Emory University Student Health Insurance Plan
Administrative Services by Aetna Student Health

Choice POS II Medical and Outpatient Prescription Drug Plan

Schedule of Benefits

Prepared exclusively for:

Policyholder:
Policyholder number:
Student policy effective date:
Plan effective date:
Plan issue date:

Emory University – International and PA Students
686178
08/01/2020
08/01/2020
07/30/2020

Plan underwritten by Emory University, administrative services by Aetna Life Insurance Company in the state of Georgia.

Important notices:

1. Except for the treatment of an emergency medical condition, you must get care from the student health services. You must get a referral from student health services for off-campus care for most services. *See the Medical necessity, referral, and precertification requirements section in the certificate of coverage for more information.

2. The Emory University Student Health Insurance Plan (EUSHIP) has also extended the necessary coverage under the plan to September 30, 2020 (or as deemed necessary), to align with Federal regulations, which include some of the following:

- Waiving all out of pocket expenses, including co-pays, deductibles and co-insurance, for medical visits and/or testing related to COVID-19 (doctor’s order not required for coverage)
- Waiving all out of pocket expenses, including co-pays, deductibles and co-insurance, for inpatient hospitalizations related to COVID-19
- Referral requirements are waived for primary care and specialists’ visits outside of Student Health.
- Students have access to an emergency 14-day maintenance medication refill or be allowed to obtain early refills as they transition their care and/or location. CVS will also offer a free home delivery option.
  - Waiving the cost share (copays, deductible and co-insurance) for behavioral and mental health telemedicine visits

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.
Schedule of benefits

This schedule of benefits lists the policy year deductibles and copayments/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 and copayments/coinsurance and any limits that apply to the services and supplies.

How to read your schedule of benefits

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

Important note:

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

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning 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:

<table>
<thead>
<tr>
<th>You pay your policy year deductible</th>
<th>Your physician charges</th>
<th>Your physician collects the copayment from you</th>
<th>The plan pays 80% coinsurance</th>
<th>You pay 20% coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000</td>
<td>$120</td>
<td>$20</td>
<td>$80</td>
<td>$20</td>
</tr>
</tbody>
</table>

We are here to answer any questions. Contact Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.

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

**Care provided at Emory University Student Health Services will be covered at 100% with a $0 deductible.**

<table>
<thead>
<tr>
<th>Plan features</th>
<th>Policy year deductibles/ maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Core Provider coverage*</td>
</tr>
</tbody>
</table>

**Policy year deductible**

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

<table>
<thead>
<tr>
<th></th>
<th>Student</th>
<th>Spouse</th>
<th>Each child</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy year deductible</strong></td>
<td>$150 per policy year</td>
<td>$150 per policy year</td>
<td>$150 per policy year</td>
</tr>
<tr>
<td><strong>Policy year deductible waiver</strong></td>
<td>$400 per policy year</td>
<td>$400 per policy year</td>
<td>$400 per policy year</td>
</tr>
<tr>
<td><strong>Out-of-network coverage</strong></td>
<td>$600 per policy year</td>
<td>$600 per policy year</td>
<td>$600 per policy year</td>
</tr>
</tbody>
</table>

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

- In-network care for **Preventive care and wellness**
- In-network care for **Pediatric Preventive Dental Benefits**
- In-network and out-of-network care for **Child Wellness Services from birth to age 5, Pediatric Vision Benefits and Prescribed Medicine Expense**

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.
Maximum out-of-pocket limits

<table>
<thead>
<tr>
<th></th>
<th>Select care coverage*</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$7,000 per policy year</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Spouse</td>
<td>$7,000 per policy year</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Each child</td>
<td>$7,000 per policy year</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Family</td>
<td>$14,000 per policy year</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

Precertification covered benefit penalty (medical)

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

Failure to precertify your eligible health services when required will result in the following benefit penalty:
- A $500 benefit penalty will be applied separately to each type of eligible health services

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

Referral penalty

You must get a referral from student health services for off-campus care. If you do not get a referral, then we won’t pay the provider.

Exceptions
- Treatment for an emergency medical condition
- Obstetric and gynecological care
- Pediatric care
- Student health services (or the Oxford College Student Health Center for Oxford students) is closed
- You are more than 50 miles from the student health services
- When the service is rendered at another facility during breaks or vacation periods; or
- When medical care is received by a Covered person who is more than 50 miles from campus; or
- When medical care is received by a Covered person who is no longer able to use the EUSHS due to a change in student status, such as graduating or LOA/withdrawal, or
- Dermatological services; or
- Chiropractic services, or
- All X-rays, Labs, and High Cost Procedures.
- Routine Dental services including the treatment and extraction of wisdom teeth
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness).
- Urgent Care/Minute Clinics when not being able to access the EUSHS
- Continuation Plan

Your covered dependents 18 years and older, must access student health services for care and a referral.

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

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.
**Coinsurance listed in the schedule of benefits**

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

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>Select care coverage*</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Preventive care and wellness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine physical exams</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed at a physician’s office</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

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 the back of your ID card.

Covered persons age 22 and over:

Maximum visits per policy year

1 visit

**Preventive care immunizations**

Performed in a facility or at a physician’s office

100% (of the negotiated charge) per visit

No copayment or policy year deductible applies

100% (of the negotiated charge) per visit

No copayment or policy year deductible applies

70% (of the recognized charge) per visit

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 the back of your ID card.

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Well woman preventive visits</th>
<th>Routine gynecological exams (including Pap smears)</th>
</tr>
</thead>
</table>
| 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  
100% (of the negotiated charge) per visit  
No copayment or policy year deductible applies  
70% (of the recognized charge) per visit |

Maximuns | Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. |

<table>
<thead>
<tr>
<th>Preventive screening and counseling services</th>
</tr>
</thead>
</table>
| Obesity and/or healthy diet counseling office visits | 100% (of the negotiated charge) per visit  
No copayment or policy year deductible applies  
100% (of the negotiated charge) per visit  
No copayment or policy year deductible applies  
70% (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  
100% (of the negotiated charge) per visit  
No copayment or policy year deductible applies  
70% (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  
100% (of the negotiated charge) per visit  
No copayment or policy year deductible applies  
70% (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. |

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Sharing</th>
<th>Yearly Deductible</th>
<th>Maximum Visits per Policy Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression screening counseling office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>No copayment or policy year deductible applies</td>
<td>1 visit*</td>
</tr>
<tr>
<td>Sexual transmitted infection counseling office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>No copayment or policy year deductible applies</td>
<td>2 visits*</td>
</tr>
<tr>
<td>Breast and ovarian cancer counseling office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>No copayment or policy year deductible applies</td>
<td>Not subject to any age limitations</td>
</tr>
</tbody>
</table>

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

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.
Routine cancer screenings
Performed at a physician’s office, specialist’s office or facility.

<table>
<thead>
<tr>
<th>Routine cancer screenings</th>
<th>100% (of the negotiated charge) per visit</th>
<th>100% (of the negotiated charge) per visit</th>
<th>70% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

Maximims
Subject to any age; family history; and frequency guidelines as set forth in the most current:
- 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.

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 the back of your ID card.

Lung cancer screening maximums
1 screening every 12 months*

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

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

<table>
<thead>
<tr>
<th>Preventive care services only</th>
<th>100% (of the negotiated charge) per visit</th>
<th>100% (of the negotiated charge) per visit</th>
<th>70% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

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

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.
**Comprehensive lactation support and counseling services**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Benefit 1</th>
<th>Benefit 2</th>
<th>Benefit 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactation counseling services - facility or office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>No copayment or policy year deductible applies</td>
<td>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactation counseling services maximum visits per policy year either in a group or individual setting</td>
<td>6 visits*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Breast feeding durable medical equipment**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Benefit 1</th>
<th>Benefit 2</th>
<th>Benefit 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast pump supplies and accessories</td>
<td>100% (of the negotiated charge) per item</td>
<td>No copayment or policy year deductible applies</td>
<td>70% (of the recognized charge) per item</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Family planning services – female contraceptives**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Benefit 1</th>
<th>Benefit 2</th>
<th>Benefit 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female contraceptive counseling services office visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>No copayment or policy year deductible applies</td>
<td>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptives (prescription drugs and devices)</td>
<td>100% (of the negotiated charge) per item</td>
<td>No copayment or policy year deductible applies</td>
<td>70% (of the recognized charge) per item</td>
</tr>
</tbody>
</table>

*See *How to read your schedule of benefits, important note about your cost sharing and important notice* at the beginning of this schedule of benefits.
<table>
<thead>
<tr>
<th>Female voluntary sterilization</th>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% (of the negotiated charge) per admission</td>
<td>100% (of the negotiated charge) per admission</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>70% (of the recognized charge) per admission</td>
<td>70% (of the recognized charge) per admission</td>
</tr>
</tbody>
</table>

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>Select care coverage*</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Physicians and other health professionals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians and specialists office visits (non-surgical)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician and specialist services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office hours visits (non-surgical and non-preventive care by a physician and specialist)</td>
<td>$25 copayment then the plan pays 90% (of the balance of the negotiated charge) per visit thereafter</td>
<td>$35 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter</td>
<td>$40 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter</td>
</tr>
<tr>
<td>Telemedicine consultation by a physician or specialist</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Allergy testing and allergy injections treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testing and allergy injections treatment performed at a physician’s or specialist’s office</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Physician and specialist surgical services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician and specialist surgical office visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery performed at a physician’s or specialist’s office or outpatient department of a hospital or ambulatory surgical facility</td>
<td>$100 copayment then the plan pays 90% (of the balance of the negotiated charge) per visit thereafter</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Consultant services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant office visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office hours visits (non-surgical and non-preventive care)</td>
<td>$25 copayment then the plan pays 90% (of the balance of the negotiated charge) per visit thereafter</td>
<td>$35 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter</td>
<td>$40 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter</td>
</tr>
<tr>
<td>Telemedicine consultation by a consultant or specialist</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Second or third surgical opinion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second or third surgical opinion</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>Select care coverage*</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Hospital and other facility care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital (room and board)</td>
<td>90% (of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(includes maternity)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board intensive care</td>
<td>90% (of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Miscellaneous inpatient hospital care services and supplies (other than room and board)</td>
<td>90% (of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td><strong>Preadmission testing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preadmission testing</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery performed on an inpatient basis in a hospital (includes anesthetist and surgical assistant expenses)</td>
<td>90% (of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Surgery performed on an outpatient basis in a hospital</td>
<td>$100 copayment plus 90% (of the balance of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>90% (of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Surgical Assistant</td>
<td>90% (of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
</tbody>
</table>

