestanding emergency department. 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.

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**

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.

Dental emergencies

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

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

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

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

Orthodontic treatment

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

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

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

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

Replacements

The plan's "replacement rule" applies to:

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

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

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

Missing teeth that are not replaced

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

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

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

Getting an advance claim review

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

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

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

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

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

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

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

6. Specific conditions

Abortion Care

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

Birthing center (facility charges)

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

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

Refer to the *Eligible health services – Maternity care* and *Well newborn nursery care* sections for more information.

Diabetic services and supplies and treatment (including equipment and training)

Eligible health services include the treatment of diabetes including but not limited to:

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

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

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

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

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**.

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**.

Dermatological treatment

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

Maternity care

Eligible health services include birthing classes (limited to one course per pregnancy), prenatal (non-preventive care), delivery, postpartum care, and other obstetrical services, and postnatal visits. Coverage includes **eligible health services** provided by a licensed mid-wife.

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

- 48 hours of inpatient care in a **hospital** or birthing center after an uncomplicated vaginal delivery
- 96 hours of inpatient care in a **hospital** or birthing center after an uncomplicated cesarean delivery
- A shorter **stay** if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier. If so, your plan covers a home visit, within 24 hours of discharge. The attending **physician** can prescribe an additional home visit
- The mother could be discharged earlier. If so, the plan will pay for 2 post-delivery home visits by a health care **provider**
- A longer **stay**, if the mother needs to stay longer. If so, she can request for the newborn to stay at the **hospital** with her for up to 4 days. We will cover the cost of the newborn **hospital stay** even when dependents are not covered under the plan.

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 an uncomplicated vaginal delivery or 96 hours for an uncomplicated cesarean delivery
- A longer **stay**, if the mother needs to stay longer. If so, she can request for the newborn to stay at the **hospital** with her for up to 4 days.
- **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.

Your plan also includes coverage for additional services in connection with gender dysphoria. These **eligible health services** are:

- The surgical procedure
- **Physician** pre-operative and post-operative **hospital** and office visits
- Inpatient and outpatient services (including outpatient **surgery**)
- **Skilled nursing facility** care
- Administration of anesthetics
- Outpatient diagnostic testing, lab work and radiological services
- The cost of collection, processing and storage of self-donated blood after the **surgery** has been scheduled
- Gender affirming counseling by a **behavioral health provider**
- Injectable and non-injectable hormone replacement therapy
- Reduction thyroid chondroplasty (tracheal shave)
- Hair removal other than for skin used for genital **surgery** (e.g., electrolysis, laser hair removal)
- Voice and communication therapy, voice lessons
- Blepharoplasty (**surgery** of the eyelid and eye region)
- Brow lift
- Cheek implants
- Chin implants
- Facial bone reduction or augmentation
- Forehead lift
- Lip enhancement or reduction
- Rhinoplasty or nose implants
- Rhytidectomy (face lift, facial liposuction, neck tightening)
- Voice modification **surgery**, laryngoplasty

Autism spectrum disorder

Autism Spectrum Disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

Eligible health services include the services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis, testing and treatment of autism spectrum disorders. We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan.

We will cover certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior
- That are responsible for observable improvements in behavior

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:

- **Emergency services** and supplies
- **Inpatient room and board** at the **semi-private room rate** or intensive care accommodations as needed (a private room is only covered if **medically necessary**), general nursing care, meals, and special diets and other services and supplies related to your condition that are provided during your **stay** in a **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:
  - Professional services by a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed, registered or certified professional counselor (includes **telehealth** consultations) or marriage and family therapists to diagnose and treat psychiatric conditions, mental illness, or mental disorders. These services include:
    - Diagnostic evaluation
    - Crisis intervention and stabilization for acute episodes
    - Medication evaluation and management (pharmacotherapy)
    - Treatment and counseling (including individual or group therapy visits)
  - Intensive outpatient treatment in an office or other professional setting
  - 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.** Treatment is not limited to those performed in an outpatient **hospital** setting
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician.** Treatment is not limited to those performed in an outpatient **hospital** setting
    - **Hospital** emergency room services and supplies
    - 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)
    - Inpatient professional fees
    - Outpatient diagnostic tests provided and billed by a behavioral health provider
    - Outpatient diagnostic tests provided and billed by an appropriately licensed, certified or registered laboratory, hospital or other covered facility
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing and neuropsychological testing necessary to determine the appropriate psychiatric treatment
    - Observation
    - Peer counseling support by a peer support specialist (including **telehealth** consultation)

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** or intensive care accommodations as needed (a private room is only covered if **medically necessary**), general nursing care, meals and special diets and other services and supplies that are provided during your **stay** in a **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:
  - Professional services by a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed, registered or certified professional counselor (includes **telehealth** consultations), or marriage and family therapists to diagnose and treat **substance related disorders**. These services include:
    - Diagnostic evaluation
    - Crisis intervention and stabilization for acute episodes
    - Medication evaluation and management (pharmacotherapy)
    - Treatment and counseling (including individual and group therapy visits)
    - Intensive outpatient treatment in an office or other professional setting
  - Other outpatient **substance related disorders** treatment such as:
    - Diagnosis and treatment of alcoholism and drug abuse, including **detoxification**, treatment and counseling
    - Partial hospitalization treatment provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**. Treatment is not limited to those performed in an outpatient **hospital** setting
    - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**. Treatment is not limited to those performed in an outpatient **hospital** setting
    - **Hospital** emergency room services and supplies
    - Ambulatory **detoxification** which are outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are **homebound**
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness**, or disease
    - Ambulatory **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Electroconvulsive therapy
    - Inpatient professional fees
    - Outpatient diagnostic tests provided and billed by a behavioral health provider
    - Outpatient diagnostic tests provided and billed by an appropriately licensed, certified or registered laboratory, **hospital** or other covered facility
    - Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment
    - Observation
    - Peer counseling support by a peer support specialist (including **telehealth** consultation)

Telehealth important note:
Your **student policy** covers **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 **telehealth** provided by a **physician** or **behavioral health provider** instead.

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

Obesity surgery and services

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

Eligible health services include:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient **prescription** drugs included under the *Outpatient prescription drugs* section
- An obesity **surgical procedure**
- A multi-stage procedure when planned and approved by us
- Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

Morbid obesity means a body mass index that is:

- Greater than 40 kilograms per meter squared; or
- Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including:
  - Hypertension
  - A cardiopulmonary condition
  - Sleep apnea
  - Diabetes

Body mass index means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

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, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast.
- Treatment of the physical complications of all stages of the mastectomy, including lymphedema and prostheses in a manner decided in consultation by the attending **physician** and patient.
- Your **surgery** is to implant or attach a covered prostheses.
- Your **surgery** corrects a congenital or genetic birth 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.

Transplant services

Eligible health services include transplant services provided by a **physician** and **hospital**. Both autologous and non-autologous transplants are **covered benefits**.

This includes the following transplant types:

- Solid organ, including:
  - Kidney
  - Liver
  - Heart
  - Lung
  - Heart/lung
  - Pancreas
- Pancreas/kidney
- Hematopoietic stem cell
- Bone marrow
- Non-solid organs
- CAR-T and T Cell receptor therapy for FDA-approved treatments
- Thymus tissue for FDA-approved treatments

Network of transplant facilities

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

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

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

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

Travel and lodging expenses

Eligible health services include travel and lodging expenses for the patient and a companion (or two companions if the patient is under 18 years of age) to travel between the patient's home and the transplant facility. **Eligible health services** include coach class round-trip air, train, or bus travel and lodging costs.

Other transplants
Eligible health services include corneal (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants. Corneal and cartilage transplants are not available at **IOE facilities**.

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.**

Limited infertility services

Eligible health services include the following infertility services provided by an infertility **specialist**:

- Ovulation induction cycle(s) using medication to stimulate the ovaries. This may include the use of ultrasound and lab tests.
- Artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination.
- **Prescription drugs** injected by your **provider** to stimulate the ovaries.
- Infertility **eligible health services** may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your plan. For plans with cycle limits, a "cycle" is defined as:
- An attempt at ovulation induction while on medication to stimulate the ovaries with or without artificial insemination
- An artificial insemination cycle with or without medication to stimulate the ovaries

Aetna's National Infertility Unit
Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with determining eligibility for benefits and **precertification**. You can call the NIU at 1-800-575-5999.

If your **provider** is not an **in-network provider**, you are responsible to request approval from us in advance.

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
- Other outpatient diagnostic imaging service

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 a disease or condition that is supported by medical and scientific evidence, including testing:

- Cleared or approved by the U.S. Food and Drug Administration
- Required or recommended for a drug approved by the U.S. Food and Drug Administration to ensure a covered person is a good candidate for the drug treatment
- Required or recommended through a warning or precaution for a drug approved by the U.S. Food and Drug Administration to identify whether a covered person will have an adverse reaction to the drug treatment or dosage
- Covered under a Centers for Medicare and Medicaid services national coverage determination or Medicare Administrative Contractor Local Coverage Determination
- Supported by nationally recognized clinical practice guidelines that are:
  - Developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and that have a conflict of interest policy
  - Established standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize a covered person's care

Eligible health services are provided in a manner that limits disruption in care, including the need for multiple 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* section when it is used to evaluate a breast abnormality seen or suspected from a prior screening examination or by other means of prior examination**,** or when it is a supplemental examination where no abnormality is seen or suspected from a prior examination and there is a personal or family history of breast cancer or additional factors that may increase your risk of breast cancer.
- Cost share will be no more than the cost share for breast cancer screening and diagnosis for diagnostic ultrasound, magnetic resonance imaging, computed tomography and image-guided biopsy for recommended follow-up diagnostic imaging to assist in the diagnosis of lung cancer when recommended by the U.S. Preventative Services Task Force.

Chemotherapy

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

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

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

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

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

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

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

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

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

Eligible health services for GCIT include:

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

Facilities/providers for gene-based, cellular and other innovative therapies

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

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

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

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

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

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

Pediatric autoimmune neuropsychiatric disorders

Eligible health services include diagnosis, evaluation and treatment of pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy.

