



Aetna Life Insurance Company
(a stock company)
151 Farmington Avenue Hartford, Connecticut 06156

Student Health Insurance

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

Schedule of Benefits

Prepared exclusively for:

Policyholder:	Illinois Institute of Technology
Policyholder number:	724532
Student policy effective date:	08/12/2018
Plan effective date:	08/12/2018
Plan issue date:	11/16/2018
Actuarial value and metallic level:	82.78% - Gold

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

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

Schedule of benefits Physician and specialist services

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

How to read your schedule of benefits

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

Important note:

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

How to contact us for help

We are here to answer your questions.

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

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

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

Important note about your cost sharing:

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

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

Here's an example of how cost sharing works:

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

Plan features	In-network coverage*	Out-of-network coverage*
Policy year deductible		
You have to meet your policy year deductible before this plan pays for benefits.		
Student	\$300 per policy year	\$400 per policy year
Spouse	\$300 per policy year	\$400 per policy year
Each Child	\$300 per policy year	\$400 per policy year
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services:		
<ul style="list-style-type: none">• In-network care for <i>Preventive care and wellness</i>• In-network care for <i>Pediatric Preventive Dental Benefits</i>• In-network and out-of-network care for <i>victims of sexual assault or abuse, Pediatric Vision Benefits, and Prescribed Medicines Expense</i>		

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Maximum out-of-pocket limits		
Maximum out-of-pocket limit per policy year		
	In-network coverage*	Out-of-network coverage*
Student	\$6,850 per policy year	N/A
Spouse	\$6,850 per policy year	N/A
Each child	\$6,850 per policy year	N/A
Family	\$13,700 per policy year	N/A

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Coinurance listed in the schedule of benefits

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

Eligible health services	In-network coverage*	Out-of-network coverage*
1. Preventive care and wellness		
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Covered persons through age 21: Maximum age and visit limits per policy year Covered persons through age 21: Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Covered persons age 22 & over: Maximum visits per policy year	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
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 onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	

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Well woman preventive visits		
Routine gynecological exams (including Pap smears)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration Women's Preventive Services Guidelines.	
Maximum visits per policy year	1 visit	
Preventive screening and counseling services		
Obesity and/or healthy diet counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Maximum visits per policy year (This maximum applies only to covered persons age 22 and older)	26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Misuse of alcohol and/or drugs counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Maximum visits per policy year	5 visits*	
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Use of tobacco products counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Maximum visits per policy year	8 visits*	
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		

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Depression screening counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Maximum visits per policy year	1 visit*	
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Sexually transmitted infection counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Maximum visits per policy year	2 visits*	
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.		
Genetic risk counseling for breast and ovarian cancer office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Age limitations	Not subject to any age limitations	
Skin cancer behavioral counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Maximum visits per policy year	1*	
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Falls prevention counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Maximum visits per policy year	1*	
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		

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<p>Routine cancer screenings</p> <p>Performed at a physician's office, specialist's office or facility.</p>				
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit		
Maximums	<p>Subject to any age; family history; and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. <p>For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.</p>			
Lung cancer screening maximums	1 screening every 12 months*			
<p>*Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.</p>				
<p>Prenatal care</p> <p>Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)</p>				
Preventive care services only	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit		
<p>Important note: You should review the <i>Maternity care</i> and <i>Well newborn nursery care</i> sections. They will give you more information on coverage levels for maternity care under this plan.</p>				

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Comprehensive lactation support and counseling services		
Lactation counseling services - facility or office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits*	
<p>*Important note: Any visits that exceed the lactation counseling services maximum are covered under the <i>Physicians and other health professionals</i> section.</p>		
Breast feeding durable medical equipment		
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	80% (of the recognized charge) per item
<p>Important note: See the <i>Breast feeding durable medical equipment</i> section of the certificate of coverage for limitations on breast pump and supplies.</p>		
Family planning services – female contraceptives		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits*	
<p>Important note: Any visits that exceed the contraceptive counseling services maximum are covered under <i>Physician services</i> office visits.</p>		

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Contraceptives (prescription drugs and devices)		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	80% (of the recognized charge) per item
Female voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) per admission No copayment or policy year deductible applies	80% (of the recognized charge) per admission
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit

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Eligible health services	In-network coverage*	Out-of-network coverage*
2. Physicians and other health professionals		
Physician and specialist services (non-surgical and non-preventive)		
Office hours visits (non-surgical and non-preventive care by a physician and specialist, includes telemedicine consultations)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physician and specialist – inpatient surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Physician and specialist –outpatient surgical services		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
In-hospital non-surgical physician services		
In-hospital non-surgical physician services	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Consultant services (non-surgical and non-preventive)		
Consultant office visits		
Office hours visits (non-surgical and non-preventive care), includes telemedicine consultations	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Second surgical opinion		
Second surgical opinion	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)		
Walk-in clinic (non-emergency visit)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Important note: Some walk-in clinics can provide preventive care and wellness services. The types of services offered will vary by the provider and location of the clinic. <i>If you get preventive care and wellness benefits at a walk-in clinic, they are paid at the cost-sharing shown in the Preventive care and wellness section.</i>		

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

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Home health care		
Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hospice care		
Inpatient facility (room and board and other miscellaneous services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient private duty nursing		
Outpatient private duty nursing	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Skilled nursing facility		
Inpatient facility (room and board) and miscellaneous inpatient care services and supplies Subject to semi-private room rate unless intensive care unit is required Room and board includes intensive care	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission

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Eligible health services	In-network coverage*	Out-of-network coverage*
4. Emergency services and urgent care		
Emergency services		
Hospital emergency room **Does not include complex imaging services, lab work and radiological services performed during a hospital emergency room visit, and any surgery which results from the hospital emergency room visit	80% (of the negotiated charge) per visit	Paid the same as in-network coverage
**See the cost-sharing that applies to these covered benefits in this schedule of benefits.		
Emergency services resulting from a criminal sexual assault or abuse	100% (of the negotiated charge) per visit No policy year deductible applies	Paid the same as in-network coverage
Important note: <ul style="list-style-type: none"> As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment and coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • 		
Urgent care		
Urgent medical care provided by an urgent care provider **Does not include complex imaging services, lab work and radiological services performed during an urgent medical care visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
**See the cost-sharing that applies to these covered benefits in this schedule of benefits.		

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Eligible health services	In-network coverage*	Out-of-network coverage*
5. Pediatric dental care		
Limited to covered persons through the end of the month in which the person turns age 19		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	70% (of the recognized charge) per visit
Type B services	70% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Dental emergency 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.
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.		

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Pediatric dental care schedule

Diagnostic and preventive care (type A services)	
Dental Code	Dental service or supply
<i>Visits and images</i>	
Non-standard	<ul style="list-style-type: none"> Office visit during regular office hours, for oral examination (office or school setting), limited to 2 visits every 12 months Routine comprehensive or recall examination, limited to 2 visits every 12 months Problem-focused examination
Non-standard	<ul style="list-style-type: none"> Oral examination performed in school setting limited to 2 visits every 12 months Prophylaxis (cleaning) (office or school setting), limited to 2 treatments per year Topical application of fluoride (office or school setting), limited to two applications of treatment per year Topical application of fluoride varnish, limited to 3 treatments per year Sealants, per tooth, limited to one application every 3 years for permanent molars and premolars only Bitewing images, limited to 2 sets per year Complete image series, including bitewings if medically necessary or panoramic image, limited to 1 set every 36 months Vertical bitewing images, limited to 1 set every 36 months Periapical images Intra-oral, occlusal view, maxillary or mandibular Emergency palliative treatment per visit
<i>Space maintainers</i>	
Space maintainers are covered only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 months after installation)	
	<ul style="list-style-type: none"> Fixed (unilateral or bilateral) Removable (unilateral or bilateral) Re-cementation of space maintainer Removal of fixed space maintainer
<i>Basic restorative care (type B services)</i>	
Dental Code	Dental service or supply
<i>Visits and images</i>	
	<ul style="list-style-type: none"> Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater) Consultation (by other than the treating dental provider)
<i>Images, pathology and prescription drugs</i>	
	<ul style="list-style-type: none"> Extra-oral radiographic image

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<i>Oral surgery</i>	
	<ul style="list-style-type: none"> • Extractions: <ul style="list-style-type: none"> • Erupted tooth or exposed root • Coronal remnants • Surgical removal of erupted tooth/root tip • Impacted Teeth: <ul style="list-style-type: none"> • Removal of tooth (soft tissue) • Odontogenic Cysts and Neoplasms: <ul style="list-style-type: none"> • Removal of odontogenic cyst or tumor • Other Surgical Procedures: <ul style="list-style-type: none"> • Alveoplasty, in conjunction with extractions, per quadrant • Alveoplasty, in conjunction with extractions, per quadrant • Alveoplasty, not in conjunction with extractions, per quadrant • Alveoplasty, not in conjunction with extractions – 1 to 3 teeth or tooth spaces, per quadrant • Excision of hyperplastic tissue • Removal of exostosis • Tooth reimplantation • Transplantation of tooth or tooth bud • Closure of oral fistula of maxillary sinus • Crown exposure to aid eruption • Frenectomy
<i>Periodontics</i>	
	<ul style="list-style-type: none"> • Occlusal adjustment (other than with an appliance or by restoration) • Root planing and scaling , per quadrant limited to 4 separate quadrants every 2 years • Root planing and scaling – 1 to 3 teeth per quadrant; limited to 4 separate quads every 2 years • Gingivectomy, per quadrant, limited to 1 per quadrant every 24 months • Gingivectomy, 1 to 3 teeth per quadrant, limited to 1 per site every 24 months • Gingival flap procedure – per quadrant, limited to 1 per quadrant every 24 months • Gingival flap procedure – 1 to 3 teeth per quadrant, limited to 1 per site every 24 months
Non-standard No limit in IL	<ul style="list-style-type: none"> • Periodontal maintenance procedures following active therapy
<i>Endodontics</i>	
	<ul style="list-style-type: none"> • Pulp capping • Pulpotomy • Pulpal therapy • Pulpal regeneration • Apexification/reclarification

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	<ul style="list-style-type: none"> • Apicoectomy • Root canal therapy including medically necessary images: <ul style="list-style-type: none"> • Anterior • Bicuspid
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Restorative dentistry

(Multiple restorations in 1 surface are considered as a single restoration)

	<ul style="list-style-type: none"> • Amalgam restorations • Resin-based composite restorations (other than for molars)
	Pins:
	<ul style="list-style-type: none"> • Pin retention – per tooth, in addition to amalgam or resin restoration
	Crowns (when tooth cannot be restored with a filling material):
	<ul style="list-style-type: none"> • Prefabricated stainless steel • Prefabricated resin crown (excluding temporary crowns)
	Re-cementation:
	<ul style="list-style-type: none"> • Inlay • Crown • Bridge

Major restorative care (type C services)

Dental Code	Dental service or supply
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Oral Surgery

	<ul style="list-style-type: none"> • Surgical removal of impacted teeth: <ul style="list-style-type: none"> • Removal of tooth (partially bony) • Removal of tooth (completely bony)
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Periodontics

	<ul style="list-style-type: none"> • Osseous surgery (including flap and closure), 1 to 3 teeth, per quadrant, limited to 1 per site every 24 months • Osseous surgery (including flap and closure), per quadrant, limited to 1 per quadrant, every 24 months • Soft tissue graft procedures • Clinical crown lengthening • Full mouth debridement, limited to 2 per year
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Endodontics

	<ul style="list-style-type: none"> • Molar Root canal therapy, including medically necessary images • Retreatment of previous molar root canal therapy, including medically necessary images
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Restorative

Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.