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.
## Anesthesia and related facility charges for oral surgery a dental procedure

<table>
<thead>
<tr>
<th></th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia and related facility charges for a dental procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## In-hospital non-surgical physician services

<table>
<thead>
<tr>
<th>In-hospital non-surgical physician services</th>
<th>90% (of the negotiated charge) per visit</th>
<th>80% (of the negotiated charge) per visit</th>
<th>60% (of the recognized charge) per visit</th>
</tr>
</thead>
</table>

## Alternatives to hospital stays

### Outpatient surgery and physician surgical services

- Performed in the outpatient department of a hospital or ambulatory surgical facility
  - Does not include physician surgical services

<table>
<thead>
<tr>
<th>Performance</th>
<th>90% (of the negotiated charge) per visit</th>
<th>80% (of the negotiated charge) per visit</th>
<th>60% (of the recognized charge) per visit</th>
</tr>
</thead>
</table>

### Home health care

**Outpatient**

<table>
<thead>
<tr>
<th>Performance</th>
<th>90% (of the negotiated charge) per visit</th>
<th>80% (of the negotiated charge) per visit</th>
<th>60% (of the recognized charge) per visit</th>
</tr>
</thead>
</table>

**Maximum visits per policy year**

<table>
<thead>
<tr>
<th>Performance</th>
<th>120</th>
</tr>
</thead>
</table>

### Hospice care

**Inpatient facility**

- (room and board and other miscellaneous services and supplies)

<table>
<thead>
<tr>
<th>Performance</th>
<th>90% (of the negotiated charge) per admission</th>
<th>80% (of the negotiated charge) per admission</th>
<th>60% (of the recognized charge) per admission</th>
</tr>
</thead>
</table>

**Outpatient**

<table>
<thead>
<tr>
<th>Performance</th>
<th>90% (of the negotiated charge) per visit</th>
<th>80% (of the negotiated charge) per visit</th>
<th>60% (of the recognized charge) per visit</th>
</tr>
</thead>
</table>

### 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

<table>
<thead>
<tr>
<th>Performance</th>
<th>90% (of the negotiated charge) per admission</th>
<th>80% (of the negotiated charge) per admission</th>
<th>60% (of the recognized charge) per admission</th>
</tr>
</thead>
</table>

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Rehabilitation facility</th>
<th>90% (of the negotiated charge) per admission</th>
<th>80% (of the negotiated charge) per admission</th>
<th>60% (of the recognized charge) per admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(room and board and miscellaneous inpatient care services and supplies)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board includes intensive care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
### 4. Emergency services and urgent care

**Emergency services**

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>Select care coverage*</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital emergency room</td>
<td>$150 copayment then the plan pays 90% (of the balance of the negotiated charge) per visit</td>
<td>$150 copayment then the plan pays 90% (of the balance of the negotiated charge) per visit</td>
<td>Paid the same as in-network coverage</td>
</tr>
</tbody>
</table>

*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, except as required if the hospital determines that the individual has an emergency medical condition and provider services either (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility in accordance with*

*See the cost-sharing that applies to these covered benefits in this schedule of benefits. Out-of-network services needed to stabilize the individual during the emergency room visit are payable without regard to (a) whether the healthcare provider is in- or out-of-network, including cost-sharing requirements; (b) does not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers; and (c) does not impose higher cost-sharing requirements for out-of-network services.*

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
Important note:
- As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/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 the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply.
- Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance.
- Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you.
- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.

<table>
<thead>
<tr>
<th>Urgent care</th>
<th>90% (of the negotiated charge) per visit $25 copay</th>
<th>80% (of the negotiated charge) per visit $25 copay</th>
<th>60% (of the recognized charge) per visit $25 copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent medical care provided by an urgent care provider</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Non-urgent use of urgent care provider</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>Select care coverage*</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Pediatric dental care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Type A services</th>
<th>100% (of the negotiated charge) per visit</th>
<th>100% (of the negotiated charge) per visit</th>
<th>100% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No copayment or deductible applies</td>
<td>No copayment or deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Type B services</td>
<td>70% (of the negotiated charge) per visit</td>
<td>70% (of the negotiated charge) per visit</td>
<td>70% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Type C services</td>
<td>60% (of the negotiated charge) per visit</td>
<td>60% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Orthodontic services</td>
<td>60% (of the negotiated charge) per visit</td>
<td>60% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Dental emergency treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

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.

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
Type A services: diagnostic and preventive care

Visits and images
- Periodic exams (limited to 2 per year)
- Comprehensive oral exam (limited to 2 per year)
- Oral evaluation-child under 3 (limited to 2 per year)
- Comprehensive periodontal evaluation (limited to 2 per year)
- Problem-focused examination (limited to 2 per year)
- Prophylaxis (cleaning) (limited to 2 treatments per year)
- Topical application of fluoride (limited to 2 applications per year)
- Topical fluoride varnish (limited to 2 applications per year)
- Sealants, per tooth (limited to: one application every 3 years for permanent molars only)
- Bitewing images (limited to 2 sets per year)
- Complete image series or panoramic radiographic image including bitewings if medically necessary (limited to 1 set every 3 years)
- Vertical bitewing images (limited to 2 sets per year)
- Periapical images
- Intra-oral, occlusal radiographic image
- Diagnostic models
- Emergency palliative treatment per visit

Space maintainers
- Space maintainers (includes all adjustments within 6 months after installation)
- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Re-cementation of space maintainer
- Removal of space maintainer

Type B services: basic restorative care

Visits and images
- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Consultation (by other than the treating dental provider)

Images, pathology
- Extra-oral posterior dental radiographic image
- Therapeutic drug injection, by report

Oral surgery
- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants
  - Surgical removal of erupted tooth/root tip
  - Surgical access of an erupted tooth
- Impacted teeth
  - Removal of tooth (soft tissue)
  - Incision and drainage of abscess

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• Other surgical procedures
  - Alveoplasty, in conjunction with extractions - per quadrant
  - Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Alveoplasty, not in conjunction with extraction - per quadrant
  - Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Excision of hyperplastic tissue
  - Removal of exostosis
  - Transplantation of tooth or tooth bud
  - Sequestrectomy
  - Crown exposure to aid eruption

Periodontics
• Occlusal adjustment (other than with an appliance or by restoration) (limited and complete)
• Periodontal scaling and root planning 4, or more teeth, per quadrant (limited to 4 separate quadrants every 2 years)
• Periodontal scaling and root planning and scaling, per quadrant – 1 to 3 teeth (limited to 1 per quadrant every 2 years)
• Periodontal maintenance procedures following active therapy (limited to 4 in 12 months combined with adult prophylaxis[cleaning] following after active therapy)
• Localized delivery of antimicrobial agents

Endodontics
• Pulp capping
• Pulpotomy (therapeutic)
• Partial pulpotomy
• Pulpal therapy

Restorative dentistry
Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges.
Multiple restorations in 1 surface are considered as a single restoration.
• Amalgam restorations
• Protective restorations
• Resin-based composite restorations (other than for molars)
• Pins
• Pin retention—per tooth, in addition to amalgam or resin restoration
• Crowns (when tooth cannot be restored with a filling material)
• Prefabricated stainless steel
• Prefabricated resin crown (excluding temporary crowns)
• Re-cementation
  - Inlay/Onlay
  - Crown
  - Partial dentures
  - Veneer
  - Post and core
  - Implant supported crown, abutment supported partial

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
Type C services: major restorative care

Periodontics
- Osseous surgery, including flap and closure, 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Osseous surgery, including flap and closure, per quadrant (limited to 1 per quadrant every 3 years)
- Soft tissue graft procedures
- Bone replacement graft – first site in quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy, 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- Bone replacement graft – first site in quadrant (1 per quadrant/tooth every 3 rolling years)
- Bone replacement graft – each additional site in quadrant (1 per quadrant/tooth every 3 rolling years)
- Clinical crown lengthening
- Full mouth debridement (limited to 1 treatment per lifetime)

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

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. (limited to 1 per tooth every 5 years)
- Inlays/Onlays (limited to 1 per tooth every 5 years)
- Veneers (non-cosmetic); (limited to 1 per tooth every 5 years)
- Crowns (limited to 1 per tooth every 5 years)
  - Resin (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)
  - 3/4 cast metallic or porcelain/ceramic (limited to 1 per tooth every 5 years)
- Post and core
- Core build-up

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### Prosthodontics

Installation of dentures and bridges is covered only if needed to replace teeth that were not abutments to a denture or bridge less than 5 years old.