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 freestanding outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in the office
  - A home care **provider** in your home
- Listed on our **specialty prescription drug** list as covered under this certificate of coverage

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

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

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

Outpatient respiratory therapy

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 for you if you have been diagnosed with significant cardiac disease, or who have suffered a myocardial infarction, or have undergone invasive cardiac treatment immediately preceding referral for cardiac rehabilitation. Cardiac rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. **Covered benefits** include:

- Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, **physician's** revision of exercise **prescription**, and follow up, examination for **physician** to adjust medication or change regimen
- Increased outpatient rehabilitation services (physical therapy, speech therapy and occupational therapy) for cardiac rehabilitation.

Pulmonary rehabilitation

Eligible health services include pulmonary rehabilitation services for individuals who have been diagnosed with significant pulmonary disease.

Cardiac and pulmonary rehabilitation services must be provided at a place of service equipped and approved to provide cardiac and pulmonary rehabilitation.

Benefits will not be provided for maintenance programs. Maintenance programs consist of activities that preserve the person's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.

Rehabilitation and habilitation therapy services

Rehabilitation therapy services

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

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

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

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

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

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

  Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive rehabilitation therapy associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Habilitation therapy services

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

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

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

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

Outpatient physical, occupational, and speech habilitation therapy
Eligible health services include:

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

If you are 20 years old or younger, benefits for habilitative services will include services for:

- Cleft lip and cleft palate
- Orthodontics
- Oral **surgery**
- Otologic
- Audiological
- Speech therapy, physical therapy, and occupational therapy

Chiropractic services

Eligible health services include chiropractic services provided by a licensed chiropractor, doctor of osteopathy or other eligible practitioner.

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

Diagnostic testing for learning disabilities

Eligible health services include diagnostic testing for:

- Attention deficit disorder
- Attention deficit hyperactive disorder
- Dyslexia

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

8. Other services

Acupuncture

Eligible health services include acupuncture services provided by a **provider** licensed to perform such services.

The following is not covered under this benefit:

- Acupressure

Ambulance services

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

Emergency

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

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

Non-emergency

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

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

Clinical trials and routine patient costs

Routine patient costs

Eligible health services include routine patient costs you have from a **provider** in connection with participation in a phase I, phase II, phase III or phase IV approved clinical trial for the prevention, detection or treatment of cancer or other life-threatening disease or condition, as defined in the federal Public Health Service Act, Section 2709.

We will cover them regardless, if the **provider** is in the service area or if you go to an **out-of-network provider**. An approved clinical trial must satisfy one of the following:

- Federally funded trials:
    - The study or investigation is approved or funded (which may include funding through in-kind contributions) 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
        - The Food and Drug Administration
        - 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
    - An institutional review board of an institution in the State which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the National Institutes of Health
  - For those approved by the Departments of Veteran 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

Experimental or investigational therapies

Eligible health services include drugs, devices, treatments or procedures from a **provider** under an "approved clinical trial" only when a qualified individual who is a participant or beneficiary in the health plan, is eligible to participate according to trial protocols with respect to the treatment of cancer or other life-threatening disease or condition.

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.
- Nebulizers and peak flow meters.
- Training to use the **DME** item.

Covered **DME** includes nebulizers, peak flow meters, prostheses such as leg, arm, back, or neck braces, artificial legs, arms, or eyes, and the training necessary to use these prostheses.

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.

Professional nutritional counseling and medical nutrition therapy

Eligible health services include coverage for nutritional counseling provided by a:

- Licensed dietician-nutritionist
- **Physician**
- **Physician** assistant
- Nurse practitioner

when you are at risk due to:

- Nutritional history
- Current dietary intake
- Medication use
- Cardiovascular disease
- Diabetes
- Malnutrition
- Cancer
- Cerebral vascular disease
- Kidney disease
- Chronic **illness** or condition

Coverage includes medical nutrition therapy provided by a licensed dietician-nutritionist, working in coordination with a **physician** to treat your chronic **illness** or condition.

Enteral formulas and nutritional supplements

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

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

Your **physician** must give you a written order for these supplies.

Eligible health services also include medical food for persons with metabolic disorders when ordered by a **provider** qualified to provide diagnosis and treatment in the field of metabolic disorders. Medical food products do not include foods that are naturally low in protein.

Orthotic devices

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

Prostheses

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

Cranial prosthetics (medical wigs)

We will cover one cranial prosthesis (medical wig) prescribed by your provider when **medically necessary**.

A hair prosthesis shall be considered **medically necessary** when:

- Prescribed by the attending oncologist if you suffer hair loss due to chemotherapy or radiation treatment for cancer.
- Prescribed by your provider if your hair loss results from a condition other than treatment for cancer and the prosthesis is appropriate or efficient.

Prostheses means:

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

Coverage includes:

- The prosthesis
- Artificial device to replace a leg, an arm, or an eye
- Custom-designed, -fabricated, -fitted, or -modified device to treat partial or total limb loss for purposes of restoring physiological function
- Repairing components or replacing the original device you outgrow or that is no longer appropriate because your physical or physiological condition changed
- Replacements required by ordinary wear and tear or damage, irreparable change in the condition, or the cost of the repairs would be more than 60% of the cost of replacing the prosthesis
- The fitting, instruction and other services (such as attachment or insertion) so you can properly use the device
- Breast prostheses for a **covered person** who has undergone a mastectomy and has not had breast reconstruction

Hearing aids

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

Hearing aid means:

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

Hearing aid services are:

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

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

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

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

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.

Telehealth

Eligible health services include **telehealth** consultations when provided by a **physician**, **specialist**, **behavioral health provider** or other **telehealth provider** who is performing a clinical medical or behavioral health service by means of electronic communication at a location other than your location, regardless of your location when services are provided and acting within the scope of their license, including **telehealth** counseling and treatment for **mental health disorders** and **substance related disorders**.

Vision care

Pediatric vision care

Routine vision exams

Eligible health services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include dilation (if needed), 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 marked as preferred by a vision **provider**
- Eyeglass frames, **prescription** lenses or **prescription** contact lenses that are marked as non-preferred by a vision **provider**
- Non-conventional **prescription** contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses
- Aphakic **prescription** lenses prescribed after cataract **surgery** has been performed
- Low vision services including comprehensive low vision evaluations and prescribed optical devices, such as high-power spectacles, magnifiers, and telescopes

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

9. Outpatient prescription drugs

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.

Supply maximums are shown in your schedule of benefits.

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 a **select care** or **in-network pharmacy**
- Calling or e-mailing a **prescription** to a **select care** or **in-network pharmacy**
- Submitting the **prescription** to a **select care** or **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.
The **coinsurance** amount will not exceed the retail or mail order price of the **prescription drug**.

Partial fill dispensing program

Our program allows only a partial fill of your **prescription** through a network pharmacy. We will apply a prorated daily cost-share rate for a partial supply of a **prescription** drug if:

- The dispensing of the partial supply of a **prescription** drug is in your best interest as determined by the pharmacist or prescribing **provider**
- The **prescription** drug is anticipated to be required for 3 months or more
- You request or agree to a partial supply for the purpose of synchronizing the dispensing of your **prescription** drugs
- The **prescription** drug is not a Schedule II controlled dangerous substance
- All prior authorization and utilization management requirements specific to the **prescription** drug at the time of synchronized dispensing are met

How to access select care and in-network pharmacies

A **select care pharmacy** or **in-network pharmacy** will submit your claim. You will pay your cost share to the **pharmacy**. Your **policyholder** will tell you how to find a **select care 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 90 day supply of a **prescription drug**.

Mail order pharmacy

Mail order pharmacies may be used to obtain a supply of **prescription drugs**. The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Each **prescription** is limited to a maximum 90 day supply.

Prescriptions can be filled at a **select care** or in-network **mail order pharmacy**.

Specialty pharmacy

Specialty pharmacies may be used to obtain a supply of **specialty prescription drugs**. A **specialty pharmacy** may be used for up to a 30 day supply of a **specialty prescription drug** and 90 day supply for **maintenance drugs**. 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 **select care pharmacy** or **in-network pharmacy**. The outcome of this review may include:

- Limiting coverage of a drug to one prescribing **provider** or one **select care pharmacy** or **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**.
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 satisfying:

- Your out-of-network outpatient **prescription drug policy year deductible**
- Your out-of-network **copayment** or **coinsurance**
- Any charges over the **recognized charge**
- Submitting your own claims

Other covered services

Abortion care drugs

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

Anti-cancer drugs taken by mouth

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

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 a **select care** or **in-network pharmacy**. At least one form therapeutically equivalent contraception in each of the methods identified by the FDA is included. 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 category identified by the FDA at no cost share. If a **generic prescription drug** or device is not available within a therapeutically equivalent category, you may obtain certain **brand-name prescription drug** or devices for that category 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 agents for blood glucose, ketones, urine

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

Immunizations

Eligible health services include preventive immunizations as required by the ACA when given by a **select care** or **in-network pharmacy**. You should contact your **school health services** for **select care pharmacies**. 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.

Prescription eye drop refills
Covered services include refills of **prescription** eye drops provided in accordance with guidance for early refills of topical ophthalmic products provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid Services; and, if

- The prescriber indicates on the original **prescription** that additional quantities of the **prescription** eye drops are needed
- The refill requested does not exceed the number of additional quantities indicated on the original **prescription** by the prescriber
- The **prescription** eye drops prescribed by the prescriber are a covered benefit under the plan

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. It also includes two 90-day courses of nicotine replacement therapy during each contract year.

Outpatient prescription drug exclusions

The following are not **eligible health services**:

- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug except where stated in the *Eligible health services– Family planning services – female contraceptives* section
- 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 except where stated in the *Eligible health services– Clinical trial therapies (experimental or investigational) and routine patient costs* section and the *Medical necessity and precertification requirements – Step therapy* section
  - 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 indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications except as described in the certificate
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the **covered person** meets one or more clinical criteria detailed in our **precertification** and clinical policies

- 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 where stated in the *Eligible health services– Treatment of infertility* section
- Injectables including:
  - Any charges for the administration or injection of **prescription drugs**
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting with the exception of Depo Provera and other **injectable drugs** for contraception
- Off-label drug use except for indications recognized for treatment in any of the standard reference compendia or through peer-reviewed medical literature
- **Prescription drugs**:
  - That are ordered by a **dentist** or prescribed by an oral surgeon in relation to the removal of teeth or **prescription drugs** for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- **Prescription drugs** indicated for the purpose of weight loss.
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- Except where stated in the *Eligible health services– Medical exceptions* section, 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 your part of the cost sharing. The schedule of benefits shows any benefit limitations and any out-of-pocket costs you are responsible for. Keep in mind that you are responsible for costs not covered under this plan.