	<ul style="list-style-type: none">• Inlays/Onlays, limited to 1 per tooth every 5 years
	<ul style="list-style-type: none">• Crowns:<ul style="list-style-type: none">• Resin, limited to 1 per tooth every 5 years• Resin with noble metal, limited to 1 per tooth every 5 years• Resin with base metal, limited to 1 per tooth every 5 years• Porcelain/ceramic substrate, limited to 1 per tooth every 5 years• Porcelain with noble metal, limited to 1 per tooth every 5 years• Porcelain with base metal, limited to 1 per tooth every 5 years• Base metal (full cast), limited to 1 per tooth every 5 years• Noble metal (full cast), limited to 1 per tooth every 5 years• Titanium, limited to 1 per tooth every 5 years• $\frac{3}{4}$ cast metallic or porcelain/ceramic, limited to 1 per tooth every 5 years
	<ul style="list-style-type: none">• Post and core
	<ul style="list-style-type: none">• Core build up

Prosthodontics

	Installation of dentures and bridges is covered only if needed to replace teeth which were not abutments to a denture or bridge less than 5 years old.
	<ul style="list-style-type: none">• Replacement of existing bridges or dentures, limited to 1 every 5 years
	<ul style="list-style-type: none">• Bridge Abutments (See Inlays and Crowns), limited to 1 every 5 years
	<ul style="list-style-type: none">• Pontics: limited to 1 every 5 years<ul style="list-style-type: none">• Base metal (full cast), limited to 1 every 5 years• Noble metal (full cast), limited to 1 every 5 years• Porcelain with noble metal, limited to 1 every 5 years• Porcelain with base metal, limited to 1 every 5 years• Resin with noble metal, limited to 1 every 5 years• Resin with base metal, limited to 1 every 5 years• Titanium, limited to 1 every 5 years
	<ul style="list-style-type: none">• Removable Bridge (unilateral), limited to 1 every 5 years
	<ul style="list-style-type: none">• One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics, limited to 1 every 5 years
	<ul style="list-style-type: none">• 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.)<ul style="list-style-type: none">• Complete upper denture, limited to 1 every 5 years• Complete lower denture, limited to 1 every 5 years• Immediate upper denture/Immediate upper partial denture, limited to 1 every 5 years• Immediate lower denture/Immediate lower partial denture, limited to 1 every 5 years• Partial upper or lower, resin base (including any conventional clasps, rests and teeth), limited to 1 every 5 years

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	<ul style="list-style-type: none"> • Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth), limited to 1 every 5 years
	<ul style="list-style-type: none"> • Stress Breakers
	<ul style="list-style-type: none"> • Interim partial denture (stayplate), anterior only
	<ul style="list-style-type: none"> • Office reline
	<ul style="list-style-type: none"> • Laboratory relines
	<ul style="list-style-type: none"> • Special tissue conditioning, per denture
	<ul style="list-style-type: none"> • Rebase, per denture
	<ul style="list-style-type: none"> • Adjustment to denture (more than 6 months after installation)
	Full and partial denture repairs:
	<ul style="list-style-type: none"> • Broken dentures, no teeth involved
	<ul style="list-style-type: none"> • Repair cast framework
	<ul style="list-style-type: none"> • Replacing missing or broken teeth, each tooth: <ul style="list-style-type: none"> • Adding teeth to an existing partial denture <ul style="list-style-type: none"> ○ Each tooth ○ Each clasp
	<ul style="list-style-type: none"> • Repairs: crowns and bridges
	<ul style="list-style-type: none"> • Occlusal guard (for bruxism only)
	<ul style="list-style-type: none"> • Occlusal guard adjustment (not eligible within the first six months after placement of appliance)

General anesthesia and intravenous sedation

	<ul style="list-style-type: none"> • Only when medically necessary and only when provided in conjunction with a covered dental surgical procedure
Non-standard	<ul style="list-style-type: none"> • Nitrous oxide/analgesia
Non-standard	<ul style="list-style-type: none"> • Therapeutic drug injection, limited to medical necessity
	<ul style="list-style-type: none"> • Non-intravenous conscious sedation
	<ul style="list-style-type: none"> • Other drugs or medicaments, by report

Orthodontic services

Medically necessary comprehensive treatment

	<ul style="list-style-type: none"> • All comprehensive orthodontic services require precertification to ensure treatment is medically necessary. To qualify for coverage, the covered person's severe, dysfunctional, handicapping malocclusion may be evaluated using the Modified Salzmann Index where coverage would need to score 42 points or greater.
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*See the *How to read your schedule of benefits*, *Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Eligible health services	In-network coverage*	Out-of-network coverage*
6. Specific conditions		
Birthing center (facility charges)		
Inpatient (room and board and other miscellaneous services and supplies)	Paid at the same cost-sharing as hospital care.	Paid at the same cost-sharing as hospital care.
Diabetic services and supplies (including equipment and training)		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Family planning services – other		
Voluntary sterilization for males		
Inpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Abortion		
Inpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment		
TMJ and CMJ treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Impacted wisdom teeth		
Impacted wisdom teeth	80% (of the negotiated charge)	80% (of the recognized charge)

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

Accidental injury to sound natural teeth		
Accidental injury to sound natural teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Dermatological treatment		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maternity care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Well newborn nursery care		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
<p><i>Note: If applicable, the per admission copayment and/or policy year deductible amounts for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.</i></p>		
Pregnancy complications		
Inpatient (room and board and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Gender reassignment (sex change) treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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

Autism spectrum disorder		
Autism spectrum disorder diagnosis and testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Autism spectrum disorder treatment (includes physician and specialist office visits)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Mental health treatment		
Mental health treatment – inpatient		
Inpatient hospital mental disorders treatment (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Inpatient residential treatment facility mental 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 disorder room and board intensive care		
Mental health treatment – outpatient		
Outpatient mental disorder treatment office visits to a physician or behavioral health provider (includes cognitive behavioral therapy consultations)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

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

Other outpatient mental disorders treatment (includes skilled behavioral health services in the home)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment)		
Intensive outpatient program (at least 2 hours per day and at least 6 hours per week of clinical treatment)		
Substance use disorder related disorders treatment-inpatient		
Detoxification – inpatient		
Inpatient hospital substance use disorder detoxification (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Inpatient hospital substance use disorder rehabilitation (room and board and other miscellaneous hospital services and supplies)		
Inpatient residential treatment facility substance use disorder (room and board and other miscellaneous residential treatment facility services and supplies)		
Subject to semi-private room rate unless intensive care unit is required		
Substance use disorder room and board intensive care		

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

Substance use disorder related disorders treatment-outpatient: detoxification and rehabilitation		
Outpatient substance use disorder office visits to a physician or behavioral health provider (includes cognitive behavioral therapy consultations)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Other outpatient substance use disorder services (includes skilled behavioral health services in the home) Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment)* Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Obesity (bariatric) surgery		
Obesity surgery-- inpatient and outpatient facility and physician services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Reconstructive surgery and supplies		
Reconstructive surgery and supplies (includes reconstructive breast surgery)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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

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

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

Eligible health services	In-network coverage*	Out-of-network coverage*
Treatment of infertility		
Basic infertility services		
Inpatient and outpatient care - basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Comprehensive infertility services		
Inpatient and outpatient care - comprehensive infertility services	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Advanced reproductive technology (ART) services		
Inpatient and outpatient care – ART services	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
For treatment that includes an oocyte retrieval, maximum number of oocyte retrievals	4, however if a live birth follows a completed oocyte retrieval, 2 additional oocyte retrievals will be covered.	

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

Eligible health services	In-network coverage*	Out-of-network coverage*
7. Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Diagnostic lab work and radiological services		
Diagnostic lab work and radiological services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Chemotherapy		
Chemotherapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient infusion therapy		
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Outpatient radiation therapy		
Outpatient radiation therapy	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.

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

Outpatient respiratory therapy		
Respiratory therapy	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Transfusion or kidney dialysis of blood		
Transfusion or kidney dialysis of blood	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation		
Cardiac rehabilitation	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Pulmonary rehabilitation		
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Short-term rehabilitation and habilitation therapy services		
Outpatient physical, occupational, speech, and cognitive therapies	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Combined for short-term rehabilitation services and habilitation therapy services		
Spinal manipulation services		
Spinal manipulation services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	Unlimited visits	
Diagnostic testing for learning disabilities		
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.

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

Eligible health services	In-network coverage*	Out-of-network coverage*
8. Other services and supplies		
Acupuncture in lieu of anesthesia		
Acupuncture in lieu of anesthesia	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Ambulance service		
Emergency ground, air or water ambulance (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
Clinical trial therapies (experimental or investigational)		
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Clinical trials (routine patient costs)		
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Durable medical equipment (DME)		
Durable medical equipment	100% (of the negotiated charge) per item	80% (of the recognized charge) per item
Enteral formulas and nutritional supplements		
Enteral formulas and nutritional supplements	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Osteoporosis (non-preventive care)		
Physician's or specialist's office visits	100% (of the negotiated charge) per visit	80% (of the recognized charge) per visit
Orthotic devices		
Orthotic devices	100% (of the negotiated charge) per item	80% (of the recognized charge) per item

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

Prosthetic and customized orthotic devices		
Prosthetic and customized orthotic devices	100% (of the negotiated charge) per item	80% (of the recognized charge) per item
Hearing aids and exams		
Hearing aid exams	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hearing aid exam maximum	One hearing exam every policy year	
Hearing aids	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Podiatric (foot care) treatment		
Physician and Specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Vision care		
Pediatric vision care		
Limited to covered persons through the end of the month in which the person turns age 19		
Pediatric routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year	1 visit	
Pediatric comprehensive low vision evaluations		
Performed by a legally qualified ophthalmologist or optometrist	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum	One comprehensive low vision evaluation every 5 years	

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

Pediatric vision care services and supplies		
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	80% (of the recognized charge) per item No policy year deductible applies
Maximum number of eyeglass frames per policy year	One set of eyeglass frames	
Maximum number of prescription lenses per policy year	One pair of prescription lenses	
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per policy year	One optical device	
*Important note: Refer to the <i>Vision care</i> section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both. Coverage does not include the office visit for the fitting of prescription contact lenses.		