- Replacement of existing bridges or dentures (limited to 1 every 5 years)
- Bridge abutments (See Inlays/Onlays and Crowns) (limited to 1 per tooth every 5 years)
- Pontics (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)
  - Porcelain with noble metal (limited to 1 per tooth every 5 years)
  - Porcelain with base metal (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)
  - Titanium (limited to 1 per tooth every 5 years)
- Removable bridge (unilateral) (limited to 1 every 5 years)
- One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics (limited to 1 every 5 years)
- Dentures and partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
  - Complete upper denture (limited to 1 every 5 years)
  - Complete lower denture (limited to 1 every 5 years)
  - Immediate upper denture (limited to 1 every 5 years)
  - Immediate lower denture (limited to 1 every 5 years)
- Partial upper or lower, resin base (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- Cleaning and inspection of complete dentures/partial dentures
- Dentures and Partials
  - Office reline
  - Laboratory relines
  - Special tissue conditioning, per denture
  - Rebase, per denture
- Adjustment to complete denture or partial denture (more than 6 months after installation)
  - Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth
    - Adding teeth to existing partial denture
    - Each tooth
    - Each clasp
- Implants (only if determined as a medical necessity and limited to 1 per tooth every 5 years)
- Implant supported complete denture, partial denture (limited to 1 every 5 years)
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Occlusal guard, patients age 13 or older

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**General Anesthesia and Intravenous Sedation**
Only when medically necessary and only when provided in conjunction with a covered dental surgical
- Evaluation - deep sedation or general anesthesia
- General anesthesia-each 15 minute increment
- IV (conscious) sedation – each 15 minute increment

**Orthodontic services**
Orthodontic treatment (includes removal of appliances, construction and placement of retainer)
- Medically necessary comprehensive treatment
- Replacement of retainer (limited to 1 per lifetime)
- Orthodontic waiting period (none)

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>Select care coverage*</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Specific conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birthing center</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient (room and board)</td>
<td>90% (of the recognized charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board intensive care</td>
<td>90% (of the recognized charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Miscellaneous inpatient services and supplies (other than room and board)</td>
<td>90% (of the recognized charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
</tbody>
</table>

*Note: The per admission copayment amount and/or policy year deductible 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.*

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

| Hypodermic needles and syringes for the treatment of diabetes                           |                                                                                      |                                                                                      |                                                                                      |
| Hypodermic needles and syringes                                                        | 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. |

| Family planning services – other                                                        |                                                                                      |                                                                                      |                                                                                      |
| Voluntary sterilization for males                                                       |                                                                                      |                                                                                      |                                                                                      |
| Inpatient                                                                               | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Outpatient                                                                              | 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. |

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<table>
<thead>
<tr>
<th>Voluntary termination of pregnancy</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporomandibular joint dysfunction treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Temporomandibular joint dysfunction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impacted wisdom teeth</td>
<td>90% (of the negotiated charge)</td>
<td>80% (of the negotiated charge)</td>
<td>80% (of the recognized charge)</td>
</tr>
<tr>
<td>Impacted wisdom teeth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental injury to sound natural teeth</td>
<td>90% (of the negotiated charge)</td>
<td>80% (of the negotiated charge)</td>
<td>80% (of the recognized charge)</td>
</tr>
<tr>
<td>Accidental injury to sound natural teeth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatological treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Dermatological treatment (non-surgical office visit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Well newborn nursery care

<table>
<thead>
<tr>
<th>Service</th>
<th>90% (of the negotiated charge)</th>
<th>80% (of the negotiated charge)</th>
<th>60% (of the recognized charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well newborn nursery care</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

Note: The per admission copayment amount and/or policy year deductible 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.

### Pregnancy complications

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient (room and board and other miscellaneous services and supplies)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Gender Affirming (sex change) treatment

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical, Hormone Replacement Therapy, and Counseling Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Autism spectrum disorder

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism spectrum disorder treatment (includes physician and specialist office visits, diagnosis and testing)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applied behavior analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Mental health treatment</th>
<th>Mental health treatment – inpatient</th>
<th>Mental health treatment – outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital mental disorders treatment (room and board)</td>
<td>90% (of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
</tr>
<tr>
<td>Inpatient residential treatment facility mental disorders treatment (room and board)</td>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
<td></td>
</tr>
<tr>
<td>Mental disorder room and board intensive care</td>
<td>90% (of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
</tr>
<tr>
<td>Other inpatient hospital mental disorder services and supplies (other than room and board)</td>
<td>90% (of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
</tr>
<tr>
<td>Other inpatient residential treatment facility mental disorder services and supplies (other than room and board)</td>
<td>Coverage is provided under the same terms, conditions as any other illness.</td>
<td>Coverage is provided under the same terms, conditions as any other illness.</td>
</tr>
<tr>
<td>Mental health treatment – outpatient</td>
<td>Outpatient mental disorder visits to a physician or behavioral health provider (includes skilled behavioral health services in the home)</td>
<td>Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment)</td>
</tr>
<tr>
<td>Other outpatient mental disorders treatment</td>
<td>90% (of the negotiated charge) per visit</td>
<td>80% (of the negotiated charge) per visit</td>
</tr>
</tbody>
</table>

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
## Substance abuse related disorders treatment - inpatient

<table>
<thead>
<tr>
<th>Detoxification – inpatient</th>
<th>90% (of the negotiated charge) per admission</th>
<th>80% (of the negotiated charge) per admission</th>
<th>60% (of the recognized charge) per admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital substance abuse detoxification (room and board)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital substance abuse rehabilitation (room and board)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient residential treatment facility substance abuse (room and board and other residential treatment facility services and supplies)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance abuse room and board intensive care</td>
<td>90% (of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Other inpatient hospital substance abuse services and supplies (other than room and board)</td>
<td>90% (of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Other inpatient hospital substance abuse rehabilitation services and supplies (other than room and board)</td>
<td>90% (of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Other residential treatment facility substance abuse services and supplies (other than room and board)</td>
<td>90% (of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
</tbody>
</table>

*See How to read your schedule of benefits, important note about your cost sharing and important notice* at the beginning of this schedule of benefits.
**Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage Provided</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient substance abuse visits to a physician or behavioral health provider</td>
<td>Coverage is provided under the same terms, conditions as any other illness.</td>
<td></td>
</tr>
<tr>
<td>Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment)</td>
<td>Coverage is provided under the same terms, conditions as any other illness.</td>
<td></td>
</tr>
<tr>
<td>Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment)</td>
<td>Coverage is provided under the same terms, conditions as any other illness.</td>
<td></td>
</tr>
<tr>
<td>Other outpatient substance abuse services</td>
<td>90% (of the negotiated charge) per visit</td>
<td>80% (of the negotiated charge) per visit</td>
</tr>
</tbody>
</table>

**Obesity surgery**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage Provided</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity surgery-Inpatient facility and physician services (includes surgical procedure, acute facility services, room and board, and other miscellaneous services and supplies)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Obesity surgery-Outpatient facility and physician services - performed at a specialist office, outpatient department of a hospital or other facility</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

**Reconstructive surgery and supplies**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage Provided</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconstructive surgery and supplies</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><em>Does not include plastic surgery</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>Select care coverage*</th>
<th>In-network coverage* (IOE facility)</th>
<th>In-network coverage* (Non-IOE facility)</th>
<th>Out-of network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ transplant services - facility and non-facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ transplant - facility services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Inpatient (room and board and other miscellaneous services and supplies) and outpatient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ transplant - physician and specialist services (including office visits)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Transplant services-travel and lodging</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ transplant services-travel and lodging</td>
<td>Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum Benefit payable for Travel and Lodging Expenses for any one transplant, including tandem transplants</td>
<td>$10,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit payable for Lodging Expenses per IOE patient</td>
<td>$50 per night</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit payable for Lodging Expenses per companion</td>
<td>$50 per night</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>Select care coverage*</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of infertility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic infertility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic infertility</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Comprehensive infertility services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient and outpatient care</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Maximum number of ovulation induction cycles with menotropins per lifetime</td>
<td>6 courses of treatment attempts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum number of Intrauterine insemination cycles per lifetime</td>
<td>6 courses of treatment attempts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced reproductive technology (ART)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient and outpatient care</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Maximum number of cycles per lifetime</td>
<td>3 courses of treatment attempts</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>Select care coverage*</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Specific therapies and tests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient diagnostic testing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic complex imaging services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility</td>
<td>90% (of the negotiated charge) per visit</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Diagnostic lab work and radiological services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic lab work and radiological services performed in the outpatient department of a hospital or other facility</td>
<td>90% (of the negotiated charge) per visit</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>90% (of the negotiated charge) per visit</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Outpatient infusion therapy</td>
<td>90% (of the negotiated charge) per visit</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Outpatient radiation therapy</td>
<td>90% (of the negotiated charge) per visit</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Outpatient respiratory therapy</td>
<td>90% (of the negotiated charge) per visit</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Transfusion or kidney dialysis of blood</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term cardiac and pulmonary rehabilitation services</td>
<td><strong>Cardiac rehabilitation</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Pulmonary rehabilitation</td>
<td>Pulmonary rehabilitation</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Short-term rehabilitation and habilitation therapy services</td>
<td>Outpatient physical, occupational, speech, and cognitive therapies</td>
<td>Combined for short-term rehabilitation services and habilitation therapy services</td>
<td>$35 copayment then the plan pays 90% (of the balance of the negotiated charge) per visit thereafter</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Chiropractic services</td>
<td>$25 copayment then the plan pays 90% (of the balance of the negotiated charge) per visit thereafter</td>
<td>$35 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter</td>
</tr>
<tr>
<td>Diagnostic testing for learning disabilities</td>
<td>Diagnostic testing for learning disabilities</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>Select care coverage*</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture in lieu of anesthesia</td>
<td>90% (of the negotiated charge) per visit</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Ambulance service</td>
<td>90% (of the negotiated charge) per trip</td>
<td>80% (of the negotiated charge) per trip</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td>Clinical trial therapies (experimental or investigational)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Clinical trials (routine patient costs)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Durable medical equipment (DME)</td>
<td>90% (of the negotiated charge) per item</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Enteral formulas (non-prescription)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td>90% (of the negotiated charge) per item</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
</tbody>
</table>