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

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

The plan may, in certain circumstances, make some preferred **brand-name prescription drugs** available to **covered persons** at the **generic prescription drug copayment** level. For more information see the *Other services – Preventive contraceptives* and *What precertification requirements apply? – Medical exceptions* sections.

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 satisfy for specific **prescription** fills or refills. You will pay any cost sharing directly to the **select care pharmacy** or **in-network pharmacy**.

What your plan doesn't cover – general exclusions

General exclusions

The plan does not cover:

- Services that are not **medically necessary**.
- Services performed or prescribed under the direction of a person who is not a **health professional**.
- Services that are beyond the scope of practice of the **health professional** performing the service.
- Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for services received for which the recipient is liable.
- Services for which you are not legally, or as a customary practice, required to pay in the absence of a health benefit plan.
- The purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic lenses and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of an **illness** or **injury**. This does not apply to the **covered benefits** for pediatric vision care.
- Personal care services and domiciliary care services.
- Services rendered by a **health professional** who is your spouse, mother, father, daughter, son, brother, or sister.
- **Experimental or investigational** procedures. See *Clinical trials* in the list of **eligible health services**.
- Practitioner, **hospital**, or clinical services related to radial keratotomy, myopic keratomileusis, and **surgery** which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.
- Ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
- Services to reverse a voluntary sterilization procedure.
- Services for sterilization or reverse sterilization for a dependent minor. This does not apply to FDA approved sterilization procedures for women with reproductive capacity.
- Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified in the **covered benefit**.
- Services incurred before the **effective date of coverage** for a **member**.
- Services incurred after a **member's** termination of coverage, including any extension of benefits.
- **Surgery** or related services for **cosmetic** purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.

- Services for injuries or **illnesses** related to your job to the extent that you are required to be covered by a worker's compensation law.

- Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

- Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.

- Charges for telephone consultations with the exception of **telehealth** services, failure to keep a scheduled visit, or completion of any form.

- Inpatient admissions primarily for diagnostic studies, unless authorized by **Aetna**.

- The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, unless otherwise specified in **covered benefits**.

- Except for covered **ambulance** services and transplant travel and lodging benefits specified under **covered benefits**, travel, whether or not recommended by a **health professional**.

- Except for **emergency services**, services received while you are outside the United States.

- Immunizations related to foreign travel.

- With the exception of covered pediatric dental benefits, dental work or treatment, which includes **hospital** or **health professional** care in connection with:
  - The operation or treatment for the fitting or wearing of dentures
  - Orthodontic care or malocclusion
  - Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of **injury** to natural teeth due to an accident if the treatment is received within 6 months of the accident
  - Dental implants

- **Accidents** occurring while and as a result of chewing. This does not apply to covered pediatric dental benefits.

- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless otherwise included as **covered benefits** or these services are determined to be **medically necessary**.

- Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be **medically necessary**.

- Inpatient admissions primarily for physical therapy, unless authorized by **Aetna**.

- Treatment of sexual dysfunction not related to organic disease.

- Services that duplicate benefits provided under federal, state, or local laws, regulations, or programs.

- Nonhuman organs and their implantation.

- Non-replacement fees for blood and blood products.

- Lifestyle improvements, including nutrition counseling, or physical fitness programs, unless included as a **covered benefit**.

- Wigs or cranial prosthesis, except for **medically necessary** hair prostheses when prescribed by the attending oncologist for **covered persons** whose hair loss results from chemotherapy or radiation treatment for cancer or by a provider for a condition other than the treatment of cancer and the prosthesis is appropriate or efficient.

- Weekend admission charges, except for emergencies and maternity, unless authorized by **Aetna**.

- Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements, unless included as a **covered benefit**.

- **Temporomandibular joint dysfunction (TMJ)** treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for **TMJ** and CPS, if **medically necessary** and if there is a clearly demonstrable radiographic evidence of joint abnormality due to **illness** or **injury**.

- Services resulting from **accidental** bodily **injuries** arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

- Services for conditions that state or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.

- Services for, or related to, the removal of an organ from a **covered person** for purposes of transplantation into another person, unless the:
  - Transplant recipient is covered under the plan and is undergoing a covered transplant
  - Services are not payable by another carrier.

- Physical examinations required for obtaining or continuing employment, insurance, or government licensing.

- Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

- Private **hospital** room, unless authorized by **Aetna**.

- Private duty nursing, unless authorized by **Aetna**.

- Treatment for mental health or substance abuse not authorized by the carrier through its managed care system, or a mental health or substance abuse condition determined by the carrier through its managed care system to be untreatable.

- Services related to smoking cessation.

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:
  - Services by pastoral or marital counselors
  - Therapy for sexual problems
  - Treatment of learning disabilities and intellectual disabilities except for diagnostic testing for conditions listed under *Diagnostic testing for learning disabilities* section
  - Travel time to a member's home to conduct therapy
  - Marriage counseling
  - Services that are not medically necessary

Blood and blood products

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

Dental care for adults

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

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

Family planning services

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

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.

Vision care for adults

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

Wilderness treatment programs

Whether or not the program is part of a **residential treatment facility** or otherwise licensed institution

Work related illness or injuries

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

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

Who provides the care

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

Select care providers

The **policyholder** will tell you about the **select care providers** who will provide **eligible health services** to you.

For you to receive the **select care** coverage level of benefits you must use **select care 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
- A **select care provider** is not available to provide the service or supply that you need

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

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

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

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

Out-of-network providers

You also have access to **out-of-network providers.** This means you can receive **eligible health services** from an **out-of-network provider,** except for **out-of-network** on-call and **hospital-**based **physicians** who have accepted an assignment of benefits**.** 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:

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

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

A continuing care patient receiving care from a participating provider may elect to continue to receive transitional care from such provider if the provider's participating provider contract is terminated or non-renewed for reasons other than for failure to meet applicable quality standards or for fraud, or if the group contract terminates resulting in a loss of benefits with respect to such provider or facility. We will notify each enrollee who is a continuing care patient at the time of termination or non-renewal on a timely basis of such termination and the enrollee's right to elect transitional care.

When elected, benefits will be provided under the same terms and conditions as would have applied with respect to items and services that would have been covered had termination not occurred, with respect to the course of treatment provided by such provider or facility relating to the enrollee's status as a continuing care patient. Benefits will be provided during the period beginning on the date we notify the continuing care patient of the termination and ending on the earlier of:

- 90 days after the date of such notice; or
- The date on which such enrollee is no longer a continuing care patient with respect to such provider or facility.

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

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

Other times you may receive continuity of care

If you are transitioning coverage from:

- One health insurer to another health insurer
- Between a health insurer and the Maryland Medical Assistance Program or the Maryland Children's Health Program

you may also be able to continue a service if your previous plan has issued a **precertification**.

You shall continue to receive health care services by an out-of-network provider for the following:

- Acute conditions
- Serious chronic conditions
- Pregnancy
- Mental health conditions and substance use disorders

At your request, we will accept a **precertification** for services from your previous plan, including a **precertification** for behavior health or dental services from your previous Maryland Medical Assistance Program, for a period of 90 days or the course of treatment, whichever is less. If you are pregnant, you may continue the **precertification** for the rest of your pregnancy and the initial postpartum visit.

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

Important exceptions – when you pay all

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

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

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

In all these cases, the **provider** may require you to pay the entire charge. Any amount you satisfy 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 incur 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 incur 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 a **select care provider** and 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 **select care** and in-network **covered benefits**
- Standby charges made by a **physician**

Where your schedule of benefits fits in

How your policy year deductible works

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

How your maximum out-of-pocket limit works

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

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

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

For claims involving **select care** and **in-network providers**. Your **select care** and **in-network provider** will take care of the claim submissions for you. And we will directly pay the **select care** and **in-network provider** for what the plan owes.

Providers that we directly pay for claims have 365 days to submit a claim to us.

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

Submit a claim

- You should notify and request a claim form from us
- The claim form will provide instructions on how to complete and where to send the form
  - We will send you a claim form within 15 days of your request.
  - If the claim form is not sent on time, we will accept a written description that is the basis of the claim as your proof of loss. It must detail the nature and extent of the loss.

Proof of loss (claim)

- Proof of loss is a completed claim form and any additional information required by us
- No later than 1 year after you have incurred expenses for covered benefits.
- We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.
- Proof of loss may not be given later than 2 years after the time proof is otherwise required except if you are legally unable to notify us.

Benefit payment

- Written proof must be provided for all benefits
- If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss
- Benefits will be paid no later than 30 days after receipt of written proof of loss to the provider or to you, if you have paid the provider.

Types of claims and communicating our claim decisions

Definitions

The following definitions apply to this section:

- "Adverse Benefit Determination" means: a denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a benefit, service or supply.