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

Eligible health services	In-network coverage*	Out-of-network coverage*
9. Outpatient prescription drugs		
Plan features		
Outpatient prescription drug benefits are subject to the medical plan's maximum out-of-pocket limits as explained in this schedule of benefits.		
Policy year deductible waiver		
The policy year deductible is waived for all prescription drugs filled at an in-network and out-of-network retail pharmacy.		
Policy year deductible and copayment waiver for risk reducing breast cancer		
The policy year deductible and the prescription copayment will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
Policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs		
The policy year deductible and the prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail in-network pharmacy . This means that such prescription drugs and OTC drugs are paid at 100%.		
Your policy year deductible and any prescription drug copayment will apply after those two regimens per policy year have been exhausted.		
Policy year deductible and copayment waiver for contraceptives		
The policy year deductible and the prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy.		
This means that such contraceptive methods are paid at 100% for:		
<ul style="list-style-type: none"> • Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. • If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%. 		
The policy year deductible and the prescription drug copayment continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		

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

Preferred generic prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	\$12 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Non-preferred generic prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	\$55 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Preferred brand-name prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	\$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Non-preferred brand-name prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	\$55 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Specialty drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	\$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Orally administered anti-cancer prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge) per prescription or refill No policy year deductible applies	100% (of the recognized charge) per prescription or refill No policy year deductible applies

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

Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a retail pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by calling the toll-free number on your ID card.	
Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer prescription drugs filled at a retail pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, contact Member Services by calling the toll-free number on your ID card.	
Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits above. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs, contact Member Services by calling the toll-free number on your ID card.	

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

General coverage provisions

This section provides detailed explanations about the:

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

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

Policy year deductible provisions

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

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

Individual

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

Copayments

In-network coverage

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

Out-of-network coverage

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

Coinsurance

Coinurance 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.

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

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 **prescription drug** benefit.

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

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 have paid for **eligible health services** during the **policy year** meets the individual **maximum out-of-pocket limits**, this plan will pay:

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

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

Family

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

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

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

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

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

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

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

Medical and Outpatient Prescription Drugs

In-network care

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

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

- Non-covered medical expenses

Out-of-network care

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

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

- Amounts you pay toward a deductible
- Amounts you pay toward a copayment/coinsurance
- Charges, expenses or costs in excess of the **recognized charge**
- Any out of pocket costs for durable medical equipment
- Any out of pocket costs for prosthetics
- Any out of pocket costs for comprehensive and ART infertility
- Any out of pocket costs for private duty nursing
- Any out of pocket costs for transplants
- Any out of pocket costs for obesity surgery
- All costs for non-covered services
- Any out of pocket costs for non-emergency use of the emergency room
- Any out of pocket costs incurred for non-urgent use of an urgent care provider
- Any out of pocket costs for non-emergency ambulance services
- Any out of pocket costs for outpatient prescription drugs

Calculations; determination of recognized charge; determination of benefits provisions

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

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

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



Aetna Life Insurance Company
(a stock company)
151 Farmington Avenue Hartford, Connecticut

Student Health Insurance

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

Certificate of Coverage

Prepared exclusively for:

Policyholder:	Illinois Institute of Technology
Policyholder number:	724532
Student policy effective date:	08/12/18
Student policy renewal date:	08/12/18
Plan effective date:	08/12/18
Plan issue date:	11/16/18

Underwritten by Aetna Life Insurance Company

IMPORTANT NOTICES:

- **Notice of Non-Discrimination:**

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

- **Sanctioned Countries:**

If coverage provided under this **student policy** violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible health services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

- **State Notice of Non-Discrimination:**

The laws of the State of Illinois prohibit insurers from unfairly discriminating against any person based upon their status as a victim of family violence, sex, sexual preference or marital status and forbids excluding coverage for dependent child maternity.

Welcome

Thank you for choosing **Aetna**.

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

This certificate of coverage will tell you about your **covered benefits** – what they are and how you get them. 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.

Entire Contract

This certificate of coverage, including the student policy, application and any amendments and riders, constitute your entire Aetna student policy. A change to the student policy is not valid unless approved by an executive officer of Aetna.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED. When you choose to use the services of an **out-of-network provider** for an **eligible health service** in non-emergency situations, benefit payments to **out-of-network provider** are not based upon the amount billed. Your benefit payment will be based on the **recognized charge**.

YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT SHOWN IN THE SCHEDULE OF BENEFITS AFTER THE PLAN HAS PAID ITS PORTION. After the plan has paid its portion of the bill as provided in 215 ILCS 5/356z.3a, **out-of-network provider** may bill you for any amount up to the billed charge.

Other than **coinsurance** and **policy year deductible**, **in-network** providers agree to accept discount payments for services without additional billing to you. You may obtain information about the participating status of professional providers and out-of-pocket expenses by calling the toll-free number on your ID card.

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Let's get started!

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

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

- When we say “you” and “your”, we mean the **covered student** and any **covered dependents**
- When we say “us”, “we”, and “our”, we mean **Aetna**
- Some words appear in **bold** type 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 in-network and out-of-network **covered benefits** for medical and pharmacy insurance coverage.

How your plan works – starting and stopping coverage

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

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

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

Eligible health services

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

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

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

Paying for eligible health services— the general requirements

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

- The **eligible health service** is **medically necessary**
- You get the **eligible health service** from a **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 exception request review organization” or EERRO for short, will make the final decision for us.

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

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

Your in-network coverage helps you:

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

School health services

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

Aetna's network of providers

Aetna's network of **physicians, hospitals** and other health care **providers** 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 into your Aetna Navigator® secure website at www.aetnastudenthealth.com.

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

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

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

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

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

Your out-of-network coverage:

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

How to contact us for help

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

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

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

You can also contact us by:

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

Your ID card

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

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

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

Who the plan covers

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

You will find information in this section about:

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

Who is eligible?

All classes of students are eligible.

If we find out that you do not meet this eligibility requirement, we are only required to refund any **premium** contribution minus any claims that we have paid.

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)

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 spouse that resides with you
- Your civil union partner that resides with you. The Religious Freedom Protection Act and Civil Union Act, 750 ILCS 75, allows both same-sex and different-sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples.
- Your domestic partner
- Your dependent children – your own or those of your spouse, civil union partner or domestic partner
 - The children must be under 26 years of age

A dependent does not include:

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

You may continue coverage for a disabled child past the age limit shown above. See the *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 the following new dependents at any time during the year:

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

- If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
- If your coverage ends during this 31 day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31 day period has not ended.
- A stepchild - You may put a child of your spouse, civil union partner or domestic partner on your plan.
 - You must complete your enrollment information and send it to us within 31 days after the date of your marriage, civil union or your Declaration of Domestic Partnership with your stepchild's parent.
 - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage, civil union or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
 - To keep your stepchild covered, we must receive your completed enrollment information within 31 days after the date of your marriage, civil union or your Declaration of Domestic Partnership.
 - You must still enroll the stepchild within 31 days after the date of your marriage, civil union or your Declaration of Domestic Partnership even when coverage does not require payment of an additional premium contribution for the stepchild.
 - If you miss this deadline, your stepchild will not have health benefits after the first 31 days.
 - If your coverage ends during this 31 day period, then your stepchild's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.
- Dependent coverage due to a court order: If you must provide coverage to a dependent because of a court order, your dependent is covered on your health plan for the first 31 days from the court order.
 - To keep your dependent covered, we must receive your completed enrollment information within 31 days of the court order.
 - You must still enroll the dependent within 31 days of the court order even when coverage does not require payment of an additional premium contribution for the dependent.
 - If you miss this deadline, your dependent will not have health benefits after the first 31 days.
 - If your coverage ends during this 31 day period, then your dependent's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

Notification of change in status

It is important that you notify us 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, civil union partner or domestic partner or a minor child on your health plan.
- When you are a victim of domestic abuse or spousal abandonment and you don't want to be enrolled in the perpetrator's health plan.

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

Effective date of coverage

Enrollment

Student coverage

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

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

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

Dependent coverage

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

Late enrollment

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

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

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 under your plan* and *Exceptions* sections plus the schedule of benefits.

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

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

Precertification

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

Precertification for medical services and supplies

In-network care

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

Out-of-network care

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

Precertification call

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

Non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
An emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness , the diagnosis of an illness , or an injury .
Outpatient non-emergency services requiring precertification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Notification calls for certain medical conditions

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

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

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

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

Precertification for prescription drugs and devices

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

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

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

Step therapy

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

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

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

How can I request a medical exception request review?

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

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

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

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

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

Eligible health services under your plan

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

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

For example,

- **Physician** care generally is covered but **physician** care for **cosmetic** surgery is never covered. This is an exception (exclusion).
- Dental check-ups for children are generally covered but they are a **covered benefit** only up to a set number of visits a year. This is a limitation.

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

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

Important note:

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

1. Preventive care and wellness

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

Important notes:

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

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

2. Diagnostic testing for the treatment or diagnosis of a medical condition will not be covered under the preventive care and wellness benefit. For those types of tests and treatment, you will pay the cost sharing specific to **eligible health services** for diagnostic testing and treatment.
3. Gender-specific preventive care and wellness benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.
4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging on to your Aetna Navigator® secure website at www.aetnastudenthealth.com or by calling the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.

5. We may use reasonable medical management techniques to determine the frequency, method, treatment, or setting of preventive care and wellness benefits when not specified in the recommendations and guidelines of the:
- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
 - United States Preventive Services Task Force
 - Health Resources and Services Administration
 - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

Routine physical exams

Eligible health services include office visits to your **physician** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, 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 for everyone ages 15-65 and other ages at increased risk
 - Screening for gestational diabetes for women, including women 24-28 weeks pregnant and those at risk of developing gestational diabetes
 - Screening for Diabetes (Type 2) for adults with high blood pressure
 - High-risk Human Papillomavirus (HPV) DNA testing for women 30 and older
 - Bone density screenings for osteoporosis
 - Aspirin use to prevent cardiovascular disease for men and women of certain ages
 - Blood pressure screening
 - Cholesterol screening for adults of certain ages or at higher risk
 - Depression screening
 - Hepatitis B screening for people and adolescents ages 11-17 at high risk. This includes:
 - People from countries with 2% or more Hepatitis B prevalence
 - U.S. born people not vaccinated as infants and with at least 1 parent born in a region with 8% or more Hepatitis B prevalence
 - Hepatitis C screening for:
 - adults at increased risk
 - 1 time for everyone born 1945-1965
 - Latent tuberculosis screening for adults at increased risk
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial **hospital** checkup

Preventive care immunizations

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

- Adults:
 - Herpes Zoster
 - Mumps
 - Rubella
 - Shingles if you are 60 years of age or over.
- Adults and children from birth to age 18:
 - Diphtheria
 - Hepatitis A
 - Hepatitis B
 - Human papillomavirus (HPV)
 - Influenza (flu shot)
 - Measles
 - Meningococcal
 - Pertussis (whooping cough)
 - Pneumococcal
 - Tetanus
 - Varicella (Chickenpox)
- Children from birth to age 18:
 - Haemophilus influenza type b
 - Inactive poliovirus
 - Rotavirus.