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.
### Hearing aids and exams

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment/Percentage</th>
<th>Plan Pays</th>
<th>Plan Pays</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aid exams</td>
<td>$100 copayment then the plan pays 90% (of the balance of the negotiated charge) per visit thereafter</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
<td></td>
</tr>
<tr>
<td>Hearing aids*</td>
<td>90% (of the negotiated charge) per item</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
<td></td>
</tr>
</tbody>
</table>

### Podiatric (foot care) treatment

<table>
<thead>
<tr>
<th>Service and Supplies</th>
<th>Copayment/Percentage</th>
<th>Plan Pays</th>
<th>Plan Pays</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician and Specialist non-routine foot care (non-surgical office visit)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td></td>
</tr>
</tbody>
</table>

### Podiatric (foot care) Services & Supplies

<table>
<thead>
<tr>
<th>Service and Supplies</th>
<th>Copayment/Percentage</th>
<th>Plan Pays</th>
<th>Plan Pays</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services and supplies for: The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches</td>
<td>90% (of the negotiated charge) per item</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
<td></td>
</tr>
<tr>
<td>The treatment of weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes</td>
<td>90% (of the negotiated charge) per item</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
<td></td>
</tr>
<tr>
<td>Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, cremes, ointment and other equipment services and Supplies</td>
<td>90% (of the negotiated charge) per item</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
<td></td>
</tr>
</tbody>
</table>

### Vision care

**Pediatric vision care**

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

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*

AL SH HSOB-H 01 35 GA
### Pediatric routine vision exams (including refraction)

<table>
<thead>
<tr>
<th>Performance by</th>
<th>100% (of the negotiated charge) per visit</th>
<th>100% (of the negotiated charge) per visit</th>
<th>70% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

**Maximum visits per policy year**: 1

### Pediatric comprehensive low vision evaluations

<table>
<thead>
<tr>
<th>Performance by</th>
<th>100% (of the negotiated charge) per visit</th>
<th>100% (of the negotiated charge) per visit</th>
<th>70% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

### Pediatric vision care services and supplies

<table>
<thead>
<tr>
<th>Service Description</th>
<th>100% (of the negotiated charge) per visit</th>
<th>100% (of the negotiated charge) per visit</th>
<th>70% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

### Important note:
Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.

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

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>Select care coverage*</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
</table>

9. Outpatient prescription drugs

**Policy year deductible and copayment/coinsurance waiver for risk reducing breast cancer**

The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network. This means that such risk reducing breast cancer prescription drugs are paid at 100%.

**Policy year deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs**

The policy year deductible and the per prescription copayment/coinsurance 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 copayment/coinsurance will apply after those two regimens per policy year have been exhausted.

**Policy year deductible and copayment/coinsurance waiver for contraceptives**

The policy year deductible and the per prescription copayment/coinsurance will not apply to female contraceptive methods when obtained at an in-network pharmacy.

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

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

The policy year deductible and the per prescription copayment/coinsurance 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 How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.
**Preferred and non-preferred generic prescription drugs**

<table>
<thead>
<tr>
<th>Per prescription copayment/coinsurance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$15 copayment per supply then the plan pays 100% (of the negotiated charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>$15 copayment per supply then the plan pays 100% (of the negotiated charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>$15 copayment per supply then the plan pays 100% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

**Preferred brand-name prescription drugs**

<table>
<thead>
<tr>
<th>Per prescription copayment/coinsurance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$30 copayment per supply then the plan pays 100% (of the negotiated charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>$30 copayment per supply then the plan pays 100% (of the negotiated charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>$30 copayment per supply then the plan pays 100% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

**Non-preferred brand-name prescription drugs**

<table>
<thead>
<tr>
<th>Per prescription copayment/coinsurance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$45 copayment per supply then the plan pays 100% (of the negotiated charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>$45 copayment per supply then the plan pays 100% (of the negotiated charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>$45 copayment per supply then the plan pays 100% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

**Specialty prescription drugs**

<table>
<thead>
<tr>
<th>Per prescription copayment/coinsurance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$150 copayment per supply then the plan pays 100% (of the negotiated charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>$150 copayment per supply then the plan pays 100% (of the negotiated charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td>$150 copayment per supply then the plan pays 100% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
### Orally administered anti-cancer prescription drugs

<table>
<thead>
<tr>
<th>Per prescription copayment/coinsurance</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 31 day supply filled at a retail or mail order pharmacy</td>
<td>100% (of the negotiated charge)</td>
<td>100% (of the negotiated charge)</td>
<td>100% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

### Preventive care drugs and supplements

<table>
<thead>
<tr>
<th>Preventive care drugs and supplements filled at a retail pharmacy</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For each 30 day supply</td>
<td>100% (of the negotiated charge) per prescription or refill</td>
<td>100% (of the negotiated charge) per prescription or refill</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

#### 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 logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.

### Risk reducing breast cancer prescription drugs

<table>
<thead>
<tr>
<th>Risk reducing breast cancer prescription drugs filled at a pharmacy</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For each 30 day supply</td>
<td>100% (of the negotiated charge) per prescription or refill</td>
<td>100% (of the negotiated charge) per prescription or refill</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

#### 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 logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
**Tobacco cessation prescription and over-the-counter drugs**

<table>
<thead>
<tr>
<th>Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy</th>
<th>100% (of the negotiated charge) per prescription or refill</th>
<th>100% (of the negotiated charge) per prescription or refill</th>
<th>Paid according to the type of drug per the schedule of benefits, above</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each 30 day supply</td>
<td>No copayment or policy year deductible applies</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

**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 below.

Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.

**Generic prescription drug substitution**

If you or your prescriber requests a covered brand-name prescription drug when a covered generic prescription drug equivalent is available, you will be responsible for the cost difference between the generic prescription drug and the brand-name prescription drug. You will also be responsible for the cost sharing copayment that applies to brand-name prescription drugs.

**Dispense as written (DAW)**

If a prescriber prescribes a covered brand-name prescription drug where a generic prescription drug equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost sharing copayment coinsurance for the brand-name prescription drug. If a prescriber does not specify DAW and you request a covered brand-name prescription drug where a generic prescription drug equivalent is available you will be responsible for the cost difference between the brand-name prescription drug and the generic prescription drug equivalent, and the cost sharing copayment coinsurance that applies to brand-name prescription drugs.

*See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
General coverage provisions

This section provides detailed explanations about the:
- **Policy year deductibles**
- **Maximums**
- **Maximum out-of-pocket limits**

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

<table>
<thead>
<tr>
<th><strong>Policy year deductible provisions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible health services</strong> applied to the out-of-network <strong>policy year deductibles</strong> will not be applied to satisfy the select care and in-network <strong>policy year deductibles</strong>. Eligible health services applied to the select care and in-network <strong>policy year deductibles</strong> will not be applied to satisfy the out-of-network <strong>policy year deductibles</strong>.</td>
</tr>
<tr>
<td>The select care, in-network and out-of-network <strong>policy year deductible</strong> may not apply to certain <strong>eligible health services</strong>. You must pay any applicable <strong>copayments/coinsurance</strong> for <strong>eligible health services</strong> to which the <strong>policy year deductible</strong> does not apply.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Individual</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This is the amount you owe for select care, in-network and out-of-network <strong>eligible health services</strong> each <strong>policy year</strong> before the plan begins to pay for <strong>eligible health services</strong>. This <strong>policy year deductible</strong> applies separately to you and each of your covered dependents. After the amount you pay for <strong>eligible health services</strong> reaches the <strong>policy year deductible</strong>, this plan will begin to pay for <strong>eligible health services</strong> for the rest of the <strong>policy year</strong>.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Copayments/Coinsurance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Select care coverage and In-network coverage</strong></td>
</tr>
<tr>
<td>This is a specified dollar amount or percentage that must be paid by you when you receive <strong>eligible health services</strong> from a <strong>select care provider</strong> or <strong>in-network provider</strong>. If <strong>Aetna</strong> compensates <strong>Core providers</strong> and <strong>in-network providers</strong> on the basis of the <strong>negotiated charge</strong> amount, your percentage <strong>copayment</strong> is based on this amount.</td>
</tr>
<tr>
<td><strong>Out-of-network coverage</strong></td>
</tr>
<tr>
<td>This is a specified dollar amount or percentage that must be paid by you when you receive <strong>eligible health services</strong> from an <strong>out-of-network provider</strong>. If <strong>Aetna</strong> compensates <strong>out-of-network providers</strong> on the basis of the <strong>recognized charge</strong> amount, your percentage <strong>copayment</strong> is based on this amount.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Coinsurance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coinsurance</strong> is both the percentage of <strong>eligible health services</strong> that the plan pays and what you pay. The specific percentage that we have to pay for <strong>eligible health services</strong> is listed earlier in the schedule of benefits.</td>
</tr>
</tbody>
</table>

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits.*
**Maximum out-of-pocket limits provisions**

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

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

### Individual

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

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

that apply towards the limits for the rest of the policy year for that person.

### Family

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

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

that apply towards the limits for the rest of the policy year for all covered family members.

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

### Medical and Outpatient Prescription Drugs

#### Select care and In-network care

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

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

- All costs for non-covered services
- **Referral** penalties because you did not get a referral from student health services for a service or supply

#### Out-of-network care

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

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

- All costs for non-covered services
- **Precertification** penalties because you did not get a service or supply precertified
- **Referral** penalties because you did not get a referral from student health services for a service or supply

*See How to read your schedule of benefit, important note about your cost sharing and important notice at the beginning of this schedule of benefits.*
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.