Such Adverse Benefit Determination may be based on, among other things:

- A coverage decision involving:
  - An initial determination by a carrier or a representative of the carrier that results in non-coverage of a health care service
  - A determination by the carrier that an individual is not eligible for coverage under the carrier's health benefit plan
  - Any determination by a carrier that results in the rescission of an individual's coverage under the health benefit plan
- A coverage decision includes non-payment of all or part of a claim.
- A coverage decision does not include an adverse decision.
- An adverse decision, involving the results of any utilization review determination by a private review agent; a carrier; or a health care provider acting on behalf of a carrier; that:
  - A proposed or delivered health care service, which would otherwise be covered under the contract, is not, or was not, **medically necessary**; appropriate; or efficient; and
  - May result in non-coverage of the health care service.
  - An Adverse decision includes a utilization review determination based on a prior authorization or step therapy requirement
- An adverse decision does not include a decision concerning a person's status as a **covered person**.
- An "appeal" means an oral or written protest filed by you, someone who represents you or a health care provider under **Aetna's** internal appeal process regarding a request to reconsider an adverse benefit determination involving a coverage decision.
- An "appeal decision" means a final determination that arises from an appeal filed with **Aetna** of a coverage decision that concerns you.
- An "administrative complaint" is an oral or written contact from you which expresses a dissatisfaction regarding:
  - The direct provision or quality of care by a **network** health care provider
  - The quality of administrative service provided by a **network** health care provider
  - The quality of administrative service provided by **Aetna**
  - The use of your protected health information
  - A plan benefit, billing, eligibility, or contract provision that does not involve a request to review an adverse benefit determination
- A "complaint" means a protest filed by you, someone who represents you or a health care provider acting on your behalf, with the Maryland Insurance Commissioner. It involves a coverage decision, appeal decision, adverse decision, or grievance decision. The address for filing an administrative complaint, a complaint for a coverage or appeal decision or an adverse or grievance decision is:
  Maryland Insurance Administration
  Consumer Complaint Investigation Unit
  Life and Health/Appeals and Grievances
  200 St. Paul Place, Suite 2700
  Baltimore, Maryland 21202

Fax: (410) 468-2260 (Life and Health)
Phone: (410) 468-2000 or (800) 492-6116 (toll free)
TDD Users: (800) 735-2258 (toll free)
Email: agcomplaints.mia@maryland.gov
http://insurance.maryland.gov/Consumer

- A "concurrent care claim" means a previously pre-authorized claim for an ongoing course of treatment that is provided over a period of time or number of treatments.
- "Someone who represents you" means a person whom you have authorized to file an appeal, a grievance or a complaint on your behalf.
- An "emergency case" means a case involving an adverse decision for which an expedited review is required if:
  - The adverse decision is made for health care services that are proposed but have not been delivered, and
  - The services are necessary to treat a condition or **illness** that, without immediate medical attention, would:
    - Seriously jeopardize your health or your ability to regain maximum functions,
    - Cause you to be in danger to yourself or others, or
    - Cause you to continue using intoxicating substance in an imminently dangerous manner.
- The "filing date" means the earlier of:
  - 5 days after the date of mailing, or
  - The date of receipt.
- A "grievance" means an oral or written protest filed by you, someone who represents you or a health care provider acting on your behalf, with a carrier. It must be filed through **Aetna's** internal grievance process for adverse decisions.
- A "grievance decision" means a final determination by **Aetna** that arises from a grievance that you, someone who represents you or a health care provider filed on your behalf under **Aetna's** internal grievance process for adverse decisions.

  The "Health Advocacy Unit" means the Health Education and Advocacy Unit. It is part of the Maryland Division of Consumer Protection, Office of the Attorney General. The address is:
  Maryland Office of the Attorney General
  Health Education and Advocacy Unit
  200 St. Paul Place
  Baltimore, Maryland 21202-2021
  Fax: (410) 576-6571
  Phone: (410) 528-1840 or (877) 261-8807 (toll free)
  E-mail: heau@oag.state.md.us
  https://www.marylandattorneygeneral.gov/Pages/contactus.aspx

- A "health care provider" means a person who is licensed or otherwise authorized in Maryland, to provide health care services in the ordinary course of business or practice of a profession and is a treating health care provider of a **covered person** or a **hospital**.
- A "health care service" means a health or medical care procedure or service, rendered by a health care provider that provides testing, diagnosis, or treatment, on a human disease or dysfunction, or dispenses drugs, medical devices, medical appliances, or medical goods, for the treatment of a human disease or dysfunction or provides any other care, service, or treatment of disease or injury, the correction of defects or the maintenance of physical or mental well-being of individuals.
- A "pre-service claim" means a claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care.

- A “post-service claim” means a claim for a benefit that is not a pre-service claim.
- An "urgent medical condition" means a medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of **Aetna**, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
  - Placing your life or health in serious jeopardy
  - Your inability to regain maximum function
  - Severe pain that cannot be adequately managed without medical treatment
  - Serious impairment to bodily function
  - Serious dysfunction of any bodily organ or part
  - Your remaining seriously mentally ill with symptoms that cause you to be a danger to self or others
  - In the case of a pregnant woman, causing serious jeopardy to the health of the fetus
  - A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours, in the opinion of a health care provider with knowledge your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of a coverage decision.

Administrative complaints

If you have an administrative complaint, please contact **Aetna** either verbally or in writing. The address and telephone number are listed in the *How to contact us for help section* or on the back of your ID card. Administrative complaints will be resolved within 30 calendar days of receipt.

Claims determination

Initial decisions

Claims Involving urgent medical conditions:
Aetna will make notification of a claim involving an urgent medical condition as soon as possible, but not more than 72 hours after the claim is made.

If more information is needed to make a claim determination involving an urgent medical condition, **Aetna** will notify you within 24 hours of receipt of the claim. You have 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify you within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given to you to provide **Aetna** with the information.

If you fail to follow plan procedures for filing a claim, **Aetna** will notify you within 24 hours following your failure to comply.

Concurrent care claim extension

Following a request for a concurrent care claim extension, **Aetna** will make notification of a claim determination for emergency or urgent care as soon as possible but not later than 24 hours, with respect to emergency or urgent care provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 1 working day with respect to all other care, following a request for a concurrent care claim extension.

Concurrent care claim reduction or termination

Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an appeal. **Aetna** will not deny reimbursement to a health care provider for the pre-authorized or approved service delivered to you unless; the information submitted to **Aetna** regarding the service to be delivered to you was fraudulent or intentionally misrepresentative; critical information requested by **Aetna** regarding the service to be delivered to the you was omitted such that **Aetna's** determination would have been different had it known the critical information; a planned course of treatment for you that was approved by **Aetna** was not substantially followed by the health care provider; or on the date the pre-authorized or approved service was delivered: you were not covered by **Aetna**; **Aetna** maintained an automated eligibility verification system that was available to the contracting provider by telephone or via the Internet; and according to the verification system, you were not covered by **Aetna**.

Pre-service claims

Aetna will make notification of a claim determination as soon as possible but not later than 2 working days after receipt of the information necessary to make the determination. If **Aetna** needs additional information to make a claim determination, **Aetna** will notify you of the specific information required within 3 calendar days of the filing date of the pre-service claim.

Post-service claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. If **Aetna** needs additional information to make a claim determination, **Aetna** will notify you of the receipt and status of the claim and include the reason why all or part of the claim has not been paid and what specific information is needed to render a final claim determination.

Coverage decisions

If **Aetna** renders a coverage decision, **Aetna** will, within 30 calendar days of the date of the coverage decision, send a written notice to you, someone who represents you and the health care provider acting on your behalf. The notice will include:

- The specific factual basis for the decision stated in detail in clear, understandable language.
- A statement advising you, someone who represents you or the health care provider acting on your behalf that they have the right to file an appeal of the coverage decision with **Aetna**.
- A statement advising you, someone who represents you or the health care provider that they may file a complaint with the Maryland Insurance Commissioner without first exhausting **Aetna's** internal appeals process, if the coverage decision involves an urgent medical condition for which care has not been rendered.
- The Commissioner's address, telephone number and facsimile number.
- A statement advising you, someone who represents you or the health care provider acting on your behalf that the Health Advocacy Unit is available to help you in both mediating and filing an appeal under **Aetna's** internal appeal process. The contact information for the Health Advocacy Unit also will be provided.

Level I – Appeal of a coverage decision

If, after reviewing the information provided by **Aetna** concerning the coverage decision, you wish to have the decision reconsidered, you, someone who represents you or the health care provider acting on your behalf can file a Level I appeal of the coverage decision no later than 180 calendar days after receipt of the notice regarding the coverage decision. An appeal of a coverage decision may be filed orally or in writing. The appeal should contain sufficient information for **Aetna** to investigate and render an appeal decision. Appeals of coverage decisions will be handled as described below.

Aetna will review and render an appeal decision and will forward a written notice stating the results of the review to you, someone who represents you and the health care provider acting on your behalf. The appeal will be reviewed by **Aetna** personnel not involved in making the initial coverage decision. The appeal decision will be rendered:

- As to claims involving an urgent medical condition, within 24 hours of the filing date of the request
- As to pre-service claims, within 15 calendar days of the filing date of the request.
- As to post-service claims, within 30 calendar days of the filing date of the request.

The notice will include:

- The specific factual basis for the decision stated in detail in clear, understandable language.
- If the coverage decision is upheld, a statement advising you, someone who represents you or the health care provider acting on your behalf, that they have the option of requesting an Appeal Hearing as described in the "Level II – Appeal Hearing" section
- A statement advising you, someone who represents you or the health care provider that, if they choose not to request the optional Appeal Hearing, you have the right to file a complaint with the Maryland Insurance Commissioner within 4 months after receipt of the appeal decision. The contact information for the Maryland Insurance Commissioner also will be provided.
- A statement advising you that the Health Advocacy Unit is available to assist you or someone who represents you in filing a complaint with the Maryland Insurance Commissioner. The contact information for the Health Advocacy Unit also will be provided.

Level II –Appeal hearing of an appeal decision

You, someone who represents you or a health care provider acting on your behalf may request a Level II Appeal Hearing to dispute an appeal decision. Level II Appeal Hearings are voluntary. If you, someone who represents you or the health care provider acting on your behalf decide not to request a Level II Appeal Hearing, you still have the option of filing a complaint with the Maryland Insurance Commissioner. Please refer to the time period specified in "Level I – Appeal of a Coverage Decision" section.

For appeal decisions, the Level II process begins when you, someone who represents you or the health care provider acting on your behalf, are not satisfied with the Level I appeal decision and requests, either orally or in writing, a Level II Appeal Hearing. You, someone who represents you or the health care provider have 10 days from the date of receipt of the Level I appeal decision to request a Level II Appeal Hearing.

Upon receipt of a request for a Level II Appeal Hearing, **Aetna** will provide you the request with the procedures governing Appeal Hearings. You will be notified of your right to have an uninvolved **Aetna** representative available to help you in understanding the Appeal Hearing process.