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

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **physician**, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes Pap smears, including surveillance tests for ovarian cancer for woman at risk for ovarian cancer. 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.
- Clinical breast exams as follows:
 - For women over 20 years of age but less than 40, at least every 3 years
 - For women 40 years of age and older, annually
- Breast cancer chemoprevention counseling
- Cervical cancer screening for sexually active woman
- Chlamydia infection screening for younger women and other women at higher risk
- HIV screening and counseling for sexually active woman
- Osteoporosis screening for women over age 60 depending on risk factors.

Eligible health services for pregnant or women who may become pregnant include:

- Anemia screening on a routine basis
- Folic acid supplements for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening
- Urinary tract or other infection screening

Well child preventive visits

Eligible health services include routine:

- Autism screening for children at 18 and 24 months
- For children ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years and 15-17 years, the following:
 - Behavioral assessments
 - Dyslipidemia screening for children at higher risk of lipid disorders
 - Height, weight and body mass index (BMI) measurements
 - Medical history throughout development
 - Tuberculin testing for children at higher risk of tuberculosis
- Cervical dysplasia screening for sexually active females
- Developmental screening for children under age 3
- Fluoride chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hematocrit or hemoglobin screening
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- Iron supplements for children ages 6-12 months at risk for anemia
- Lead screening for children at risk of exposure
- Oral health risk assessment for young children ages: 0-11 months, 1-4 years and 5-10 years
- Phenylketonuria (PKU) screening for newborns.
- Critical newborn congenital heart defect screening
- Dental caries prevention: infants and children up to age 5
- Newborn blood screening
- Sensory vision screening

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
- Abdominal aortic aneurysm one-time screening for men of specified ages who have never smoked
- Treatment visits
- Class visits

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

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

- **Sexually transmitted infection counseling**

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

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

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

- **Skin cancer behavioral counseling**

If you have fair skin and are between the ages of 10 to 24 years old, **eligible health services** include counseling services to help you reduce the risk of developing skin cancer. The counseling services will teach you how to minimize exposure to ultraviolet radiation.

- **Falls prevention counseling**

If you are age 65 years or older, **eligible health services** include counseling and evaluation services to help you assess whether exercise or physical therapy and vitamin D supplements can aid you in lowering your risk for falls.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Low dose mammography screening, for women age 35 and older (including x-ray examination, digital mammography and breast tomosynthesis) for the presence of occult breast cancer as follows:
 - For women 35-39, a baseline mammogram
 - For women 40 years of age and older, an annual mammogram
 - For women under 40, with a family or prior personal history of breast cancer, positive genetic testing or other risk factors, at necessary age and intervals
 - Comprehensive ultrasound screening and MRI of the entire breast(s) when a mammogram demonstrates heterogeneous or dense breast tissue, as determined by your **physician**
 - Screening MRI, as determined by your **physician**
- Annual digital rectal exams
- Prostate specific antigen (PSA) tests as recommended by your **physician**. This includes:
 - Asymptomatic men age 50 and older
 - African-American men age 40 and over
 - Men age 40 and over with family history of prostate cancer
- Colorectal cancer screening for adults over 50
- 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 adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years

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

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

Prenatal care

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

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height
- Preeclampsia screening
- Hepatitis B screening at their first visit
- Expanded tobacco intervention and counseling for pregnant tobacco users

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

Important note:

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

Comprehensive lactation support and counseling services

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

Breast feeding durable medical equipment

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

Breast pump

Eligible health services include:

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

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

Breast pump supplies and accessories

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

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

Family planning services – female contraceptives

Eligible health services include family planning services such as:

Counseling services

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

Contraceptives

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

Voluntary sterilization

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

Important note:

See the following sections for more information:

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

2. Physicians and other health professionals

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

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

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

Important note:

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

Telemedicine may have different cost sharing than other outpatient services. See the schedule of benefits for more information.

Allergy testing and treatment

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

- Allergy testing

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.

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

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

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

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

Anesthetist

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

Surgical assistant

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

Physician and specialist – outpatient surgical services

Eligible health services include the services of:

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

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

Anesthetist

Covered benefits for your **surgery** include the services of an anesthetist who is not employed or retained by the **hospital** 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** during the periods before and after **surgery**. A surgical assistant is under the supervision of a **physician**.

In-hospital non-surgical physician services

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

Consultant services (non-surgical and non-preventive)

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

Covered benefits include treatment by the consultant.

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

Important note:

Your **student policy** covers **telemedicine**. All in-person consultant office visits that are **covered benefits** are also covered if you use **telemedicine** instead.

Telemedicine 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 **specialist** to confirm your need for a **surgery**. The **specialist** must be board-certified in the medical field for the **surgery** that is being proposed by your **physician**.

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

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

Alternatives to physician and specialist office visits

Walk-in clinic (non-emergency visit)

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

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

3. Hospital and other facility care

Hospital care (facility charges)

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

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

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **health professionals** employed by the **hospital**
- Operating and recovery rooms
- **Intensive care units** of a **hospital**
- Administration of blood and blood derivatives, but not the expense of the blood or blood product
- Radiation therapy
- Inhalation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a **hospital**

Preadmission testing

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

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

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

Anesthesia and related facility charges for oral surgery or a dental procedure

Eligible health services include:

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

for your **oral surgery** or dental procedure.

The following conditions must be met:

- Your **dental provider** cannot safely perform the **oral surgery** in a dental office setting

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 *Short-term rehabilitation services and Habilitation therapy services* sections and the schedule of benefits.

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

Hospice care

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

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

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a **hospice care agency** or **hospice care** provided in a **hospital**
- Psychological and dietary counseling
- Pain management and symptom control
- 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**

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

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

4. Emergency services and urgent care

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

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

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

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

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

For follow-up care, you are covered when:

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

In case of a medical emergency

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

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**.

5. Pediatric dental care

Eligible health services include dental services and supplies provided by a **in-network** or **out-of-network dental provider**.

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

Dental emergencies

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

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

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

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

What rules and limits apply to dental care?

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

When does your plan cover orthodontic treatment?

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

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

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

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

When does your plan cover replacements?

Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's "replacement rule". The replacement rule is that certain replacements of, or additions to, existing crowns, inlays, onlays and veneers, dentures or bridges are covered only when you give us proof that:

- 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.

When does your plan cover missing teeth that are not replaced?

The first 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 that were removed while you were covered by the plan. (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.

When does your plan cover other treatment?

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

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

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

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

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

6. Specific conditions

Birthing center (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 under your plan-Maternity care and Well newborn nursery care* sections for more information.

Diabetic services and supplies (including equipment and training)

Eligible health services include:

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

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

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

Family planning services – other

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

- Voluntary sterilization for males
- Abortion

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

Eligible health services include the:

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

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

Impacted wisdom teeth

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

Accidental injury to sound natural teeth

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

Dermatological treatment

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

Maternity care

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

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

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

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 four days for a normal delivery
- **Hospital** or **birthing center** visits and consultations for the well newborn by a **physician** but for not more than 1 visits per day

Pregnancy complications

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

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

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

Gender reassignment (sex change) treatment

Eligible health services include services and supplies for gender reassignment (sometimes called sex change) treatment.

Eligible health services include:

- 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
- Blood transfusions and the cost of un-replaced blood and blood products as well as the collection, processing and storage of self-donated blood after the surgery has been scheduled
- Gender reassignment counseling by a **behavioral health provider**
- Injectable and non-injectable hormone replacement therapy

Important Note:

As a reminder, gender reassignment (sex change) treatment requires **precertification** by **Aetna**. Your **in-network provider** is responsible for obtaining **precertification**. You are responsible for obtaining **precertification** when you use an **out-of-network provider**. Just log into your Aetna Navigator® secure website at www.aetnastudenthealth.com for detailed information about this **covered benefit**, including eligibility requirements. You can also call **Member Services** at the toll-free number on your ID card.

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 **provider** with expertise in treating autism spectrum disorder or 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

Important note:

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

Mental health treatment

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

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

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

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

Treatment of a **mental disorder** in a general medical **hospital** is only covered if you are transferred to its separate psychiatric section or unit.

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

- Outpatient treatment received while not confined as an inpatient in a general medical **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
 - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor
 - Individual, group and family therapies for the treatment of mental health
 - Other outpatient mental health treatment such as:
 - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**
 - **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**
 - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
 - You are homebound
 - Your **physician** orders them
 - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
 - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
 - Electro-convulsive therapy (ECT)
 - Mental health injectables
 - Transcranial magnetic stimulation (TMS)
 - Psychological testing
 - Neuropsychological testing
 - 23 hour observation

Substance use related disorders treatment

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

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

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

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

Treatment of **substance use disorder** in a general medical **hospital** is only covered if you are:

- Admitted for the treatment of medical complications of **substance use disorder**
- Transferred to its separate **substance use disorder** section or unit

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

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

- Outpatient treatment received while not confined as an inpatient in a general medical **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
 - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor
 - Individual, group and family therapies for the treatment of **substance use disorder**
 - Other outpatient **substance use disorder** treatment such as:
 - Outpatient **detoxification**
 - **Partial hospitalization treatment** provided in a facility or program for treatment of **substance use disorder** provided under the direction of a **physician**
 - **Intensive outpatient program** provided in a facility or program for treatment of **substance use disorder** provided under the direction of a **physician**
 - Ambulatory **detoxification** which are outpatient services that monitor withdrawal from alcohol or other **substance use disorder**, including administration of medications
 - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
 - You are homebound
 - Your **physician** orders them
 - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
 - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
 - Treatment of withdrawal symptoms
 - Substance use disorder injectables
 - 24 hour observation

Important note:

Mental health and addiction parity

- Financial requirements applicable to mental, emotional, nervous, or **substance use disorders** or condition benefits are no more restrictive than the predominant financial requirements applied to substantially all **hospital** and medical benefits covered by the **student policy**. There is no separate cost sharing requirements applicable only to mental, emotional, nervous, or **substance use disorders** or condition benefits.
- Treatment limitations applicable to mental, emotional, nervous, or **substance use disorders** or condition benefits are no more restrictive than the predominant treatment limitations applied to substantially all **hospital** and medical benefits covered by the **student policy**. There are no separate treatment limitations that are applicable only to mental, emotional, nervous or **substance use disorders** or condition benefits.

Obesity (bariatric) surgery

Eligible health services include obesity surgery, which is also known as “weight loss surgery.” Obesity surgery is a type of procedure performed on people who are **morbidly obese**, for the purpose of losing weight.

Obesity is typically diagnosed based on your **body mass index (BMI)**. To determine whether you qualify for obesity surgery, your **physician** will consider your **BMI** and any other condition or conditions you may have. In general, obesity surgery will not be approved for any **covered person** with a **BMI** less than 35.