*See How to read your schedule of benefit, important note about your cost sharing and important notice at the beginning of this schedule of benefits.
Emory University Student Health Insurance Plan

Choice POS II Medical and Outpatient Prescription Drug Plan

Certificate of Coverage

Prepared exclusively for:
Policyholder: Emory University –
               International and PA Students
Policyholder number: 686178
Student policy effective date: 08/01/2020
Plan effective date: 08/01/2020
Plan issue date: 07/30/2020

Plan underwritten by Emory University, administrative services by Aetna Life Insurance Company in the state of Georgia.

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

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

Thank you for choosing the Emory University Student Health Insurance Plan, underwritten by Emory University and administered by Aetna Student Health Insurance Company.

This is your certificate of coverage. It is one of three documents that together describe the benefits covered by your Emory Student Health Insurance plan for select care, in-network and out-of-network coverage.

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

The third document is the student policy between the Emory Student Health Insurance Plan and the Aetna Life Insurance Company (“Aetna”), who administers the plan. Ask Emory University if you have any questions about the student policy.

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

Where to next? Flip through the Table of contents or try the Let’s get started! section right after it. The Let’s get started! section gives you a thumbnail sketch of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your Emory University Student Health Insurance Plan for select care coverage and, in-network and out-of-network coverage.
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Schedule of benefits  Issued with your certificate of coverage
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 both the covered student and any covered dependents
- When we say “us”, “we”, and “our”, we mean the Emory University Student Health Insurance Plan
- Some words appear in bold type. We define them in the Glossary section

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

What your plan does – providing covered benefits

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

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

How your plan works – starting and stopping coverage

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

Your coverage typically ends when you are no longer a student. Family members can lose coverage for many reasons, such as growing up and leaving home. 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.

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

Your select care coverage and in-network coverage:

- Helps you get and pay for a lot of – but not all – health care services. These are called eligible health services.
- You will usually pay less cost share when you use a select care provider or in-network provider.

1. Eligible health services

   Doctor 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 doctor 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 – some eligible health service exceptions section. (We refer to this section as the “Exceptions” section.)
   - They are not beyond any limits in the schedule of benefits.
2. **Student health services and Core providers**

*Student health services* can give you most of the care that you need. Contact them first before seeking care from a *select care provider* or an *in-network provider*.

*If student health services* is unable to give you the care that you need, they will give you a *referral* to a *select care provider* or an *in-network provider*.

You must obtain a *referral* from *student health services* before you can get services and supplies from *Core providers* or *in-network providers*.

3. **Aetna's network of providers**

The Emory University Student Health Insurance Plan utilizes the Aetna network. Aetna’s network of doctors, *hospitals* and other health care *providers* are there to give you the care 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 the Member Services toll-free number on the back of 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.

4. **Paying for eligible health services— the general requirements**

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

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

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

5. **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.

6. **Disagreements**

We know that people sometimes see things differently.

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

For more information see the *When you disagree - claim decisions and appeals procedures* section.
How your plan works while you are covered out-of-network

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

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

It’s called out-of-network coverage.

Your out-of-network coverage:

- Means you can get care from providers who are not part of the Aetna network or Core providers.
- 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, referral 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.

Register 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 Emory University Student Health Services at 404-727-7551
- Calling our Aetna Member Services at the toll-free number on the back of your ID card
- Writing us at Aetna Life Insurance Company, 151 Farmington Ave, Hartford, CT 06156

Your ID card

Your ID card tells doctors, hospitals, and other providers that you are covered by this plan. Show your ID card each time you get health care from a provider to help them bill us correctly and help us better process their claims.

Remember, only you and your covered dependents can use your 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.

We will not be mailing you an ID card. You can print out your ID card by logging into your Aetna Navigator® secure website at www.aetnastudenthealth.com.
Who the plan covers

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

You will find information in this section about:
- Who is eligible?
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible?

All classes of students are eligible. Students must be considered by their individual program to be an active and enrolled student for the current semester and are progressing appropriately in obtaining their stated degree. Eligibility is then communicated by OPUS to Aetna.

**COVID-19 Eligibility Note:** Those students who would have been eligible to participate in the Emory University Student Health Insurance Plan previous to the University's COVID-19 response remain qualified to participate regardless of their physical location. Online students enrolled and making progress in their stated degree will be enrolled in the Emory University Student Health Insurance Plan by default unless a waiver is properly submitted and approved by the Sept 15th deadline.

You may not enroll under this plan if you are not enrolled in the health service plan sponsored by the policyholder. Once you make a coverage selection, you may not change the selection.

For continuation of coverage plans, you must have been:
- A covered student under the student policy during this policy year or in the previous policy year and
- Covered under the student policy for at least 1 semester in a row

Medicare eligibility

You are 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 Premium Part A (receiving free Part A) or enrolled in Part B, Part C or Part D.

The Emory University Student Health Insurance Plan will only cover your Medicare copays, deductible and coinsurance and will not cover expenses which are not covered by Medicare, including prescription medications.

Under this plan, Medicare will act as your primary insurance and all medical expenses should be submitted to Medicare first.

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)
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.

For continuation of coverage plans, you must:
- Enroll within 31 days before your coverage ends of the date you lose coverage under the student policy
- Elect a continuation period of up to 3 months
- Pay the premium contribution for that period

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

The continuation of coverage plan of benefits is the same as the current active student policy. See the Continuation of coverage plan section for more information.
Who can be on your plan (who can be your dependent)
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 (under the age of 26yo) – your own or those of your spouse, civil union partner or domestic partner

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.

For continuation of coverage plans, your dependent must have been:
- A covered dependent under the student policy during this policy year or in the previous policy year and
- Covered under the student policy for at least 6 months in a row

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

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

Adding new dependents
You can add the following new dependents at any time during the year:
- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    o No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    o 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:
    o No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    o 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 after 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 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 of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us as soon as possible of status changes such as:
  • Change of address
  • Change of covered dependent status
  • Enrollment in Medicare or any other health plan of any covered dependent

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 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.

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

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

If you enroll after the effective date of the student policy and you are eligible for health benefits at the time, your coverage will take effect as of that date as long as:
  • We agree
  • We receive your completed request for enrollment
  • You pay any premium contribution.
**Dependent coverage**
Your dependent’s coverage will take effect on the date we receive a completed enrollment application and you pay any required **premium** contribution. See the *Adding new dependents* section for details.

Continuation of coverage plan
You and your dependent’s effective date of coverage under a continuation of coverage plan is the later to occur of:

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

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

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

This late enrollment provision does not apply to coverage under a continuation of coverage plan except for a dependent that must be enrolled due to a court order.
Medical necessity, referral 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 get a referral from student health services when required
- You or your provider precertifies the eligible health service when required

This section addresses the medical necessity, referral 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.

Referrals

You may need a referral from student health services for some eligible health services. If you do not have a referral when it is required, then a referral penalty may apply. Refer to the schedule of benefits and the Referral penalty section.

In some situations, student health services may refer you to an out-of-network provider.

If the service or supply requires precertification, you must obtain precertification before receiving the service or supply. If precertification:

- Is obtained when it is required, you will pay the cost sharing that applies to select care or in-network coverage. The select care coverage level will apply when there is a select care provider available to provide the service or supply. If not, then we will pay the cost-sharing that applies to the in-network level of coverage.
- Is not obtained when it is required, you may be subject to higher out-of-pocket expenses.

Your covered dependents don’t use the student health services for care so they don’t need to get referrals.

Precertification

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification.

Precertification for medical services and supplies

Select care and In-network care

Your select care provider or in-network physician is responsible for obtaining any necessary precertification before you get the care. If your select care provider or in-network physician doesn’t get a required precertification, we won’t pay the provider who gives you the care. You won’t have to pay either if your select care provider or in-network physician fails to ask us for precertification. If your select care provider or in-network physician requests precertification and we refuse it, you can still get the care but the plan won’t pay for it. You will find details on requirements in the What the plan pays and what you pay - Important exceptions – when you pay all section.
Out-of-network care
When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify, your benefits may be reduced, or the plan may not pay any benefits. Refer to your schedule of benefits for this information. The list of services and supplies requiring precertification appears later in this section. Also, for any precertification benefit penalty that is applied see the schedule of benefits Precertification 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 listed on the back of 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. |
| For 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. |
| For 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. |
| For 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. |
| Delivery: | You, your physician, or the facility must call within 48 hours of the birth or as soon thereafter as possible. No penalty will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery. |

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 listed on the back of 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. |
| Notification call for prenatal care: | As soon as possible after your physician confirms pregnancy so that we can enroll you in our Healthy Beginnings program. |

We will provide a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 30 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 penalty section.
- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your out-of-network policy year deductibles or maximum out-of-pocket limits.

What types of services require precertification?
Precertification is required for the following types of services and supplies:

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<th>Inpatient services and supplies</th>
<th>Outpatient services and supplies</th>
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<td>Applied behavioral analysis (ABA)</td>
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<td>Gender affirming (sex change) surgery</td>
<td>Biofeedback</td>
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<tr>
<td>Inpatient services: observation stays greater than 24 hours, inpatient hospital non-surgical, inpatient hospital surgical confinements, maternity confinements which exceed the standard length of stay (LOS), newborn confinements which exceed the standard length of stay (LOS), rehabilitation facility, skilled nursing facility, hospice stays in a Hospital</td>
<td>Clinical trials</td>
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<td>Hip/knee arthroplasties</td>
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<td>Obesity (bariatric) surgery</td>
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<td>Orthognathic surgery procedures (bone grafts, osteotomies and surgical management of the temporomandibular joint dysfunction disorder)</td>
<td>Emergency transportation by airplane</td>
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<td>Service Description</td>
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<td>treatment of mental disorders and substance abuse</td>
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<td>Proton beam radiotherapy</td>
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<td>Psychological testing/neuropsychological testing</td>
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<td>Transplant services (pre-transplant, evaluation and post-transplant)</td>
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<td>Uvulopalatopharyngoplasty, including laser-assisted procedures</td>
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*For a current listing of the prescription drugs and medical injectable drugs that require precertification, contact Member Services by logging onto the Aetna website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.*
How can I request a medical exception?
Sometimes you or your prescriber may ask for a medical exception to get health care services for prescription drugs that are not covered under this plan or for which health care services are denied through 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 process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-preferred drug. You, someone who represents you or your prescriber may submit a request for a quicker review for an urgent situation by:

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

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

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

For example,

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

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

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

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 will not be covered under the preventive care and wellness benefit. For those tests, you will pay the cost sharing specific to eligible health services for diagnostic testing.