A review body at the local market (hereinafter the "Appeal Hearing Panel") will be formed to handle the Appeal Hearing. The reviewers must not have participated in any prior review determinations. The composition of the review body must be peers of the treating health care provider (**physician** to **physician**; chiropractor to chiropractor).

Aetna will hold Appeal Hearings in its offices as needed, but no more than 20 working days after the filing date of the Appeal Hearing request. Written notification will be sent to you indicating the time, date, and location of the hearing.

In the event you are unable to attend the hearing on the scheduled hearing day, the dispute will be heard in your absence.

You will have the right to the following:

- Attend the Appeal Hearing
- Question the representative of **Aetna** designated to appear at the hearing and any other witnesses
- Present your case
- Be assisted or represented by a person of your choice.
- Submit written material in support of your dispute

You may bring a **physician** or other expert(s) to testify on your behalf. **Aetna** will also have the right to present witnesses. Your counsel may present your case and question witnesses; if you are so represented. Similarly, **Aetna** also may choose to be represented by counsel. The Appeal Hearing Panel will have the right to question the **Aetna** representative, you and any other witnesses.

The appeal hearing will be informal. It will not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of the Appeal Hearing Panel will have the right to exclude redundant testimony or excessive argument by any party or witness.

A written record of the appeal hearing will be made by stenographic transcription. All testimony will be under oath.

Before the record is closed, the Chair of the Appeal Hearing Panel will ask both you and the **Aetna** representative (or their counsel) whether there is any additional evidence or argument which the party wishes to present to the Appeal Hearing Panel. Once all evidence and arguments have been received, the record of the appeal hearing will be closed. The deliberations of the Appeal Hearing Panel will be confidential and will not be transcribed.

The Appeal Hearing Panel will render a written decision within 5 working days of the conclusion of the Appeal Hearing.

For final appeal decisions, the written decision will contain:

- The specific factual basis for the decision stated in detail in clear, understandable language.
- A statement advising you, someone who represents you or the health care provider that they have the right to file a complaint with the Maryland Insurance Commissioner within 4 months after receipt of the final appeal decision. The contact information for the Maryland Insurance Commissioner as listed in the "Definitions" section also will be provided.
- A statement advising you that the Health Advocacy Unit is available to assist you or someone who represents you in filing a complaint with the Maryland Insurance Commissioner. The contact information for the Health Advocacy Unit also will be provided.

Adverse decisions

If **Aetna** renders an adverse decision on a non-emergency case, **Aetna** will inform you, your representative or the **provider** orally by telephone or with you, your representative or the **provider** acting on your behalf affirmative consent by text, fax, e-mail, online portal or other expedited means communicate this adverse decision to you, someone who represents you or the health care provider acting on your behalf. **Aetna** also will, within 5 working days of the date of the adverse decision, send a written notice to you, someone who represents you and the health care **provider** acting on your behalf. The notice will include:

- The specific factual basis for the decision stated in clear, understandable language, and the reasoning used to determine that the health care service is not medically necessary and did not meet Aetna's criteria and standards used in conducting the utilization review.
- Provides the specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines, on which the adverse decision was based, and may not solely use generalized terms or language directing the member to review the additional coverage criteria in the member's policy or plan document.
- The name, business address and business telephone number of the designated employee or representative of the plan who has responsibility for the internal grievance process and the physician who is required to make all adverse decisions
- The details of the internal grievance process and procedures.
- A statement advising your, someone who represents you or the health care provider that they may, within 4 months of receiving the notice of a grievance decision (please refer to the "Level I – Filing a Grievance of an Adverse Decisions" section), file a complaint with the Maryland Insurance Commissioner. The contact information for the Maryland Insurance Commissioner also will be provided.
- A statement advising you, someone who represents you or the health care provider that they may file a complaint with the Maryland Insurance Commissioner without first filing a grievance if:
  - **Aetna** waives the requirement that its internal grievance process be exhausted before filing a complaint with the Maryland Insurance Commissioner.
  - **Aetna** has failed to comply with any of the requirements of its internal grievance process as described herein.
  - You, someone who represents you or the health care provider provides sufficient information and supporting documentation in the complaint that shows a compelling reason to do so. The "compelling reason" must show that the potential delay in receiving the health care service until after you, someone who represents you or the health care provider acting on your behalf, has exhausted the **Aetna's** internal grievance process and obtained a final decision, could result in:
    - Loss of life
    - Serious impairment to a bodily function
    - Serious dysfunction of a bodily organ
    - Your remaining seriously mentally ill or using intoxicating substances with symptoms that cause you to be a danger to yourself or others. You are considered to be a danger to yourself or others if you are unable to function in activities of daily living or care for yourself without imminent dangerous consequences
    - You continue to experience severe withdrawal symptoms

When filing a complaint with the Maryland Insurance Commissioner you or someone who represents you will be required to authorize the release of any your medical records that may be required for the purpose of reaching a decision on the complaint.

The contact information for the Maryland Insurance Commissioner also will be provided.

In the case of a post-service adverse decision there is no compelling reason to bypass **Aetna's** internal grievance procedure and file a complaint with the Maryland Insurance Commissioner.

- A statement advising you, you representative or the health care provider acting on your behalf, that the Health Advocacy Unit:
  - Is available to help you or your representative with filing a grievance under the carrier's internal grievance process
  - Is not available to represent or accompany you during the procedures of the internal grievance process
  - Can help you in mediating a resolution of the adverse decision with the carrier, but that any time during the mediation, you, someone who represents you or the health care provider acting on your behalf, may file a grievance

The contact information for the Health Advocacy Unit also will be provided.

Level I – Filing a grievance of an adverse decision
If, after reviewing the information provided by **Aetna**, you, someone who represents you or the health care provider acting on your behalf wishes to have the adverse decision reconsidered, you, someone who represents you or the health care provider acting on your behalf can file a grievance within the next 180 calendar days. A grievance may be filed orally or in writing.

The grievance should contain sufficient information for **Aetna** to investigate and render a decision. All grievances will be handled as described below.

The appropriate **Aetna** Grievance Unit will review all of the information submitted. It will gather any additional information necessary to prepare and render a decision about the grievance. If there is insufficient information available to make a decision, the Grievance Unit will notify you, someone who represents you or the health care provider acting on your behalf, of the need for additional information. This will occur within 5 working days of the filing date of the grievance. The Grievance Unit will help you, someone who represents you or the health care provider acting on your behalf to obtain the information without further delay. If necessary for the review, it also will send an "authorization for release" form to you for the purpose of obtaining medical records or other information.

Except for an emergency case (please see "Expedited review of adverse decisions") **Aetna's** Grievance Unit will review and render a grievance decision within:
- 24 hours of the filing date of the request with respect to a claim involving an emergency case
- 30 working days of the filing date of the request with respect to a pre-service claim
- 45 working days of the filing date of the request with respect to a post-service claim

The Grievance Unit will orally communicate this grievance decision to you, someone who represents you or the health care provider acting on your behalf. A written notice stating the results of the review by the appropriate Grievance Unit will be forwarded to you, someone who represents you and the health care provider acting on your behalf. This will occur within 5 working days of the date of the decision. This notice will include:
- The specific factual basis for the decision and the reasoning used to determine that the health care service is not medically necessary and did not meet our criteria and standards used in conducting utilization review stated in detail in clear, understandable language.
- The specific reference, language or requirements from the criteria and standards, including any interpretive guidelines, on which the grievance decision was based. Generalized terms will not be used or language directing he member to review he additional coverage criteria in the member's handbook or plan documents.
- The name, business address and business telephone number of the designated employee or representative who has responsibility for the internal grievance process and the physician who is required to make all adverse decisions.

- If the adverse decision is upheld, a statement advising you, someone who represents you or the health care provider acting on your behalf that they have the option of requesting a Committee Review as described in the "Level II – Committee Review" section, within the next 10 days after receipt of the notice.
- A statement advising you, someone who represents you or the health care provider acting on your behalf that, if they choose not to request the optional Committee Review, they have the right to file a complaint with the Maryland Insurance Commissioner, within 4 months after receipt of the grievance decision. The contact information for the Maryland Insurance Commissioner also will be provided.
- A statement advising you that the Health Advocacy Unit is available to assist you or someone who represents you in filing a complaint with the Maryland Insurance Commissioner. The contact information for the Health Advocacy Unit also will be provided.
- A statement informing you about where this information can be found in the policy; enrollment materials; or other evidence of coverage.

A complaint also may be filed with the Maryland Insurance Commissioner, using the contact information referenced above, if **Aetna** does not render a grievance decision within 30 working days of the filing date of the pre-service grievance; and 45 working days of the filing date of the post-service grievance.

Level II – Committee review of a grievance decision
You, someone who represents you or a health care provider acting on your behalf may request a Level II Committee Review to dispute a grievance decision. Level II Committee Reviews are voluntary. If you, someone who represents you or a health care provider acting on your behalf decide not to request a Level II Committee Review, they still have the option of filing a complaint with the Maryland Insurance Commissioner. Please refer to the time periods specified in "Level I – Filing a Grievance of an Adverse Decision" section.

For grievances, the Level II process begins when you, someone who represents you or a health care provider acting on your behalf, is not satisfied with the Level I grievance decision and requests, either orally or in writing, a Level II Committee Review. To request a Level II Committee Review, you, someone who represents you or a health care provider acting on your behalf must request a Committee Review within 10 days from the date of oral notification of the Level I grievance decision. You, someone who represents you or a health care provider acting on your behalf also must agree, in writing, to give **Aetna** a 30 working day extension to render a final grievance decision.

Upon receipt of a request for a Level II Committee Review, **Aetna** will provide you with the procedures governing Committee Reviews. You will be notified of your right to have an uninvolved **Aetna** representative available to help you in understanding the Committee Review process.

A review body at the local market (hereinafter the "Committee Review Panel") will be formed to handle the Committee Review. The reviewers must not have participated in any prior review determinations. The composition of the review body must be peers of the treating health care provider (**physician** to **physician**; chiropractor to chiropractor). If the dispute involves a medical necessity issue, they must be board certified or board eligible in a discipline pertinent to the issue under review.

Aetna will hold Committee Reviews in its offices as needed, but no more than 20 working days after the filing date of the Committee Review request. Written notification will be sent to you indicating the time, date, and location of the hearing.