Your **physician** will request approval from us in advance of your obesity surgery. We will cover charges made for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient **prescription drug** benefits included under the *Outpatient prescription drugs* section
- Other related outpatient services

Reconstructive surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed. Services and supplies include:
 - An implant.
 - Areolar and nipple reconstruction.
 - Areolar and nipple re-pigmentation.
 - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
 - Treatment of physical complications of all stages of the mastectomy, including lymphedema and prosthetic devices.
 - A **physician** office visit or in-home nurse visit within 48 hours after discharge.
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
 - The defect results in severe facial disfigurement or major functional impairment of a body part.
 - The purpose of the **surgery** is to improve function.
- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Transplant services

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

Organ means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow

Aetna's network of transplant specialist facilities

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

For in-network services, you must get services from an **Institutes of Excellence™ (IOE) facility** we designate to perform the transplant you need. Coverage is not available for services from an in-network non-**IOE facility**.

You can choose in-network transplant services from either:

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

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

Travel and lodging expenses

If an **IOE** patient lives 100 or more miles from the **IOE facility**, **eligible health services** include travel and lodging expenses for the **IOE** patient and a companion to travel between the **IOE** patient's home and the **IOE facility**.

Eligible health services will be reimbursed by the plan and include coach class round-trip air, train, or bus travel and lodging costs.

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

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

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

Treatment of infertility

Basic infertility services

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

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

Comprehensive infertility services

Eligible health services include comprehensive **infertility** care. The first step to using your comprehensive infertility health care services is enrolling with our National Infertility Unit (NIU). To enroll you can reach our dedicated NIU at 1-800-575-5999.

Infertility services

You are eligible for **infertility** services if:

- You are covered under this plan as a student or as a **covered dependent** who is the student's legal spouse, civil union partner or domestic partner, referred to as "your partner" or as a **covered dependent** age 18 or over.
- There exists a condition that:
 - Is demonstrated to cause the **illness of infertility**.
 - Has been recognized by your **physician** or **infertility specialist** and documented in your or your partner's medical records.
- You or your partner has not had a voluntary sterilization with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- You or your partner do not have **infertility** that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- You have met the requirement for the number of months trying to conceive through egg and sperm contact.

Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators with expertise in all areas of **infertility** who can help:

- Enroll you in the **infertility** program
- Assist you with **precertification** of **eligible health services**
- Coordinate **precertification** for comprehensive **infertility** when these services are **eligible health services**
- Evaluate your medical records to determine whether comprehensive **infertility** services are reasonably likely to result in success
- Determine whether comprehensive **infertility** services are **eligible health services**

Your **provider** will request approval from us in advance for your **infertility** services. We will cover charges made by an **infertility specialist** for the following **infertility** services:

- Ovulation induction cycle(s) with menotropins
- Intrauterine insemination/artificial insemination

A "cycle" is an attempt at ovulation induction or intrauterine insemination. The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

Advanced reproductive technology services

Eligible health services include Assisted Reproductive Technology (ART) services. ART services are more advanced medical procedures or treatments performed to help a woman achieve pregnancy.

ART services

ART services include:

- In vitro fertilization (IVF)
- Zygote intrafallopian transfer (ZIFT)
- Gamete intrafallopian transfer (GIFT)
- Cryopreserved embryo transfers (Frozen Embryo Transfers (FET))
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery

You are eligible for ART services if:

- You are covered under this plan as a student or as a **covered dependent** who is the student's legal spouse, civil union partner or domestic partner, referred to as "your partner" or as a **covered dependent** age 18 and above.
- There exists a condition that:
 - Is demonstrated to cause the disease of **infertility**.
 - Has been recognized by your **physician** or **infertility specialist** and documented in your or your partner's medical records.
- You or your partner has not had a voluntary sterilization with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- You or your partner does not have **infertility** that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- You have exhausted the comprehensive **infertility** services benefits or have clinical need to move on to ART procedures. You have met the requirement for the number of months trying to conceive through egg and sperm contact.
- If you have been diagnosed with premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services through age 45 regardless of FSH level.

Fertility preservation

Fertility preservation involves the retrieval of mature eggs and/or sperm or the creation of embryos that are frozen for future use.

You are eligible for fertility preservation only when you:

- Are believed to be fertile
- Have planned services that will result in **infertility** such as:
 - Chemotherapy
 - Pelvic radiotherapy
 - Other gonadotoxic therapies
 - Ovarian or testicular removal

Along with the eligibility requirements above, you are eligible for fertility preservation benefits if, for example:

- You, your partner or dependent child are planning treatment that is demonstrated to result in **infertility**. Planned treatments include:
 - Bilateral orchectomy (removal of both testicles).
 - Bilateral oophorectomy (removal of both ovaries).
 - Hysterectomy (removal of the uterus).
 - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**.
- The eggs that will be retrieved for use are reasonably likely to result in a successful pregnancy by meeting the criteria below:

You are	You need to have an un-medicated day 3 FSH test done within the past:	The results of your un-medicated day 3 FSH test:
A female under 35 years of age	12 months	Must be less than 19 mIU/mL in your most recent lab test to use your own eggs.
A female 35 years of age or older	6 months	If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40.

Eligible health services for fertility preservation will be paid on the same basis as other ART services benefits for persons who are **infertile**.

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators with expertise in all areas of **infertility** who can help:

- Enroll in the **infertility** program.
- Assist you with **precertification** of **eligible health services**.
- Coordinate **precertification** for ART services and fertility preservation services when these services are **eligible health services**. Your **provider** should obtain **precertification** for fertility preservation services through the NIU either directly or through a reproductive endocrinologist.
- Evaluate your medical records to determine whether ART services and fertility preservation services are reasonably likely to result in success.
- Determine whether ART services and fertility preservation services are **eligible health services**.
- Case manage for the provision of ART services and fertility preservation services for an eligible **covered person**.

Your **provider** will request approval from us in advance for your ART services and fertility preservation services. We will cover charges made by an ART specialist for the following ART services:

- Any combination of the following ART services:
 - In vitro fertilization (IVF)*
 - Uterine embryo lavage
 - Zygote intrafallopian transfer (ZIFT)
 - Gamete intrafallopian transfer (GIFT)
 - Low tubal ovum transfer (LTOT)
 - Cryopreserved embryo transfers (Frozen Embryo Transfer (FET).)
 - Prescription drug therapy used during an oocyte retrieval cycle

- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. The embryo transfer itself is not covered. (See the *What your plan doesn't cover – some eligible health service exceptions and exclusions* section.)
- Charges associated with obtaining sperm from your partner when they are covered under this plan for ART services.
- The procedures are done while not confined in a **hospital** or any other facility as an inpatient.

A “cycle” is an attempt at a particular type of **infertility** treatment (e.g., GIFT, ZIFT, cryopreserved embryo transfers). The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

*Note: In some plans with limits on the number of cycles of IVF covered, “one” cycle of IVF may be considered as one elective single embryo transfer (ESET) cycle followed consecutively by a frozen single embryo transfer cycle. This cycle definition applies only to persons who meet the criteria for ESET, as determined by our NIU and for whom the initial ESET cycle did not result in a documented fetal heartbeat. **Eligible health services** for ESET will be paid on the same basis as any other ART services benefit.

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

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

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

Diagnostic lab work and radiological services

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

Outpatient therapies

Breast cancer pain medication and therapy

Pain therapy is medically based and includes reasonably defined goals to stabilize or reduce pain with breast cancer. Your **provider** will periodically evaluate the effectiveness of the pain therapy against these goals.

Pain medication related to the treatment of breast cancer is covered under the outpatient **prescription drug** section.

Chemotherapy

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

Outpatient infusion therapy

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

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

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

Eligible health services also include the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including but not limited to the use of intravenous immunoglobulin therapy.

Immune gamma globulin therapy will be covered for persons diagnosed with a primary immunodeficiency when medically appropriate and ordered by a **physician**. Initial authorization will be for no less than 3 months with reauthorization every 6 months after. If you have been in treatment for 2 years, reauthorization will be every 12 months, unless more frequently indicated by your **physician**.

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

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

Outpatient radiation therapy

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

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

Specialty prescription drugs

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

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

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

Outpatient respiratory therapy

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

Transfusion or kidney dialysis of blood

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

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

Short-term cardiac and pulmonary rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

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

Short-term rehabilitation and habilitation therapy services

Short-term rehabilitation therapy services

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

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

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

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

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

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

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

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

Short-term habilitation therapy services

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

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

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

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

Outpatient physical, occupational, and speech habilitation therapy

Eligible health services include:

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

Spinal manipulation services

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

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

Diagnostic testing for learning disabilities

Eligible health services include diagnostic testing for:

- Attention deficit disorder
- Attention deficit hyperactive disorder

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

8. Other services

Acupuncture in lieu of anesthesia

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

Ambulance service

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

For emergency services:

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

For non-emergency services:

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

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

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

Clinical trial therapies (experimental or investigational)

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

- Standard therapies have not been effective or are not appropriate
- You may benefit from the treatment based on published, peer-reviewed scientific evidence

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

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

Clinical trials (routine patient costs)

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

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 use.
- A new **DME** item you need because your physical condition has changed. It also covers buying a new **DME** item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.
- The fitting and adjustment of such **DME** items.

We:

- Assume no responsibility
- Make no express or implied warranties

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

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

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

Enteral formulas and nutritional supplements

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

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

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

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

Orthotic devices

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

Osteoporosis (non-preventive care)

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

Prosthetic and customized orthotic devices

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

Prosthetic device means a:

- 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

Customized orthotic device means a prosthetic device based on your physical **illness**.

Coverage includes:

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

Hearing aids and exams

Eligible health services include hearing care that includes hearing exams, prescribed hearing aids and hearing aid services as described below. And just a reminder, you'll find coverage limitations in the schedule of benefits.

Hearing aid means:

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

Eligible health services also include bone anchored hearing aids and cochlear implants.

Hearing Aids Alternate Treatment Rule

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

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

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

Podiatric (foot care) treatment

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

Non-routine treatment means:

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

Vision care

Pediatric vision care

Routine vision exams

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

Vision care services and supplies

Eligible health services include:

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

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

9. Outpatient prescription drugs

What you need to know about your outpatient prescription drug benefits

Read this section carefully so that you know:

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

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

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

How to access in-network pharmacies

How do you find an in-network pharmacy?

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

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

You may go to any of our **in-network pharmacies**.

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

Pharmacies include **in-network retail** and **specialty pharmacies**.

How to access out-of-network pharmacies

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

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

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

Eligible health services under your outpatient prescription drug benefit

What does your outpatient prescription drug benefit cover?

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

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

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

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

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

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

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

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

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

What outpatient prescription drugs are covered

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

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

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

Types of pharmacies

Retail pharmacy

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

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

Specialty pharmacy

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

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

Prescription drug refill synchronization

You have the right to request synchronization of your **prescription drug** refills once per year when those **prescription drugs**:

- Are covered under your plan
- Are maintenance medications and have refills available when the request is made
- Are not Schedule II, III, or IV controlled substances
- Have met any applicable utilization management criteria at the time of the request
- Are of a type that can be safely split into short-fill periods
- Do not have special handling or sourcing needs that require a single, designated pharmacy to fill or refill

We will apply a prorated daily cost-share rate when needed to synchronize **prescription drugs** that meet all of the above criteria and are dispensed by a **network pharmacy**. Any dispensing fees will not be prorated and will be based on the number of prescriptions filled or refilled at the time of synchronization.