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 at the toll-free number on the back of your ID card. This information can also be found at the www.HealthCare.gov website.
Routine physical exams

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

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

Preventive care immunizations

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

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

Well woman preventive visits

Eligible health services include your routine:

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

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

Here is more detail about those benefits:

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

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

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

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

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

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

Eligible health services include the following routine cancer screenings:

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

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, which is the initial and subsequent history and physical exam such as:

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

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 and related 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 and related well newborn nursery care
- Outpatient prescription drugs
- Treatment of basic infertility
2. Physicians and other health professionals

Physician and specialist services
Eligible health services include services by your physician to treat an illness or injury. 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

Allergy testing and allergy injections treatment
Eligible health services include the services and supplies that your physician or specialist may provide for:
- Allergy testing
- Allergy injections treatment
- Allergy sera and extracts administered via injection

Physician and specialist surgical services
Eligible health services include the services of:
- The surgeon who performs your surgery
- Your surgeon who you visit before and after the surgery

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

Covered benefits include treatment by the consultant.

Second or third 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.

If your physician and the specialist don’t agree, we will pay for a third surgical opinion.

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

Alternatives to physician and specialist office visits

Walk-in clinic
Eligible health services include health care services provided in walk-in clinics for:
- Unscheduled, non-medical emergency illnesses and injuries
- The administration of immunizations administered within the scope of the clinic’s license
3. Hospital and other facility care

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

The types of hospital care services that are eligible for coverage include:
- Room and board charges up to the hospital's semi-private room rate. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of health professionals employed by the hospital
- Operating and recovery rooms
- Intensive care units of a hospital
- Administration of blood and blood derivatives, 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

If you cancel the scheduled surgery, we will pay covered benefits at the cost-sharing that applies to Outpatient diagnostic testing.

Surgery
Eligible health services include inpatient and outpatient surgery done in a hospital or surgery center.

When your surgery requires two or more surgical procedures:
- Using the same approach and at the same time or
- Right after each other

we will pay for the one that costs the most.

Your surgeon may perform two or more surgical or bilateral procedures on your during one operation but in separate operative fields. When this happens, we will pay:
- 100% of the surgery for the primary procedures
- 50% of the surgery for the secondary procedure
- 25% of the surgery for each of the other procedures, if any
If the surgeon performs both the **surgical procedure** and the anesthesia service, we will reduce the benefit that the plan pays for anesthesia by 50%.

When surgery is performed in the outpatient department of a **hospital**, covered benefits include hospital 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 Expense**

**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**.

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

**Eligible health services** include:
- General anesthesia
- Related **hospital** or **surgery center** charges

for your oral **surgery** dental procedure but only when your **physician** cannot safely perform the oral **surgery** dental procedure 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.

**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**.

**Alternatives to hospital stays**

**Outpatient surgery**

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

**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 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.
- If you are discharged from a hospital or skilled nursing facility after a stay, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services. See the schedule of benefits for more information on the intermittent requirement.
- 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 provided during a hospice benefit period and when given as part of a hospice care program because your physician diagnoses you with a terminal illness.

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

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

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

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

Eligible health services include inpatient skilled nursing facility care.

The types of skilled nursing facility care services that are eligible for coverage include:
- Room and board, up to the semi-private room rate
- Services and supplies that are provided during your stay in a skilled nursing facility

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

Important note:
We cover home short-term physical, speech, or occupational therapy when the skilled nursing facility criteria above are met.

Rehabilitation facility

Eligible health services include inpatient rehabilitation facility care.

The types of rehabilitation 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 rehabilitation facility

For your stay in a rehabilitation facility to be eligible for coverage, the following conditions must be met:
- The rehabilitation facility admission must occur within 24 hours following a hospital or skilled nursing facility admission
- The admission must be for the same or related cause(s)
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 includes your use of the:
- Emergency room facilities
- Emergency room staff physician services
- Hospital nursing staff services
- Staff radiologist and pathologist services

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

The select care or 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 select care provider or in-network provider if you need more care.

You are covered for follow-up care only when:
- Your select care provider or in-network physician provides the care, or
- Student health services coordinates the care by giving you a referral

If you use an out-of-network provider to receive follow up care, you may be subject to a higher out-of-pocket expense.

In case of a medical emergency

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

Non-emergency condition

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

In case of an urgent condition

Urgent condition

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

Non-urgent care

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

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

Eligible health services include dental services and supplies provided by a select care dental provider and an in-network dental provider or an 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 treatment services.

Dental emergencies

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

A dental emergency is any dental condition which:

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

If you have a dental emergency, you may get treatment from any dental provider. You should consider calling your select care dental provider or in-network dental provider who may be more familiar with your dental needs. If you cannot reach your select care dental provider or in-network dental provider or are away from home, you may get treatment from any dental provider. You may also call Member Services for help in finding a dental provider by calling the toll-free number on the back of your ID card. Services given for other than the temporary relief of the dental emergency by an out-of-network dental provider can cost you more. To get the maximum level of benefits, services should be provided by your dental select care provider or in-network dental provider.

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. (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**

*Eligible health services* include prenatal (non-preventive care) and postpartum care and obstetrical services.

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

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.

**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.

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

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.
Hypodermic needles and syringes
Eligible health services include hypodermic needles and syringes.

Family planning services – other
Eligible health services include certain family planning services provided by your physician such as:
- Voluntary sterilization for males
- Voluntary termination of pregnancy

Temporomandibular joint dysfunction treatment
Eligible health services include the diagnosis and non-surgical treatment of temporomandibular joint (TMJ) dysfunction by a provider, including craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder and other conditions of the joint linking the jawbone and the skull.

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.

- Excision of partially or completely impacted teeth;
- Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth;
- A referral from the Student Health Services is not required

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, non-surgical treatment of skin disorders by a physician or specialist.

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

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

After your child is born, eligible health services include:
- 48 hours of inpatient care in a hospital after a vaginal delivery
- 96 hours of inpatient care in a hospital after a cesarean delivery
- A shorter stay if the attending physician, with the consent of the mother, discharges the mother or newborn earlier
- The mother could be discharged earlier. If so, the plan will pay for 2 post-delivery home visits by a health care provider

Well newborn nursery care
Eligible health services include routine care of your well newborn child in a hospital such as:
- Well newborn nursery care during the mother’s stay but for not more than four days for a normal
• Services and supplies needed for circumcision by a provider
• Hospital visits and consultations for the well newborn by a physician but for not more than 1 visit per day
Pregnancy complications

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

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

- Hyperemesis gravidarum (pernicious vomiting of pregnancy); toxemia with convulsions; severe bleeding before delivery due to premature separation of the placenta from any cause; bleeding after delivery severe enough to need a transfusion or blood
- 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 affirming (sex change) treatment

Eligible health services include services and supplies for gender affirming (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 affirming counseling by a behavioral health provider
- Injectable and non-injectable hormone replacement therapy

Important Note:

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 the back of 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 of the American Psychiatric Association.

Eligible health services include the services and supplies provided by a physician or behavioral health provider for the diagnosis 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:

Applied behavior analysis requires precertification by Aetna. Your select care or 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. Once a general medical hospital has stabilized your condition, it will send you to a psychiatric facility that can treat your mental disorder by either:
  - Admitting you to its separate psychiatric section or unit
  - Transferring 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 a psychiatric facility is not available to you for the treatment of a mental disorder, then we will cover the eligible health services provided by a general medical hospital for the treatment of a mental disorder.

- **Outpatient treatment** received while not confined as an inpatient in a general medical hospital, psychiatric hospital, or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine consultations)
  - All other outpatient mental health treatment including:
    - 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
    - Electro-convulsive therapy (ECT)
    - Mental disorder injectables
    - Transcranial magnetic stimulation (TMS)

Eligible health services also include 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 general medical hospital or a residential treatment facility, or needing 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
Substance abuse related disorders treatment

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

- **Inpatient room and board** at the semi-private room rate and other services and supplies that are provided during your stay in a general medical hospital, psychiatric hospital or residential treatment facility. Once a general medical hospital has stabilized your condition, it will send you to a psychiatric facility that can treat your substance abuse by either:
  - Admitting you to its separate substance abuse section or unit
  - Transferring you to a psychiatric hospital or residential treatment facility

Treatment of substance abuse in a general medical hospital is only covered if you are:

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

If a psychiatric facility is not available to you for the treatment of substance abuse, then we will cover the eligible health services provided by a general medical hospital for the treatment of substance abuse.

As used here, “medical complications” mean conditions such as detoxification, 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:
  - Partial hospitalization treatment provided in a facility or program for treatment of substance abuse provided under the direction of a physician
  - Intensive Outpatient Program provided in a facility or program for treatment of substance abuse provided under the direction of a physician
  - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other substance abuse, including administration of medications
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine consultations)
  - Other outpatient substance abuse treatment such as outpatient monitoring of injectable therapy

Obesity 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 doctor 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 doctor will request approval from us in advance of your obesity surgery. We will cover charges made by a select care provider or in-network provider 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

Health care services include one obesity surgical procedure. However, eligible health services also include a multi-stage procedure when planned and approved by us. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

You may go to any of our network facilities that perform obesity surgeries.
Reconstructive surgery and supplies

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

- Your surgery reconstructs the breast where a necessary mastectomy was performed. Services and supplies include:
  - An implant
  - Areolar and nipple reconstruction
  - Areolar and nipple re-pigmentation
  - Surgery on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema and prosthetic devices.