In the event you are unable to attend the hearing on the scheduled hearing day, the dispute will be heard in your absence.

You will have the right to the following:

- Attend the Committee Review
- Question the representative of **Aetna** designated to appear at the review and any other witnesses.
- Present your case
- Be assisted or represented by a person of your choice
- Submit written material in support of your dispute

You may bring a **physician** or other expert(s) to testify on your behalf. **Aetna** will also have the right to present witnesses. Your counsel may present your case and question witnesses; if you are so represented. Similarly, **Aetna** also may choose to be represented by counsel. The Committee Review Panel will have the right to question the **Aetna** representative, you and any other witnesses.

The Committee Review will be informal. It will not apply formal rules of evidence in reviewing documentation or accepting testimony at the review. The Chair of the Committee Review Panel will have the right to exclude redundant testimony or excessive argument by any party or witness. A written record of the Committee Review will be made by stenographic transcription. All testimony will be under oath.

Before the record is closed, the Chair of the Committee Review Panel will ask both you and the **Aetna** representative (or their counsel) whether there is any additional evidence or argument which the party wishes to present to the Committee Review Panel. Once all evidence and arguments have been received, the record of the Committee Review will be closed. The deliberations of the Committee Review Panel will be confidential and will not be transcribed.

The Committee Review Panel will render a written decision within 5 working days of the conclusion of the Committee Review.

For grievances, the written decision will contain:

- The specific factual basis for the decision stated in detail in clear, understandable language.
- A reference to the specific criteria and standards, including interpretive guidelines on which the grievance decision was based.
- The name, business address and business telephone number of the medical director who made the grievance decision.
- A statement that a list of individuals participating in the review of the dispute, along with their titles and credentials is available upon written request.
- A statement of the reviewer's understanding of the pertinent facts of the dispute.
- A reference to the evidence or documentation used as the basis for the decision.
- A statement advising you, someone who represents you or the health care provider acting on your behalf that they have the right to file a complaint with the Maryland Insurance Commissioner within 4 months after receipt of the grievance decision. The contact information for the Maryland Insurance Commissioner also will be provided.
- A statement advising you that the Health Advocacy Unit is available to assist you or someone who represents you in filing a complaint with the Maryland Insurance Commissioner. The contact information for the Health Advocacy Unit also will be provided.

Expedited review of adverse decisions
You, someone who represents you or a health care provider acting on your behalf, may request an expedited review when an adverse decision is rendered for health care services that are proposed but have not been delivered. The services must be necessary to treat a condition or **illness** that, without immediate medical attention, would:

- Seriously jeopardize the life or health of the covered person or the covered person's ability to regain maximum function
- Cause you to be a danger to yourself or others
- Cause you to continue using intoxicating substances in an imminently dangerous manner

You, someone who represents you or a health care provider acting on your behalf will be notified immediately if **Aetna** does not have sufficient information to complete the expedited review. After a complete review of any information already submitted by the health care provider, we will:

- Notify you, your representative, or the health care provider that we cannot proceed with the grievance review unless additional information is provided
- Request specific information, including any lab or diagnostic test or other medical information, that must be submitted to complete the internal grievance process and
- Provide the specific reference, language, or requirements from the criteria and standards used by us to support the need for additional information

Aetna will help you, someone who represents you or a health care provider acting on your behalf in gathering the necessary information without further delay.

Expedited reviews will be completed within 24 hours of the time the covered person, the covered person's representative or the health care provider initiates the request. You may file a complaint with the Maryland Insurance Commissioner if the expedited review is not completed within 24 hours of the request.

Within 1 day after a decision has been orally communicated to you, someone who represents you or a health care provider acting on your behalf, a written notice will be sent to you, someone who represents you or a health care provider acting on your behalf. The notice will include:

- The specific factual basis for the decision stated in detail in clear, understandable language.
- A reference to the specific criteria and standards (including interpretive guidelines) on which the expedited review was based.
- The name, business address and business telephone number of the designated employee or representative of the carrier who has responsibility for the internal grievance process and the physician who performed the expedited review.
- A statement informing you, someone who represents you or a health care provider acting on your behalf, that they have the right to file a complaint with the Maryland Insurance Commissioner within 4 months of receipt of the grievance decision. The contact information for the Maryland Insurance Commissioner also will be provided.
- A statement advising your that the Health Advocacy Unit is available to assist you or someone who represents you in filing a complaint with the Maryland Insurance Commissioner. The contact information for the Health Advocacy Unit also will be provided.

If the expedited review is a concurrent review determination, the service should be continued without liability to you until you are notified of the decision. This does not apply if the service is related to an initial unauthorized admission.

Expedited reviews for retrospective non-certifications are not required.

Timeframes for deciding appeals

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

Claim type	Decision timeframe	Extensions
Urgent care claim	24 hours	None
Pre-service claim	15 calendar days	None
Post-service claim	30 calendar days	None
Concurrent care claim	As appropriate to type of claim	As appropriate to type of claim

For urgent care claims, if you had an involuntary or voluntary psychiatric admission, we will not issue an adverse benefit determination for the admission during the first 24 hours after a voluntary admission or during the first 72 hours after an involuntary admission.

We will make all initial determinations on whether to authorize or certify after receipt of the information necessary to make the determination:

- A nonemergency course of treatment or health care service, including pharmaceutical services not submitted electronically, for a patient within 2 working days
- An extended stay in a health care facility or additional health care services within 1 working day
- A request for additional visits or days of care submitted as part of an existing course of treatment or treatment plan within 1 working day and
- Promptly notify the health care **provider** of the determination.

After receipt of the initial request for health care services and confirming through a complete review of information already submitted by the health care **provider**, we will determine if we have sufficient information to continue the review, if we do not have sufficient information, we will promptly but not later than 3 calendar days inform the health care **provider** that additional information must be provided**.** The information to the health care **provider** will specify:

- Any lab or diagnostic test or other medical information that must be submitted to complete the request and
- The criteria and standards to support the need for additional information

If we require prior authorization for an emergency inpatient admission, or an admission for residential crisis services for the treatment of a mental, emotional, or substance abuse disorder we will:

- Make all determinations on whether to authorize or certify inpatient admission, or an admission for residential crisis services within 2 hours after receipt of the information necessary to make the determination
- Promptly request any additional information that is needed, including any lab or diagnostic test or other medical information and
- Promptly notify the health care **provider** of the determination

When a step therapy exception request or a prior authorization request for pharmaceutical services is submitted electronically, we will:

- Make a determination in real time if no additional information is needed by us to process the request and the request meets our criteria for approval or
- Make a determination within 1 working day, if the determination is not done in real time, after we receive all of the information necessary to make the determination
- Promptly request but no later than 3 calendar days any additional information, after confirming through a complete review of the information already submitted by the health care **provider,** that is needed to make the determination. We will specify:
  - The information needed, including any lab or diagnostic test or other medical information must be submitted to complete the request and
  - The criteria and standards to support the need for additional information

We will make initial determinations on whether to authorize or certify an emergency course of treatment or health care service for you within 24 hours after the initial request after receipt of the information necessary to make the determination. If after confirming through a complete review of the information already submitted, that additional information is needed, we will:

- Promptly request the specific information needed, including any lab or diagnostic test or other medical information

We will notify the health care **provider** promptly but no later than 2 hours after receipt of information of an authorization or certification determination is made

We will initiate the expedited procedure for an emergency case if you or your representative requests or if the health care **provider** attests that the services must be necessary to treat a condition or illness that, without immediate medical attention, would:

- Seriously jeopardize your life or health or your ability to regain maximum function;
- Cause you to be a danger to yourself or others; or
- Cause you to continue using intoxicating substances in an imminently dangerous manner.

If we do not make a determination with the time limits specified above, the request is deemed approved.

We will not deny reimbursement to a **provider** for **precertified** or approved service delivered to you unless:

- The information submitted to **us** regarding the service to be delivered to you, was fraudulent or intentionally misrepresentative
- Critical information requested by **us** regarding the service to be delivered to you, was omitted such that **our** determination would have been different had we known the critical information
- A planned course of treatment for you that was approved by **us** was not substantially followed by the **provider**
- On the date the **precertified** or approved service was delivered we maintained an automated eligibility verification system that was available to the **provider** by telephone or via the internet and according to the verification system you were not covered by **Aetna.**

Exhaustion of appeals process

In most situations you must complete the appeal process with us before you can take these other actions:

- Contact the Maryland Insurance Administration Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Maryland Insurance Administration to request an appeal through an external review process
- Pursue 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 external review process.
- We waived the requirement of exhaustion of appeal process.
- The combined two levels of appeals exceed the time listed in the *Timeframes for deciding appeals* section.
- We did not follow all of the claim determination and appeal requirements of the state of Maryland.

External review

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

You have a right to external 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, investigational, or unproven**
- You have received an adverse determination

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

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

You must submit the Request for External Review Form:

- To the Maryland Insurance Commissioner
- 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 ERO. We will pay for information we send to the ERO plus the cost of the review.
The Maryland Insurance Commissioner will contact the ERO that will conduct the review of your claim

- The ERO will:
  - Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
  - Consider appropriate credible information that you sent
  - Follow our contractual documents and your plan of benefits
  - Collect additional information from you or us
  - 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 ERO provides to the Maryland Insurance Commissioner

You can contact the Maryland Insurance Commissioner to file a complaint at the following address:

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
Fax: (410) 468-2260
Phone: (410) 468-2000 or (800) 492-6116 (toll free)
TDD Users: (800) 735-2258 (toll free)
Email: agcomplaints.mia@maryland.gov
http://insurance.maryland.gov/Consumer

You can contact the Health Advocate Unit to help with mediating or filing an internal appeal with us at the following address:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, Maryland 21202
Fax: (410) 576-6571
Phone: (410) 528-1840 or (877) 261-8807 (toll free)
E-mail: heau@oag.state.md.us
https://www.marylandattorneygeneral.gov/Pages/contactus.aspx

Recordkeeping

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

Fees and expenses

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

Coordination of benefits (COB)

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

Key terms

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

Allowable expense means:

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

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

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

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

The term "plan" does not include:

- **Hospital** or fixed indemnity policy
- Accident only policy
- Specified accident policy
- Automobile Insurance policy
- Individual intensive care policy
- Individual specified disease policy
- Limited benefit health policy
- School accident policy, including athletic injuries
- A long –term care policy for non-medical services such as assistance with daily living and custodial care
- Medicare supplement policies or state Medicaid plans
- A government plan that provides benefits in excess of private insurance plans

Here's how COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage
- When this is your secondary plan:
  - We calculate payment as if the primary plan does not exist. Then we reduce our payment based on any amount the primary plan paid.
  - We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable submitted expenses.