Other services

Preventive contraceptives

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

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

We may cover the dispensing of up to a 12 month supply worth of contraception at one time.

Important Note:

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

Diabetic supplies

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

- Injection devices including insulin syringes, needles and pens
- Test strips - blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs

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

Immunizations

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

You should contact:

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

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

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

Infertility drugs

Eligible health services include oral and injectable **prescription drugs** used primarily for the purpose of treating the underlying cause of **infertility**.

Off-label use

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

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

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

Opioid antagonist drugs

Eligible health services include opioid antagonist drugs, including the medication product, administrative devices and any pharmacy administrative fees relating to the dispensing of opioid antagonists. Included are refills for expired or utilized opioid antagonists.

An “opiod antagonist” is a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.

Orally administered anti-cancer drugs, including chemotherapy drugs

Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

Over-the-counter drugs

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

Prescription inhalants

Eligible health services include inhalant **prescription drugs** for diagnoses of asthma or other life-threatening bronchial ailments.

Preventive care drugs and supplements

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

Risk-reducing breast cancer prescription drugs

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

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

Tobacco cessation prescription and over-the-counter drugs

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

Topical eye medication prescription drugs

Eligible health services include topical eye **prescription drugs**. They are paid according to the tier of drug as indicated in the schedule of benefits.

Refills of a **prescription** for topical eye medication will not be denied when:

- The **prescription drug** is used to treat a chronic condition of the eye
- You requested the refill before the last day of the prescribed dosage period and after at least 75% of the predicted days of use

The **prescriber** indicates on the original **prescription** that refills are permitted and early refills do not exceed the total number of refills prescribed

How you get an emergency prescription filled

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

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

Where your schedule of benefits fits in

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

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

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

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

How your copayment works

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

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

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

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

What precertification requirements apply?

Precertification

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

Step therapy

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

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

If you want to request an exception to a **medical necessity** or **step therapy** requirement, see the *How can I request a medical exception request review?* section or call the toll-free number on your member ID card for more information.

Medical exceptions request review

Sometimes you or your **prescriber** may ask for a medical exception request review to request coverage for a **prescription drug** that is not covered or for which coverage is being discontinued (for reasons other than safety or drug manufacturer withdrawal) or from a **step therapy** requirement or dosage limitation. You, someone who represents you or your **prescriber** can contact us. You will need to provide us with the required clinical documentation. We will process your request through our standard medical exception request review within 72 hours after receipt. Any exception granted is based upon an individual, case by case decision, and will not apply to other members. If the medical exception request is approved by us, you will receive the **preferred drug non-preferred** benefit level and coverage for the **prescription drug** according to the terms of your plan.

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

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

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

- The reason for the denial
- An alternate covered medication (if applicable)
- Information for submitting an appeal of the denial

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

Prescribing units

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

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

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

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

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

General exceptions and exclusions

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

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

Acupuncture therapy

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

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

Alternative health care

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

Armed forces

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

Beyond legal authority

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

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

Examples of these are:

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

Breasts

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

Cosmetic services and plastic surgery

- Any treatment, **surgery (cosmetic or plastic)**, service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons, except where described in the *Eligible health services under your plan - Reconstructive surgery and supplies* section. **Injuries** that occur during medical treatments are not considered accidental **injuries** even if unplanned or unexpected.

This exclusion does not apply to:

- **Surgery** after an accidental **injury** when performed as soon as medically feasible
- Coverage that may be provided under the *Eligible health services under your plan - Gender reassignment (sex change) treatment* section.
- This exclusion does not apply to:
 - The removal of breast implants due to an **illness or injury**

Custodial care

Examples are:

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

Dental care for adults

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

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

Early intensive behavioral interventions

Examples of these services are:

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

Educational services

Examples of these services are:

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

Elective treatment or elective surgery

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

Experimental or investigational

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

Facility charges

For care, services or supplies provided in:

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

Family planning services - other

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

Foot care

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

Gender reassignment (sex change) treatment

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

Genetic care

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

Growth/Height care

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

Hearing aids and exams except as described in the *Eligible health services under your plan - (Hearing aids)* section

The following services or supplies:

- A replacement of:
 - A hearing aid that is lost, stolen or broken
 - A hearing aid installed within the prior 12 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist
- Hearing exams given during a stay in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**
- Any tests, appliances and devices to:
 - Improve your hearing. This includes hearing aid batteries, amplifiers, and auxiliary equipment
 - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Home health care, except as described in the *Eligible health services under your plan - (Home health care)* section

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

Hospice care, except as described in the *Eligible health services under your plan - (Hospice care)* section

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

Incidental surgeries

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

Jaw joint disorder

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

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

Judgment or settlement

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

Mandatory no-fault laws

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

Medical supplies – outpatient disposable

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

Mental health treatment

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

Motor vehicle accidents

- Services and supplies given by a **provider** for **injuries** sustained from a motor vehicle accident but only when benefits are provided under any motor vehicle no-fault law. This applies whether or not a claim is made for such benefits.

Non-medically necessary services and supplies

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

Non-U.S .citizen

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

Organ removal

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

Personal care, comfort or convenience items

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

Private duty nursing

Prosthetic devices

Except as described in the *Eligible health services under your plan – Prosthetic devices and customized orthotic devices section*

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

Riot

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

Routine exams

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

School health services

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

by **health professionals** who

- Are employed by
- Are affiliated with
- Have an agreement or arrangement with, or
- Are otherwise designated by

the **policyholder**.

Services provided by a family member

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

Therapies and tests

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

Tobacco cessation

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

Treatment in a federal, state or governmental entity

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

Treatment of infertility

- All charges associated with:
 - Cryopreservation (freezing) of eggs, embryos or sperm. However, subsequent non-experimental **or investigational** procedures that use the cryopreserved substance are covered.
- Reversal of voluntary sterilizations, including follow-up care. However, if a voluntary sterilization is successfully reversed, **infertility** benefits are available if your diagnosis meets the definition of **infertility**
- Travel costs within 100 miles of your home or travel cost not required by **Aetna**
- **Infertility** treatment for covered dependents under age 18
- Non-medical costs of an egg or sperm donor
- Selected termination of an embryo, unless the life of the mother would be in danger if all embryos were carried to full term
- **Experimental or investigational infertility** treatment as determined by the American Society for Reproductive Medicine
- Services provided to a surrogate. If you choose to use a surrogate, this does not apply to the cost for procedures to obtain the eggs, sperm or embryo from a covered individual
- ART services are not provided for out-of-network care

Vision care

Pediatric vision care services and supplies, except as described in the *Eligible health services under your plan – Pediatric vision care* section

Adult vision care

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

Adult vision care services and supplies

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

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

Work related illness or injuries

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

Exceptions and exclusions that apply to outpatient prescription drugs

Contraceptive methods, procedures, services, and supplies for contraceptive purposes

- Contraceptive methods, procedures, services, and supplies for contraceptive purposes as elected by the **policyholder** due to an exemption or accommodation in accordance with applicable federal or state law and regulation
- Services provided as a result of complications resulting from voluntary sterilization procedure and related follow-up care

Drugs or medications

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

Genetic care

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

Who provides the care

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

In-network providers

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

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section
- Urgent care – refer to the description of emergency services and urgent care in the *Eligible health services under your plan* section

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

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

Out-of-network providers

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

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

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

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

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

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

	If you are a new enrollee and your provider is an out-of-network provider	When your provider stops participation with Aetna
Request for approval	You need to complete a Transition Coverage Request form and send it to us. You can get this form by contacting Member Services at the toll-free number on your ID card.	You or your provider should call us for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. This date is based on the date the provider terminated their participation with us.

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

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

What the plan pays and what you pay

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

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

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

The general rule

When you get **eligible health services**:

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

And then

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

And then

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

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

Important exception – when your plan pays all

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

Important exceptions – when you pay all

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

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

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

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

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

Where your schedule of benefits fits in

How your policy year deductible works

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

How your copayment works

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

How your maximum out-of-pocket limit works

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

Important note:

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

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

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

Notice	Requirement	Deadline
Submit a claim	<ul style="list-style-type: none">You should notify and request a claim form from the policyholder.The claim form will provide instructions on how to complete and where to send the form(s).	<ul style="list-style-type: none">You must send us notice and proof within 20 days or as soon as reasonably possible.If you are unable to complete a claim form, you may send us:<ul style="list-style-type: none">A description of servicesBill of chargesAny medical documentation you received from your provider
Proof of loss (claim)	<ul style="list-style-type: none">A completed claim form and any additional information required by us.	<ul style="list-style-type: none">You must send us notice and proof within 90 days or as soon as reasonably possible.
Benefit payment	<ul style="list-style-type: none">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.	<ul style="list-style-type: none">Benefits will be paid within 30 days after the necessary proof to support the claim is received. If benefits are not paid within 30 days after proof of loss is received, you are entitled to 9% interest. Interest will be calculated from the 30th day until the date the benefits are paid. However, interest less than \$1 may not be paid.

Types of claims and communicating our claim decisions

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

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

Urgent care claim

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

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

Pre-service claim

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

Post-service claim

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

Concurrent care claim extension

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

Concurrent care claim reduction or termination

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

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

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

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination by (us)	72 hours	15 days	30 days	24 hours for urgent request* or 72 hours if clinical information is required and received more than 24 hours after request* 15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable
Additional information request (us)	72 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

*We have to receive the request at least 24 hours before the previously approved health care services end.

Adverse benefit determinations

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

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

The difference between a complaint and an appeal

A Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call Member Services at the toll-free number on your ID card or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision. When a complaint is received from the Division of Insurance, we will respond within 21 days of receiving the complaint.

You may contact the Department of Insurance at any time. Complaints to the Department of Insurance may be submitted in the following ways:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 W. Washington Street
Springfield, IL 62767
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number
Consumer_complaints@ins.state.il.us Email address
<https://mc.insurance.illinois.gov/messagecenter.nsf>

An Appeal

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

Appeals of adverse benefit determinations

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

The deadline for filing an appeal will not be postponed or delayed by a **provider** appeal unless the **provider** is acting as your authorized representative.

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

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

You may also contact **Aetna** at the following address:

Aetna Life Insurance Company
Appeals Resolution Team
PO Box 14464
Lexington, KY 40512

You may also contact us by calling Member Services at the toll-free number on the back of your ID card.