- Your surgery is to implant or attach a covered prosthetic device.

- Your surgery corrects 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

Organ transplants

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

Organ means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow

Network of transplant specialist facilities

The amount you will pay for covered transplant services is determined by where you get transplant services.

You can get transplant services from:

- An Institutes of Excellence™ (IOE) facility we designate to perform the transplant you need
- 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 the back of your ID card.
Treatment of infertility

Basic infertility

 Eligible health services include basic infertility care, including seeing a select care or in-network provider to diagnose the underlying medical cause of infertility and any surgery needed to treat the underlying medical cause of infertility.

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”
• 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 which includes tubal ligation, hysterectomy, and vasectomy with or without surgical reversal, regardless of post reversal results
• 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 met the requirement for the number of months trying to conceive through egg and sperm contact
• Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level meets the following criteria:

<table>
<thead>
<tr>
<th>You are A female under 35 years of age with a male partner</th>
<th>Number of months of unprotected timed sexual intercourse:</th>
<th>Number of donor artificial insemination cycles: Self paid/not paid for by plan</th>
<th>You need to have an unmedicated day 3 FSH test done within the past:</th>
<th>The results of your unmedicated day 3 FSH test:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A female under 35 years of age with a male partner</td>
<td>A. 12 months or more</td>
<td>B. At least 12 cycles of donor insemination</td>
<td>12 months</td>
<td>Must be less than 19 mIU/mL in your most recent lab test</td>
</tr>
<tr>
<td>A female under 35 years of age without a male partner</td>
<td>Does not apply</td>
<td>At least 12 cycles of donor insemination</td>
<td>12 months</td>
<td>Must be less than 19 mIU/mL in your most recent lab test</td>
</tr>
<tr>
<td>Category Description</td>
<td>Requirement 1</td>
<td>Requirement 2</td>
<td>Requirement 3</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
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</tr>
</tbody>
</table>
| A female 35 years of age or older with a male partner                                | A. 6 months or more | B. At least 6 cycles of donor insemination | 6 months       | If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test  
If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40. |
| A female 35 years of age or older without a male partner                             | Does not apply | At least 6 cycles of donor insemination | 6 months       | If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test  
If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40. |
| A male of any age with a female partner under 35 years of age                        | 12 months or more | Does not apply | Does not apply | Does not apply                                                                                                                                  |
| A male of any age with a female partner 35 years of age or older                     | 6 months or more | Does not apply | Does not apply | Does not apply                                                                                                                                  |

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 in-network infertility specialist for the following infertility services:

- Ovulation induction cycle(s) with menotropins
- Intrauterine 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**

**Eligible health services** include Assisted Reproductive Technology (ART) services. ART services are 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”.

Covered dependent children are covered under this plan for ART services only in the case of fertility preservation due to:

- Planned cancer treatment that will leave the child sterile
- The removal of reproductive organs to treat an illness

- 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 which includes tubal ligation, hysterectomy and vasectomy with or without surgical reversal, regardless of post reversal results.
- 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.
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level meets the following criteria:

<table>
<thead>
<tr>
<th>You are</th>
<th>Number of months of unprotected timed sexual intercourse:</th>
<th>Number of donor artificial insemination cycles: Self paid/not paid for by plan</th>
<th>You need to have an unmedicated day 3 FSH test done within the past:</th>
<th>The results of your unmedicated day 3 FSH test:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A female under 35 years of age with a male partner</td>
<td>A. 12 months or more or B. At least 12 cycles of donor insemination</td>
<td>12 months</td>
<td>Must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.</td>
<td></td>
</tr>
<tr>
<td>A female under 35 years of age without a male partner</td>
<td>Does not apply</td>
<td>At least 12 cycles of donor insemination</td>
<td>12 months</td>
<td>Must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.</td>
</tr>
<tr>
<td>A female 35 years of age or older with a male partner</td>
<td>A. 6 months or more or B. At least 6 cycles of donor insemination</td>
<td>6 months</td>
<td>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 greater than 19 mIU/mL, you can use donor eggs or embryos but not 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 to use your own eggs, embryos or donor eggs or embryos.</td>
<td></td>
</tr>
<tr>
<td>Scenario</td>
<td>Requirement</td>
<td>Timeframe</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>A female 35 years of age or older without a male partner</td>
<td>Does not apply</td>
<td>At least 6 cycles of donor insemination</td>
<td>6 months</td>
<td>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 greater than 19 mIU/mL, you can use donor eggs or embryos but not 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 to use your own eggs, embryos or donor eggs or embryos.</td>
</tr>
<tr>
<td>A male of any age with a female partner under 35 years of age</td>
<td>12 months or more</td>
<td>Does not apply</td>
<td>Does not apply</td>
<td>Does not apply</td>
</tr>
<tr>
<td>A male of any age with a female partner 35 years of age or older</td>
<td>6 months or more</td>
<td>Does not apply</td>
<td>Does not apply</td>
<td>Does not apply</td>
</tr>
</tbody>
</table>
Fertility preservation
Only cancer patients and persons who have undergone the removal of reproductive organs to treat an illness are eligible for fertility preservation. Fertility preservation involves the creation of embryos or the retrieval of eggs and sperm that are frozen for future use. Along with the eligibility requirements above, you are eligible for fertility preservation benefits if:
- You, your partner or dependent child are planning treatment that is demonstrated to result in infertility. Planned treatments include:
  - Bilateral orchiectomy (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:

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

Eligible health services for fertility preservation will be paid on the same basis as other ART services for persons who are infertile and not diagnosed with cancer or other illnesses resulting in infertility.

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 in-network ART specialist for the following ART services:

- Any combination of the following ART services:
  - In vitro fertilization (IVF)*
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers (Frozen Embryo Transfer (FET))
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Charges associated with your care when you will receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with obtaining the spouse’s, civil union partner’s or domestic partner’s sperm for ART services, when the spouse, civil union partner’s or domestic partner is also covered under this plan.
- 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, but only when you get them from a licensed radiological facility or lab.

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

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 his/her office
- A home care provider in your home

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

Infusion therapy is the parenteral (i.e. 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 or by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card to determine if coverage is under the outpatient prescription drug benefit or this certificate.

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
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 your inpatient hospital stay if it is part of a treatment plan ordered by your physician.

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

Short-term rehabilitation and habilitation therapy services

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

Eligible health services include short-term rehabilitation therapy services your physician prescribes. The services have to be performed by:
  • A licensed or certified physical, occupational or speech therapist
  • A hospital, skilled nursing facility, or hospice facility
  • A home health care agency
  • A physician
Short-term rehabilitation therapy services have to follow a specific treatment plan, ordered by your physician.

**Outpatient cognitive rehabilitation, physical, occupational, and speech therapy**

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

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

**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
- Audiology services
**Chiropractic services**

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

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

**Diagnostic testing for learning disabilities**

*Eligible health services* include diagnostic testing for:

- Attention deficit disorder
- Attention deficit hyperactive disorder

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

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

**Ambulance service**  
*Eligible health services* include transport by professional ground **ambulance** 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  
- 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

**** As standard practice, many ambulance services choose not to contract with insurance companies and as a result, there are very few Ambulance services in the Aetna network. For an ambulance transport, services may be paid at the out-of-network benefit level. Higher out-of-pocket expenses may apply.

**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  
- We determine based on published, peer-reviewed scientific evidence that you may benefit from the treatment

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

**Clinical trials (routine patient costs)**

*Eligible health services* include "routine patient costs" incurred 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 abuse.
- A new DME item you need because your physical condition has changed. It also covers buying a new DME item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.
- The fitting and adjustment of such DME items.
- Medically-necessary DME required by Essential Health Benefits (EHB), including Diabetes equipment

We:
- Assume no responsibility
- Make no express or implied warranties

concerning the outcome of any covered DME items.

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

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

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

Enteral formulas

Eligible health services include enteral formulas used to treat malabsorption of food caused by:
- Crohn’s Disease
- Ulcerative colitis
- Gastroesophageal reflux
- Gastrointestinal motility;
- Chronic intestinal pseudoobstruction
- 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.

Your physician must give you a written order.
Prosthetic devices

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

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

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

Hearing aids and exams

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

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

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

Hearing Aids Alternate Treatment Rule

Sometimes there are several types of hearing aids that can be used to treat a medical condition, all of which provide acceptable results. When alternate hearing aids can be used, the plan’s coverage may be limited to the cost of the least expensive device that is:
- Customarily used nationwide for treatment and
- Deemed by the medical profession to be appropriate for treatment of the condition in question. The device must meet broadly accepted standards of medical practice for your physical condition.

You should review the differences in the cost of alternate treatment with your physician. Of course, you and your physician can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover for hearing aids.
Podiatric (foot care) treatment
Eligible health services include non-routine foot care for the treatment of illness or injury of the feet by physicians and health professionals.

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

Vision care
Pediatric vision care
Routine vision exams
Eligible health services include a routine vision exam provided by an ophthalmologist 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 not identified as preferred by a vision provider, (non-preferred)
- 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 select care pharmacies and 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
- What your plan doesn’t cover – some eligible health service exceptions
- How you share the cost of your outpatient prescription drugs

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.

How to access select care pharmacies and in-network pharmacies

How do you find a select care pharmacy?

Your policyholder will tell you how to do that.

How do you find an in-network pharmacy?

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

- **Online:** By logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com.
- **By phone:** Call the Member Services toll-free number on the back of 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 the in-network pharmacies.

If you fill your prescriptions at a preferred in-network pharmacy, you may be eligible to get prescription drugs at a lower cost share. See the schedule of benefits for details.

You can access the list of preferred in-network pharmacies by contacting Member Services at the toll-free number on the back of your ID card.