Determining who pays

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

COB rule	Primary plan	Secondary plan
Covered under this plan as a student or dependent	Plan covering you as a student	Plan covering you as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the **calendar year** (Birthday rule)	Plan of parent whose birthday is later in the **calendar year**
Child – parents separated, divorced, or not living together	• Plan of parent (with actual knowledge) 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
Child of: Parents who are married or living together and also has coverage under a spouse's plan	The plan that has covered a parent or spouse longer is primary. If the parent or spouse's coverage began on the same date then the "birthday rule" applies. The plan of the parent or spouse whose birthday (month and day only) falls earlier in the **calendar year** is primary	The plan that has covered a parent or spouse for the shorter period of time is secondary. If the parent or spouse's coverage began on the same date then the "birthday rule" applies. The plan of the parent or spouse born later in the year (month and day only)
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

How COB works with Medicare

This section explains how the benefits under this plan interact with benefits available under **Medicare**.

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

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

When you have **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before **Medicare** pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after **Medicare**. Sometimes, this plan is the primary plan, which means that the plan pays benefits before **Medicare** pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after **Medicare**.

Who pays first?

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

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

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

How are benefits paid?

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

Charges that satisfy your Part B deductible will be applied in the order received. We will apply the largest charge first when two or more charges are received at the same time.

Other health coverage updates – contact information

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

- **Online:** Log 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 the reason stated in this certificate of coverage or the **student policy**
- 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
- Non-payment of **premiums** by the end of the grace period
- An act or practice of fraud
- Intentional misrepresentation of material facts under the terms of coverage

We will notify you at least 90 calendar days before the date your coverage will end. Refer to the **student policy** and the Termination by us provision for more information.

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 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.

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 because:

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

We will give you 30 days advance written notice if we 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.
- You no longer live in the **service area**.

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

Special coverage options after your plan coverage ends

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

Continuation of coverage for other reasons

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

How can you extend coverage if you are totally disabled when coverage ends?

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

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

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

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

- When you or your dependents are no longer totally disabled
- 12 months of coverage

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

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

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

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

- When you are discharged.
- 12 months of coverage.

How can you extend pediatric dental coverage for dental work when coverage ends?

If your coverage ends while you are not totally disabled**,** your pediatric dental coverage may end while you are in the middle of treatment. The plan does not cover pediatric dental services that are given after your coverage terminates. There are some exceptions, including:

- For non-orthodontic treatment that began before your coverage terminated:
  - Your coverage will continue for 90 days after your coverage ends.
- For orthodontic treatment that began before your coverage terminated, your coverage will continue for:
  - 60 days after coverage terminated, if payments are made on a monthly basis, or
  - 60 days after coverage terminates or the end of the quarter in progress (whichever is later) if payments are made on a quarterly basis.

How can you extend coverage for pediatric vision care services and supplies when coverage ends?

If your coverage ends while you are not totally disabled, your plan will cover pediatric vision services and supplies for eyeglasses and contact lenses within 31 days after your coverage ends if:

- Eyeglasses or contact lenses are ordered before the date coverage ends
- You receive the eyeglasses or contact lenses within 30 days after the date of the order

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

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

How we administer this plan

We administer this plan to comply with all applicable laws and regulations. We also apply policies and procedures we've developed to administer this plan.

Who's responsible to you

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

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

Coverage and services

Your coverage can change

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

When an emergency or epidemic is declared, we may temporarily waive the following for **prescription** related benefits if you are affected:

- **Precertification**
- Quantity limits

We may also temporarily reduce or waive your **prescription** cost share. Once the emergency or epidemic is over, you will have to meet the requirements stated in your Certificate or Schedule. Only we may waive a requirement of your plan. No other person – including your employer or **provider** – can do this.

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

A retroactive change in your student status will not cause a retroactive change in your coverage.
If your dependent status changes the amount of your dependent coverage or benefit levels, the change will take effect on the date of the status change and the amount of coverage or benefit level will be changed to the new amount.

If a service cannot be provided to you
Sometimes things happen outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we will reimburse you for the expenses necessarily incurred for **covered services** from an **out-of-network provider**, to the extent required by the Insurance Commissioner of Maryland.

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

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

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 advance 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

Some other money issues

Legal action

You must wait 60 days from the date that you sent us proof of loss for any expense or bill before you can take legal action against **Aetna**. See the *When you disagree - claim decisions and appeals procedures* section.

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

Assignment of benefits

When you see a **select care provider** or **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.

Financial sanctions

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.

Grace period

You have a grace period of 31 days after the due date for the payment of each premium due after the first premium payment.

Payment of premium

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

Recovery of overpayments

We sometimes pay too much for **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 to the person that we paid by the amount we paid by mistake.

When you are injured

If someone else caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money. We are entitled to that money recovered from a cause of action, up to the amount we pay for your care. We have that right no matter who the money comes from – for example, the other driver, the **policyholder** or another insurance company. However, we do not have the right to the money you received under your personal **injury** protection coverage of a motor vehicle insurance policy.

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

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

Your health information

We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your plan.

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

When you accept coverage under this plan, you agree to let your **providers** share information with us. We need information about your physical and mental condition and care.

Effect of benefits under other plans

Effect of a Health Maintenance Organization plan (an HMO Plan) or a Preferred Provider Organization plan (PPO plan) on coverage

If you have coverage under another group medical plan (such as an HMO or PPO plan) and that other plan denies coverage of benefits because you received the services or supplies outside of the plan's network geographic area, this student plan will cover those denied benefits as long as they are **covered benefits** under this plan. **Covered benefits** will be paid at the applicable level of benefits under the student plan.

Glossary A-M

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

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

Behavioral health provider
An individual professional that is licensed, registered, certified or otherwise authorized by law 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.

Biomarker
A characteristic that is objectively measured and evaluated as an indicator of normal biological or pathogenic processes or pharmacologic responses to specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. This includes gene mutations, characteristics of genes or protein expressions.

Biomarker testing
An analysis of tissue, blood, or other biospecimen for the presence of a biomarker. Which results in:

- Providing information for the use of treatment formulation or monitoring strategy that informs a covered person's outcome and impacts the clinical decision
- Includes both information that is actionable and some information that cannot be immediately use in the formulation of a clinical decision

Testing also includes:

- single analyte tests
- multiplex panel tests
- protein expression
- whole exome
- whole genome
- whole transcription sequencing

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

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

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

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

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

Copayments
The specific dollar amount 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 **precertification** if required

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

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

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

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

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

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

Dental emergency
Any dental condition that:

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

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

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

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

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

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

Directory
The list of **in-network providers** for your plan. The most up-to-date **directory** for your plan appears at https://www.aetnastudenthealth.com. When searching from our online **provider directory**, you need to make sure that you are searching for **providers** that participate in your specific plan. **In-network providers** may only be considered for certain **Aetna** plans. When searching for **in-network dental providers**, you need to make sure you are searching under Pediatric Dental plan.

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

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

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

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

Eligible health services
The health care services and supplies and outpatient **prescription drugs** listed in the *Eligible health services* 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

A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including sever pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

Emergency services

For an **emergency medical condition**:

- An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a **hospital** or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such **emergency medical condition**;
- Within the capabilities of the staff and facilities available at the **hospital** or the independent freestanding emergency department, as applicable, such further medical examination and treatment, as are required under section 1867 of the Social Security Act, (42 U.S.C. 1395dd) or as would be required under such section is such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the **hospital** in which such further examination or treatment is furnished); and
- Except as provided in the 4th bullet below, covered services that are furnished by a non-participating provider or non-participating emergency facility after the individual is stabilized and as part of outpatient observation or an inpatient or outpatient **stay** with respect to the visit in which the services described in the 1st bullet above are furnished.
- The covered services described in the 3rd bullet above are not included as **emergency services** if all of the following conditions are met:
    - The attending emergency physician or treating provider determines that the individual is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition;

- The provider or facility furnishing such additional items and services satisfies the notice and consent criteria of 45 C.F.R. §149.420(c) through (g) with respect to such items and services, provided that the written notice additionally satisfies the following, as applicable:
    - In the case of a participating emergency facility and a non-participating provider, the written notice must also include a list of any participating providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or you may be referred, at their option, to such a participating provider.
    - In the case of a non-participating emergency facility, the written notice must include the good faith estimated amount that the individual may be charged for items or services furnished by the non-participating emergency facility or by non-participating providers with respect to the visit at such facility (including any item or service that is reasonably expected to be furnished by a non-participating emergency facility or non-participating provider in conjunction with such items or services);
- The individual (or authorized representative of such individual) is in a condition to receive the information described in the 2nd dash item above, as determined by the attending emergency physician or treating provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law; and
- The covered services are not rendered by an on-call physician or a **hospital** based physician who has obtained an assignment of benefits from you

Experimental, investigational, or unproven

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

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

Generic prescription drug

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

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional
A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, **physicians**, physician assistants, nurse practitioners 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 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 and has the meaning stated in 42 U.S.C. § 1395x(dd).

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

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

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

Hospital
An institution licensed as a **hospital** by applicable law and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can stay overnight for care. Or they can be treated and leave the same day. All **hospitals** must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

Hospital stay
This is your **stay** of 18 or more hours in a row as a resident bed patient in a **hospital**.

Illness or illnesses
Poor health resulting from disease of the body or mind.

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

In-network pharmacy
A **retail pharmacy**, **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**.

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.

Maintenance drug
This means a **prescription drug** which is anticipated to be needed for a period of 6 months or more to treat a chronic condition. We allow up to a 90 day supply of **maintenance drugs** in a single dispensing except for the first **prescription** or change in a **prescription**.