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

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Urgent care or pre-service claim appeals

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

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

Timeframes for deciding appeals

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	24 hours	15 business days	30 business days	As appropriate to type of claim
Extensions	None	None	None	

Exhaustion of appeals process

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

- Contact the Illinois Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Illinois Department of Insurance
- Appeal through an external exception request review process
- Pursue arbitration, litigation or other type of administrative proceeding

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

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external exception request review process.
- You filed an appeal under the internal appeal process and we did not provide a written decision within:
 - 30 days from the date you filed an appeal of a concurrent or preservice claim
 - 60 days from the date you filed an appeal of a post-service claim except to the extent you agreed to a delay.
- You filed a request for an expedited internal review and we did not provide a decision within 48 hours, except to the extent you requested or agreed to a delay.
- Your **provider** certifies in writing that the recommended health care service or treatment is **experimental or investigational** would be significantly less effective if delayed.
- We did not follow all of the claim determination and appeal requirements of the Illinois or the Federal Department of Health and Human Services. But, you will not be able to proceed directly to external exception request review if:
 - The rule violation was minor and not likely to influence a decision or harm you.
 - The violation was for a good cause or beyond our control.
 - The violation was part of an ongoing, good faith exchange between you and us.

External exception request review

External exception request review is a review done by people in an organization outside of **Aetna**. This is called an external exception request review organization (EERRO).

You have a right to external exception request review only if:

- Your claim is denied, reduced or terminated because we determined that it was **experimental or investigation** or it did not meet our requirements for:
 - **medical necessity**
 - appropriateness
 - health care setting
 - level of care
 - effectiveness
- Coverage was rescinded. This does not include a cancellation of coverage due to failure to pay any required **premium**.
- You have received an adverse determination.

You have a right to external exception request review only if:

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

If our claim decision is one for which you can seek external exception request 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 exception request review process. It will include a copy of the Request for External Exception Request Review form at the final adverse determination level. It will also include the Authorized Representative form and the Health Care Provider Certification form for expedited and experimental requests.

You must submit the Request for External Exception Request Review Form:

- To the Illinois Department of Insurance
- Within 4 months of the date you received the final determination from us
- And you must include a copy of the notice from us and all other important information that supports your request

You or your authorized representative may submit additional information with the Request for External Exception Request Review form.

The deadline for filing an external exception request review will not be postponed or delayed by a provider's external exception request review unless the provider is acting as your authorized representative.

The address and toll-free number for the Office of Consumer Health Information at the Illinois Department of Insurance is:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Exception Request Review Unit
320 W. Washington Street
Springfield, IL 62767
(877) 850-4740 Toll-free phone
(217) 557-8495 Fax number
Doi.externalreview@illinois.gov Email address
<https://mc.insurance.illinois.gov/messagecenter.nsf>

You will pay for any cost associated with obtaining documentation (i.e. medical records fees, copying fees, etc.) for additional information you send and want reviewed by the EERRO. We will pay for information we send to the EERRO plus the cost of the review.

The Illinois Department of Insurance will:

- Contact the EERRO that will conduct the review of your claim

The EERRO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

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

How long will it take to get an EERRO decision?

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

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

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

For initial adverse determinations

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

- Jeopardize your life, health or ability to regain maximum function or
- Be much less effective if not started right away

For final adverse determinations

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

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

Upon receipt from the Department of Insurance, we will respond to the eligibility request for an external exception request review within 24 hours. Once assigned to an EERRO, a decision will be made within 72 hours, except for expedited experimental/investigational decisions which will be made within 5 days.

Recordkeeping

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

Fees and expenses

Except for the fees associated with the external exception request review, we do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Coordination of benefits (COB)

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

Key terms

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

Allowable expense means:

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

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

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

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

Here's how COB works

- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the 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.

If you are:	Primary plan	Secondary plan
Covered under this plan as a student or dependent	The plan covering you as a student.	The plan covering you as a dependent.
Dependent under your spouse's plan and your parent's plan	The plan that has covered the person longer*	The other plan covering you as a dependent*

COB rules for dependent children		
Child of: • Parents who are married or living together	The “birthday rule” applies. The plan of the parent whose birthday* (month and day only) falls earlier in the calendar year . *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*. *Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together • With court-order	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then their spouse's plan is primary.	The plan of the other parent. But if that parent has no coverage, then their spouse's plan is primary.
Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
Child of: • Parents separated or divorced or not living together and there is no court-order • Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last Treat the person the same as a parent when making the order of benefits determination: See <i>Child of</i> content above.	
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?	
Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	<p>The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that was not covered by the primary plan.</p> <p>The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.</p>
Benefit reserve each family member has a separate benefit reserve for each policy year	<p>The benefit reserve:</p> <ul style="list-style-type: none"> • Is made up of the amount that the secondary plan saved due to COB • Is used to cover any unpaid allowable expenses • Balance is erased at the end of each policy year

How COB works with Medicare

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

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

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

When you have **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. In the case of someone who is eligible but not covered, the plan may pay as if you are covered by **Medicare** and coordinates benefits with the benefits **Medicare** would have paid had you enrolled in **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** or after an amount that **Medicare** would have paid had you been covered.

How are benefits paid?		
If you have Medicare because of:	Primary plan	Secondary plan
Age	Medicare	This plan
Disability	Medicare	This plan
ALS / Lou Gehrig's disease	Medicare	This plan
End stage renal disease (ESRD)*	This plan will pay first for the first 3 months unless you take a self-dialysis course, there is no Medicare waiting period and Medicare becomes primary payer on the first month of dialysis. Also, 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.	Medicare

*Note regarding ESRD: 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?	
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 and 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 on to your Aetna Navigator® secure member website at www.aetnastudenthealth.com. Select Find a Form, then select Your Other Health Plans.
- **By phone:** Call Member Services at the toll-free number on your ID card.

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 to occur:

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

If your coverage ends because you die, **premiums** will be refunded, on a pro-rata basis, upon receipt of notice of your death. Refund of **premium** will not be computed by the use of a short-rate table.

If your coverage ends because you withdraw from school for reasons other than entering the armed forces, we will not refund **premium** contributions. You are covered for the policy term for which you enrolled and paid the **premium** contribution.

If you withdraw from school because you have entered the armed forces, **premiums** will be refunded, on a pro-rata basis, when we receive your application within 90 days from the date of the withdrawal.

As an Illinois resident, if your coverage lapses due to military service and you were honorably discharged, you and your dependents, that may have been eligible for a federal government sponsored health insurance program, may be reinstated in this plan if you otherwise remain eligible for coverage. Reinstatement is subject to payment of the current required **premium**.

We must receive a request for reinstatement no later than 63 days following the later of:

- Deactivation
- Loss of coverage under the federal government-sponsored health insurance program.

We may request proof of loss of coverage and the timing of the loss of coverage of the government-sponsored coverage in order to determine eligibility for reinstatement. The effective date of the reinstatement will be the first of the month following receipt of the notice requesting reinstatement.

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 or civil union partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners or civil unions.
- The date the domestic partnership or civil union 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 and your dependents' coverage?

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

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

We may immediately end your and your dependents coverage if:

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

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

Special coverage options after your plan coverage ends

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

Continuation of coverage for other reasons

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly (more than 50% of income) on you for support

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

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

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

Your disabled child's coverage will end:

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

How can your dependents continue coverage after you die?

Your dependents can continue coverage after your death if:

- You were covered at the time of your death
- The request is made within 31 days after your death
- Payment is made for the coverage

Your dependent's coverage will end on the earliest date:

- The end of the 12th month period after your death
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- Any required contributions stop or
- The date your spouse remarries

To request extension of coverage, the dependent or their representative can just call Member Services at the toll-free number on your ID card.

General provisions – other things you should know

Entire student policy

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

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

Administrative provisions

How you and we will interpret this certificate of coverage

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

How we administer this plan

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

Who's responsible to you

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

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

Coverage and services

Your coverage can change

Your coverage is defined by the **student policy**. This document may have amendments or riders too. Under certain circumstances, we or the **policyholder** or the law may change your plan according to requirements of the **student policy**. Only **Aetna** may waive a requirement of your plan. No other person – including the **policyholder** 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 that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund you or the **policyholder** any unearned premium.

Legal action

You must complete the appeal process before you take any legal action against us for any expense or bill. See the *When you disagree - claim decisions and appeals procedures* section. You cannot take any action until 60 days after we receive written submission of claim.

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

Physical examinations and evaluations

At our expense, we have the right and opportunity to have a **physician** of our choice examine you. This will be done at all reasonable times while a claim is pending. We may also conduct an autopsy in the case of death, when law does not forbid it.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

- Names of **physicians, dental providers** and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

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

Intentional deception

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

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

We also may report fraud to criminal authorities.

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

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

- We will give you 30 days advanced written notice of any rescission of coverage
- You have the right to an **Aetna** appeal
- You have the right to a third party review conducted by an independent external exception request review organization

Some other money issues

Grace period

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

Payment of premiums

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

Recovery of overpayments

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

When you are injured

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

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

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

We don't have to reduce the amount we're due for any reason, even to help pay your lawyer or pay other costs you incurred to get a recovery.

Your health information

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

You can get a free copy of our Notice of Privacy Practices. Just call Member Services at the toll-free number on your ID card.

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

Effect of benefits under other plans

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

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

Glossary A-M

Accident or accidental

An **injury** to you that is not planned or anticipated.

Aetna

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

Ambulance

A vehicle staffed by medical personnel and equipped to transport an **ill** or **injured** person.

Behavioral health provider

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

Brand-name prescription drug

A U.S. Food and Drug Administration (FDA) approved **prescription drug** marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Calendar year

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

Clinical related injury

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

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

Coinsurance

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

Copayments

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

Cosmetic

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

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(s)

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

Detoxification

The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This can be done by metabolic or other means as determined by a **physician** or a nurse practitioner working within the scope of their licenses. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Directory

The list of **in-network providers** for your plan. The most up-to-date directory for your plan appears at www.aetnastudenthealth.com under the DocFind® label. When searching DocFind®, you need to make sure that you are searching for **providers** that participate in your specific plan. **In-network providers** may only be considered for certain Aetna plans. When searching for **in-network dental providers**, you need to make sure you are searching under Pediatric Dental plan.

Durable medical equipment (DME)

Equipment and the accessories needed to operate it, that is:

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

Effective date of coverage

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

Elective treatment:

Services and supplies provided to you when there is no evidence of pathology, dysfunction, or **illness** in any part of your body. Examples of elective treatment are:

- Breast reduction
- Sub mucous resection and/or other surgical correction for deviated nasal septum, other than for the treatment of a covered medical condition

Eligible health services

The health care services and supplies and outpatient **prescription drugs** listed in the *Eligible health services under your plan* section and not carved out or limited in the *Exceptions* section of this certificate of coverage or in the schedule of benefits.

Emergency admission

An admission to a **hospital** or treatment facility ordered by a **physician** within 24 hours after you receive **emergency services**.

Emergency medical condition

A recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, **illness**, or **injury** is of a severe nature. And that if you don't get immediate medical care it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus
- In the case of a pregnant woman:
 - Serious jeopardy to the health of the fetus
 - One who is having contractions and there is inadequate time to effect a safe transfer to another **hospital** before delivery or
 - A transfer may pose a threat to the health or safety of the woman or unborn child

Emergency services

Treatment given in an **ambulance** and a **hospital's** emergency room for an **emergency medical condition**. This includes evaluation of, and treatment to stabilize an **emergency medical condition**.

Experimental or investigational

A drug, device, procedure, or treatment that we find is **experimental or investigational** because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness or injury** involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational**.

Formulary exclusions list

A list of **prescription drugs** not covered under the plan. This list is subject to change.

Generic prescription drug

A **prescription drug** with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Health professional

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

Home health aide

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

Home health care agency

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

Home health care plan

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

Homebound

This means that you are confined to your home because:

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

You are not homebound if:

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

Hospice benefit period

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

Hospice care

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

Hospice care agency

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

Hospice care program

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

Hospice facility

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

Hospital

An institution licensed as a **hospital** by applicable state and federal laws, and is accredited as a **hospital** by The Joint Commission (TJC).

Hospital does not include a:

- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility for substance use disorder**
- **Residential treatment facility for mental disorders**
- Extended care facility
- Intermediate care facility
- Skilled nursing facility

Hospital stay

This is your **stay** of 18 or more hours in a row as a resident bed patient in a **hospital**.

Illness or illnesses

Poor health resulting from disease of the body or mind.

In-network dental provider

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

In-network pharmacy

A **retail pharmacy** or **specialty pharmacy** that has contracted with **Aetna**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** to you.

In-network provider

A **provider** listed in the **directory** for your plan. However, a NAP provider listed in the NAP directory is not an **in-network provider**.

Infertile or infertility

The inability to:

- Conceive after 1 year of unprotected heterosexual sexual intercourse or 6 months of unprotected heterosexual sexual intercourse if the female partner is over age 35, or attempts to produce conception
- Conceive after diagnosed with a condition affecting fertility
- Sustain a successful pregnancy

Women without a male partner may be considered **infertile** if they are unable to conceive or produce conception after 1 year of donor insemination 6 cycles for women aged 35 or older.

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.

Intensive outpatient program (IOP)

The clinical treatment provided must be:

- No more than 5 days per week
- No more than 19 hours per week
- A minimum of 2 hours each treatment day

Services must be **medically necessary** and delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a **mental disorder** or **substance use disorder** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder

This is:

- A disorder of the jaw joint
- A Myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

Lifetime maximum

This is the most this plan will pay for **eligible health services** incurred by a **covered person** during their lifetime. Lifetime maximums do not apply to essential health benefits as classified by the Affordable Care Act (ACA) unless permitted.

Maximum out-of-pocket limit

The maximum out-of-pocket amount for payment of **copayments** and **coinsurance** including any **policy year deductible**, to be paid by you or any **covered dependents** per **policy year** for **eligible health services**.

Medically necessary/Medical necessity

Health care services that we determine a **provider** exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness** or **injury**, or its symptoms, and that we determine are:

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

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Consistent with the standards set forth in policy issues involving clinical judgment

Medicare

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

Mental disorder

A **mental disorder** as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. **Mental disorders** are usually associated with significant distress or disability in social, occupational, or other important activities.

Morbid obesity/Morbidly obese

This means the **body mass index** is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea or
- Diabetes

Glossary N-Z

Negotiated charge

Health coverage

This is either:

- The amount an **in-network provider** has agreed to accept
- The amount we agree to pay directly to a **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 **in-network pharmacy**.

The **negotiated charge** does not reflect any amount an affiliate or we may receive under a rebate arrangement between us or an affiliate and a drug manufacturer for any **prescription drug**.

The rebates will not change the **negotiated charge** under this plan.

Prescription drug coverage from a in-network pharmacy

In-network pharmacy

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

The **negotiated charge** does not reflect any amount an affiliate or we may receive under a rebate arrangement between us, an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

We may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Non-preferred drug

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

Out-of-network dental provider

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

Out-of-network pharmacy

A **pharmacy** that is not an **in-network pharmacy**, a National Advantage Program (NAP) **provider** and does not appear in the directory for your plan.

Out-of-network provider

A **provider** who is not a **in-network provider** or National Advantage Program (NAP) **provider** and does not appear in the **directory** for your plan.

Partial hospitalization treatment

Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. Services must be **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental disorder or substance use disorder** issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Care is delivered according to accepted medical practice for the condition of the person.

Pharmacy

An establishment where **prescription drugs** are legally dispensed. This includes a **in-network retail pharmacy** and **specialty pharmacy**. It also includes an out-of-network **retail pharmacy**.

Physician

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

Policyholder

The school named on the front page of the **student policy** and your certificate of coverage and schedule of benefits for the purpose of coverage under the **student policy**.

Policy year

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

Policy year deductible

The amount you pay for **eligible health services** per **policy year** before your plan starts to pay as listed in the schedule of benefits.

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 drug guide

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

Preferred in-network pharmacy

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

Premium

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

Prescriber

Any **provider** acting within the scope of his or her license, who has the legal authority to write an order for outpatient **prescription drugs**.

Prescription

As to hearing care:

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

As to prescription drugs:

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

As to vision care:

A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

Prescription drug

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

Provider(s)

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

Psychiatric hospital

An institution specifically licensed as a **psychiatric hospital** by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of **substance use disorders** and **mental disorders**.

Mental disorder includes related **substance use disorders**.

Psychiatrist

A **psychiatrist** generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

Recognized charge

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

The **recognized charge** depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Service or supply	Recognized charge
Professional services and other services or supplies not mentioned below	105% of the Medicare allowed rate
Services of hospitals and other facilities	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.	

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- **Medicare** allowed rates are the rates CMS establishes for services and supplies provided to **Medicare** enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If **Medicare** does not have a rate, we use one or more of the items below to determine the rate:
 - The method CMS uses to set **Medicare** rates
 - What other **providers** charge or accept as payment
 - How much work it takes to perform a service
 - Other things as needed to decide what rate is reasonable for a particular service or supply
- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.

Our reimbursement policies

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

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

Our reimbursement policies are based on our review of:

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

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

R.N.

A registered nurse.

Residential treatment facility (mental disorders)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by **Aetna** or is accredited by one of the following agencies, commissions or committees for the services being provided:
 - The Joint Commission (TJC)
 - The Committee on Accreditation of Rehabilitation Facilities (CARF)
 - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
 - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating **mental disorders**:

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week
- The patient must be treated by a **psychiatrist** at least once per week
- The medical director must be a **psychiatrist**
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

Residential treatment facility (substance use disorder)

An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for **substance use disorder** residential treatment programs. And is credentialed by **Aetna** or accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for **substance use disorder** residential treatment programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a **physician**
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

In addition to the above requirements, for **substance use disorder detoxification** programs within a residential setting:

- An **R.N.** must be onsite 24 hours per day for 7 days a week within a residential setting
- Residential care must be provided under the direct supervision of a **physician**

Respite care

This is care provided to you when you have a **terminal illness** for the sole purpose of providing temporary relief to your family (or other care givers) from the daily demands of caring for you.

Retail pharmacy

A community **pharmacy** that dispenses outpatient **prescription drugs** at retail prices.

Room and board

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

School health services

Any:

- Organization
- Facility
- Clinic
- **Pharmacy**

that is operated, maintained, or supported by the **policyholder** (or other entity under contract to the **policyholder**) which provides health care services to **covered students** and their **covered dependents**. **School health services** will either provide or coordinate the care provided to **covered students**.

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, **Aetna** will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Serious mental illness

Serious mental illness is defined in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM is a book published by the American Psychiatric Association. **Serious mental illness** includes the following **mental disorders**:

- Schizophrenia
- Paranoids and other psychotic disorders
- Bipolar disorders (hypomanic, manic, depressive and mixed)
- Major depressive disorders (single episode or recurrent)
- Schizoaffective disorders (bipolar or depressive)
- Pervasive developmental disorders
- Obsessive-compulsive disorders
- Depression in childhood & adolescence
- Panic disorder
- Post-traumatic stress disorders (acute, chronic, or with delayed onset)
- Eating disorders, including but not limited to:
 - Anorexia nervosa
 - Bulimia nervosa
 - Pica
 - Rumination disorder
 - Avoidant/restrictive food intake disorder
 - Other specified feeding or eating disorder (OSFED)
 - Any other eating disorder contained in the most recent version of the DSM

Service area

The geographic area where **in-network providers** for this plan are located.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation **hospitals**, and portions of a rehabilitation **hospital** and a **hospital** designated for skilled or rehabilitation therapy services.

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of **mental disorders** or **substance use disorder**.

Skilled nursing services

Services provided by an **R.N.** or **L.P.N.** within the scope of his or her license.

Sound natural teeth

These are natural teeth. If there is a filling in a tooth, the major portion of the tooth must be present. A tooth cannot be decayed, abscessed, or defective. Sound natural teeth are not capped teeth, implants, crowns, bridges, or dentures.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty and is board-certified.

Specialty prescription drugs

These are **prescription drugs** that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

You can access the list of these **specialty prescription drugs** by calling Member Services at the toll-free number on your ID card or by logging on to your Aetna Navigator® secure website at www.aetnastudenthealth.com.

This list can be reviewed and changed monthly by **Aetna** or an affiliate. On a yearly basis, **Aetna** evaluates this entire list to provide you with the most clinically appropriate and cost effective **prescription drugs**. Notice of a negative change to this list will be sent to affected **covered persons** within 60 days before the change. A negative change includes:

- Tier changes resulting in a higher out-of-pocket cost
- Addition of **precertification, step therapy** or quantity limit requirements
- Removal of a **prescription drug** from the **preferred drug guide**

Specialty pharmacy

This is a **pharmacy** designated by Aetna as an **in-network pharmacy** to fill **prescriptions for specialty prescription drugs**.

Stay

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

Step therapy

A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.aetnastudenthealth.com/formulary.

Student policy

The **student policy** consists of several documents taken together. The list of documents can be found in the *Entire student policy* section of this certificate of coverage.

Substance use disorder

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a **mental disorder** that are a focus of attention or treatment. Or an addiction to nicotine products, food or caffeine intoxication.

Substance use disorder also includes the following mental disorders as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

- Substance use disorders
- Substance dependence disorders
- Substance induced disorders

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

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 care facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition**.

Urgent condition

An **illness or injury** that requires prompt medical attention but is not an **emergency medical condition**.

Urgent admission

This is an admission to the **hospital** due to an **illness or injury** that is severe enough to require a **stay** in a **hospital** within 2 weeks from the date the need for the **stay** becomes apparent.

Walk-in clinic

A free-standing health care facility. Neither of the following should be considered a **walk-in clinic**:

- An emergency room
- The outpatient department of a **hospital**

10,20,30,40,50,60,70,80,95,100,102,110,120,130,140,150,160,170,180,190

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call the number listed on your ID card at no cost.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

Language Assistance

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。 (Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقة التعرفية. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。 (Japanese)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)