Maximum out-of-pocket limit
The maximum out-of-pocket amount for payment of **copayments** and **coinsurance** including any **policy year deductible**, to be satisfied 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 **medically necessary, experimental, investigational, or unproven**. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact us. See the *How to contact us for help* section.

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

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

Negotiated charge

Health coverage

This is either:

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

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

Select care pharmacy

Reach out to **school health services** for information.

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 underprice guarantees. These amounts may change the **negotiated charge** under this plan.

Non-preferred drug

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

Non-physician specialist

A health care provider who:

- Is not licensed as a physician
- Is licensed or certified under the Health Occupation Article
- Is certified or trained to treat or provide health care services within the scope of the license or certification of the health care provider for a specified condition or disease
- Is licensed as a behavioral health program under § 7.5–401 of the Health – General Article.

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

Out-of-network pharmacy
A **pharmacy** that is not a **select care pharmacy** or 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 a **select care provider** or 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 a **select care pharmacy**, 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; including, 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 satisfy for **eligible health services** per **policy year** before your plan starts to pay as listed in the schedule of benefits.

Policyholder
The school named on the front page of the **student policy** and your certificate of coverage and schedule of benefits for the purpose of coverage under the **student policy**.

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

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

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

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

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. For **hospitals** regulated by the Maryland Health Services Cost Review Commission (HSCRC) the **recognized charge** is the rate approved by the HSCRC:

Professional services and other services or supplies not mentioned below	105% of the **Medicare** allowed rate
Services of **hospitals** and other facilities other than those **hospital** services regulated by the Maryland HSCRC	140% of the **Medicare** allowed rate
Prescription drugs	100% of the average wholesale price (AWP)
Dental expenses	80% of the prevailing charge rate

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

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

Special terms used

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

  When the **recognized charge** is based on a percentage of the **Medicare** allowed rate, it is not affected by adjustments or incentives given to **providers** under **Medicare** programs.
- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.

Our reimbursement policies

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

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

Our reimbursement policies are based on our review of:

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

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

The **recognized charge** paid to an **out-of-network provider** for a particular type of **eligible health service** will never be less than the **negotiated charge** paid to a similarly licensed **in-network provider** in the same geographic area for that same type of **eligible health service**.

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

R.N.
A registered nurse.

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

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

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**.

Select care
Eligible health services provided by a **select care provider**.

Select care pharmacy
A **retail pharmacy**, **mail order pharmacy** or **specialty pharmacy** that is affiliated with, or has an agreement or arrangement with, or is otherwise designated by, the the **policyholder's school health services** to provide services and supplies to **covered students**.

Select care provider
A **provider** identified by the **policyholder** as a **select care provider** for your plan. **School health services** may be a **select care provider** for your plan.

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

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

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

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

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of **mental health disorders** or **substance related disorders**.

Skilled nursing services
Services provided by an **R**.**N**. or **L.P.N.** within the scope of his or her license.

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

Specialist
A **physician** who practices in any generally accepted medical or surgical specialty or sub-specialty.

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

Specialty prescription drug
These are **prescription drugs** that are prescribed for a person with a complex, chronic or rare medical condition.

A "complex or chronic medical condition" means a:
- Physical
- Behavioral or
- Developmental condition

It may have no known cure or is progressive or can be debilitating or fatal if left untreated.

A "complex or chronic medical condition" includes:
- Multiple sclerosis
- Hepatitis C
- Rheumatoid arthritis

A "rare medical condition" means a disease or condition that affects fewer than 200,000 individuals in the United States or approximately 1 in 1,500 individuals worldwide.

A "rare medical condition" includes:
- Cystic fibrosis
- Hemophilia
- Multiple myeloma

Specialty prescription drugs cost $600 or more for up to a 30-day supply and are not typically stocked at **retail pharmacies**. They generally require a difficult or unusual process of delivery or require enhanced patient education, management or support before or after their use.

Specialty prescription drug does not include a drug prescribed to treat:
- Diabetes
- HIV, or
- AIDS

You can access the list of these **specialty prescription drugs** by calling Member Services at the toll-free number in the *How to contact us for help* section or by logging on to your Aetna secure website at www.aetnastudenthealth.com. The list also includes **biosimilar prescription drugs**.

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

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

Student policy
The **student policy** consists of several documents taken together. The list of documents can be found in the *Entire student policy* section of this certificate of coverage.

Substance related disorder
As defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association:

- Alcohol use disorder, alcohol abuse, alcohol dependence, alcohol misuse, alcohol intoxication, or alcohol withdrawal;
- Nonalcohol substance use disorder, drug dependence, drug misuse, nonalcohol substance induced intoxication, or nonalcohol substance withdrawal; or
- Any combination of the disorders listed in the above bullets of this paragraph.

Important note: When appropriate, Aetna uses the American Society of Addiction Medicine (ASAM) for its medical necessity reviews of substance use disorder benefits.

Surgery center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all **Medicare** accreditation standards (even if it does not participate in **Medicare**).

Surgery, surgeries or surgical procedures
The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution or
- Otherwise physically changing body tissues and organs

Telehealth
Use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care **provider** who is performing a clinical medical or behavioral health service to deliver a **covered service** within the scope of their practice at a location other than your location, regardless of your location when services are provided. **Telehealth** includes delivery of mental health services in a patient's home setting. It also includes **telehealth** counseling and treatment for **mental health disorders** and **substance related disorders**.

Services can be provided by:

- Two way interactive audiovisual teleconferencing or other telecommunications or electronic technology
- Audio-only phone calls that result in the delivery of billable **covered services**
- Any other method required by state law

Telehealth does not include:

- Audio-only phone call except as required by state law
- Email
- Fax

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**

TTY: **711**

English	**To access language services at no cost to you, call the number on your ID card.**
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ፡፡
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કોલ કરવો.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	**無料の言語サービスは、IDカードにある番号にお電話ください。**
Karen	လၢၓတၢကမၠၢကျိာ်တၢမၤစၢၤအတၢဖံးတၢမၤတဖၣ လၢၓတအိၣ်ဒီးအပှၤလၢၓနကဘၣ်ဟ့ၣ်အီၤအကို္ၤကီးဘၣ်လီၤတံၢ်စိနီၣ်ဂံၢ်လၢၓအအိၣ်လၢၓနခီၣ်ဂီၤ ဗ (ၡ) အလိၤ်ၣ်တကုၢ်ၡ်
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó naaltsoos bee atah nílį́igo nanitinígíí bee nééhó'dólzinígíí béésh bee hane'í biká'ígíí áaji' hólne'.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	[illegible]
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน

Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.

Aetna Life Insurance Company

Notice Of Protection Provided By
Maryland Life And Health Insurance
Guaranty Corporation

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty Corporation (the Corporation) and the protection it provides for policyholders and contract holders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your health maintenance organization or your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Corporation are:

Life Insurance
- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance or Health Benefit Plan
- $500,000 for coverage provided by health benefit plans
- $300,000 for disability insurance
- $300,000 for long-term insurance
- $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above

Annuities
- $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
- With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts is:
- $300,000 in aggregate for all types of coverage listed above, with the exception of coverage provided by health benefit plans
- $500,000 in aggregate for coverage provided by health benefit plans

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

Insurance companies, health maintenance organizations, and insurance producers are not allowed by* Maryland *law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance or a health benefit plan. When selecting an insurance company or health maintenance corporation, you should not rely on Corporation coverage. If there is any inconsistency between this notice and* Maryland *law, then* Maryland *law will control.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org or contact:

Maryland Life and Health
Insurance Guaranty Corporation
6210 Guardian Gateway
Suite 195APG
Aberdeen, Maryland 21005
410-248-0407

Aetna Life Insurance Company Rider

Travel and Lodging Reimbursement

Rider effective date: 08/01/2025

This rider is added to the *Eligible health services and exclusions* section of your certificate of coverage. This rider is subject to all other requirements described in your certificate, including general exclusions and defined terms.

Eligible health services and exclusions

Travel and lodging expenses

We will reimburse you for travel and lodging expenses when you need to travel at least 100 miles to access **eligible health services** because a law or regulation where you are located prohibits those **eligible health services**. The following are covered travel and lodging expenses:

- U.S. domestic travel expenses for the **covered person** and the **covered person's** travel companion in the 48 contiguous states (coach class air, bus, train or shuttle fares, taxi or ride share fares for local travel.) Expenses for two travel companions will be reimbursed when two parents travel with a minor child.
- Mileage costs, not to exceed amounts permitted by Internal Revenue Service guidelines
- Parking and tolls
- Lodging costs of up to $50 per night, per **covered person** or $100 per night, total, for the **covered person** and the **covered person's** travel companions, not to exceed amounts permitted by Internal Revenue Service guidelines

You must submit a travel and lodging claim form to be reimbursed. You will need to confirm travel was necessary because no **provider** within 100 miles of where you are located was available to provide the **eligible health services** when you submit your travel and lodging claim form.

Call the toll-free number on your ID card to:

- Obtain a travel and lodging claim form
- Get assistance in locating a **provider**
- Get information about these **eligible health services** including specific eligibility requirements and limitations

We will reimburse your covered travel and lodging expenses as described in the schedule of benefits below.

Exclusions

The following are not covered travel and lodging expenses under this rider:

- Expenses for more than one travel companion
- Gasoline/fuel costs
- Car rentals
- Meals, groceries, hotel room service, alcohol/tobacco products
- Personal care/convenience items, (e.g. shampoo, clothing, deodorant)
- Entertainment/souvenir expenses
- Telephone calls
- Taxes
- Tips, gratuities
- Childcare expenses
- Lost wages

Schedule of benefits

This rider is subject to the requirements described in your medical plan schedule of benefits unless otherwise noted below.

Travel and lodging expenses

Description	Amount
Travel and lodging reimbursement	100% No **policy year deductible** applies
Limit per **policy year**	$2,000

Discrimination is Against the Law

Aetna Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). Aetna Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aetna Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 1-877-480-4161 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332,
Woonsocket, RI 02895

Phone: 1-800-648-7817, TTY: 711
Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
This notice is available at Aetna Inc.'s website: https://www.aetnastudenthealth.com