Pharmacies include in-network 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/coinsurance
- Any charges over our recognized charge
- Submitting your own claims

Eligible health services under your outpatient prescription drug benefit include:
Any pharmacy service that meets these three requirements:

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

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

- You need a prescription from your prescriber
- Your drug needs to be medically necessary for your illness or injury. See the Medical necessity, referral 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 non-preferred preferred value 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.

What 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 select care pharmacy or in-network pharmacy
- Calling or e-mailing a select care pharmacy or in-network pharmacy to order the medication
- Submitting your prescription electronically

Once you receive a prescription from your prescriber, you may fill the prescription at a select care or in-network pharmacy.

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 select care pharmacy or in-network pharmacy every time you get a prescription filled. The select care pharmacy or in-network pharmacy will submit your claim. You will pay any cost sharing directly to the select care pharmacy or in-network pharmacy.

You do not have to complete or submit claim forms. The select care pharmacy or in-network pharmacy will take care of claim submission.

See the schedule of benefits for details on supply limits and cost sharing.
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 number on your ID card.

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

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

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

- Injection devices including insulin syringes, needles and pens
- Test strips - blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs
- Blood glucose meters and external insulin pumps without special features, unless required due to blindness

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

Immunizations
Under the outpatient prescription drugs benefit, eligible health services include immunizations for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention administered at a select care pharmacy or in-network pharmacy. You should contact your select care pharmacy or in-network pharmacy for vaccine availability.

Your medical plan also provides coverage for immunizations in a physician's office and a walk-in clinic. For details, refer to your medical benefits.

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 symptom(s). Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your symptom(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 symptom(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 symptom(s) is equal to the dosage for the same symptom(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 symptom(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.

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.

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 ACA guidelines when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing.

Risk-reducing breast cancer prescription drugs
Eligible health services include prescription drugs used to treat people who are at:
- Increased risk for breast cancer
- Low risk for adverse medication side effects

Tobacco cessation prescription and over-the-counter drugs
Eligible health services include FDA-approved prescription drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing.
How you get an emergency prescription filled

You may not have access to a select care or 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.

<table>
<thead>
<tr>
<th>Type of pharmacy</th>
<th>Your cost share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select care pharmacy or In-network pharmacy</td>
<td>• You pay the copayment/coinsurance.</td>
</tr>
</tbody>
</table>
| Out-of-network pharmacy | • 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/coinsurance. |

Where your schedule of benefits fits in

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

Your outpatient prescription drug costs are based on:

- The type of prescription you use, (generic, brand-name, preferred, non-preferred)
- Where you fill your prescription, at a select care or in-network pharmacy

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

How your copayment/coinsurance works

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

Medical exceptions

Sometimes you or your prescriber may ask for a medical exception to get health care services for drugs not covered or for brand-name, specialty or biosimilar prescription drugs or for which health care services are denied through 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 and will tell you and your prescriber of our decision. Any exception granted is based upon an individual, case by case decision, and will not apply to other members. If approved by us, you will receive the non-preferred benefit level and the exception will apply for the entire time of the prescription.
You, someone who represents you or your prescriber may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-preferred drug. You, someone who represents you or your prescriber may submit a request for a quicker review for an urgent situation by:

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

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

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

We reserve the right to review all requests for reimbursement. Within our reasonable authority, we will make reimbursement determinations subject to the When you disagree - claim decisions and appeals procedures section.

We reserve the right to include only one manufacturer’s product on the preferred drug guide when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.

We reserve the right to include only one dosage or form of a drug on the preferred drug guide when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our preferred drug guide will be covered at the applicable copayment or coinsurance.
What your plan doesn’t cover – some eligible health service exceptions

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

In this section we tell you about the exceptions.

And just a reminder, you’ll find coverage limitations in the schedule of benefits.

General exceptions

Acupuncture therapy

- Maintenance treatment
- Acupuncture when provided for the following conditions:
  - Acute low back pain
  - Addiction
  - AIDS
  - Amblyopia
  - Allergic rhinitis
  - Asthma
  - Autism spectrum disorders
  - Bell’s Palsy
  - Burning mouth syndrome
  - Cancer-related dyspnea
  - Carpal tunnel syndrome
  - Chemotherapy-induced leukopenia
  - Chemotherapy-induced neuropathic pain
  - Chronic pain syndrome (e.g., RSD, facial pain)
  - Chronic obstructive pulmonary disease
    Diabetic peripheral neuropathy
    Dry eyes
  - Erectile dysfunction
  - Facial spasm
  - Fetal breech presentation
  - Fibromyalgia
  - Fibrotic contractures
  - Glaucoma
  - Hypertension
  - Induction of labor
  - Infertility (e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
  - Insomnia
  - Irritable bowel syndrome
  - Menstrual cramps/dysmenorrhea
  - Mumps
  - Myofascial pain
- Myopia
- Neck pain/cervical spondylosis
- Obesity
- Painful neuropathies
- Parkinson’s disease
- Peripheral arterial disease (e.g., intermittent claudication)
- Phantom leg pain
- Polycystic ovary syndrome
- Post-herpetic neuralgia
- Psoriasis
- Psychiatric disorders (e.g., depression)
- Raynaud’s disease pain
- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

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

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

**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 **sickness** contracted, while in the service of the Armed Forces of any country. When you enter the Armed Forces of any country, we will refund any unearned pro-rata **premium** to the **policyholder**.

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

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

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

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** except In connection with hospice care, adult (or child) day care, or convalescent care
• Institutional care. This includes **room and board** for rest cures, adult day care and convalescent care
• Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
• Any other services that a person without medical or paramedical training could be trained to perform
• Any service that can be performed by a person without any medical or paramedical training
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:
- Excision of partially or completely impacted teeth;
- Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth;
- Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth and related biopsy of bone, tooth, or related tissues when such conditions require pathological examinations;
- Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation;
- Services required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Reduction of fractures and dislocation of the jaw;
- External incision and drainage of cellulitis and abscess;
- Incision and closure of accessory sinuses, salivary glands or ducts;
- Frenectomy (the cutting of the tissue in the midline of the tongue); and
- Orthognathic surgery for a congenital anomaly, bodily injury or sickness causing a functional impairment.

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

Except DME covered under Essential Health Benefits (EHB) benchmark plan page 46, including diabetes supplies
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
- Infirmaries at schools, colleges, or camps

Family planning services - other
- Reversal of voluntary sterilization procedures, including related follow-up care
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

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

Foot care
- Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet
Gender affirming (sex change) treatment

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

Genetic care

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

Growth/Height care

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

Hearing aids and exams

The following services or supplies:

- Replacement parts or repairs for a hearing aid
- Batteries or cords
- Cochlear implants (except as required by Essential Health Benefits (EHB) benchmark plan page 51 for profound sensorineural deafness)
- 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

- Nursing and **home health aide** services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Homemaker or housekeeper services
- Food or home delivered services
- Maintenance therapy
Hospice care
- Funeral arrangements
- Pastoral counseling
- **Respite care**
- Financial or legal counseling which includes estate planning and the drafting of a will
- Homemaker or caretaker services that are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

Incidental surgeries
- Charges made by a **physician** for incidental surgeries

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
  - Does not include an up to 30-day supply of surgical dressings, catheters, colostomy bags, rings and belts and flotation pads as required by Essential Health Benefits benchmark plan (page 51).

Medicare
- Services and supplies to the extent they would have been covered under Medicare Part A, Part B, Part C and Part D even though you are eligible but did not enroll in Parts B, C or D.
Mental health treatment
- Mental health services for the following categories (or equivalent terms as listed in the most recent version of the International Classification of Diseases (ICD)):
  - **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 covered in the *Preventive care and wellness* section)
  - Pathological gambling, kleptomania, pyromania
  - School and/or education service including special educational, remedial education, wilderness treatment programs, or any such related or similar programs
- Mental health services provided in conjunction with school, vocation, work or recreational activities

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

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

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

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

Obesity (bariatric) surgery and weight management
- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Eligible health services under your plan – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric **surgery**
  - **Surgical procedures**, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement
Organ removal
- Services and supplies given by a provider to remove an organ from your body for the purpose of donating or selling the organ except as described in the Eligible health services under your plan section. This does not apply if you are donating the organ to a spouse, domestic partner, 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
- 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 (except as required by Essential Health Benefits (EHB) benchmark plan page 51 for profound sensorineural deafness)

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

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

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

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

Pediatric vision care services and supplies
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, prescription lenses and prescription contact lenses that are not identified as preferred by a vision in-network provider
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Adult vision care
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, prescription lenses and prescription contact lenses that are not identified as preferred by a vision in-network provider
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes
- Exceptions to the policy do not include the initial pair of eyeglasses or contacts needed due to cataract surgery or an accident if the eyeglasses or contacts were not needed prior to the accident, as required by the Essential Health Benefits benchmark plan page 51.

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 that apply to outpatient prescription drugs

Contraceptive methods, procedures, services, and supplies for contraceptive purposes
- 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 outpatient prescription drug (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved)
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan while an inpatient of a healthcare facility
- Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by Aetna's Pharmacy and Therapeutics Committee
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the share 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 the network. This section tells you about Core providers and in-network and out-of-network providers.

Core providers
The policyholder will tell you about the Core providers who will provide eligible health services to you.

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

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

In-network providers
We have contracted with providers to provide eligible health services to you. These providers make up the network for your plan. For you to receive the 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.

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.

<table>
<thead>
<tr>
<th>Request for approval</th>
<th>When your provider stops participation with Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you are a new enrollee and your provider is an out-of-network provider</td>
<td>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 the back of your ID card.</td>
</tr>
<tr>
<td>You or your provider should call Aetna for approval to continue any care.</td>
<td></td>
</tr>
</tbody>
</table>

| Length of transitional period | Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. |
| Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. This date is based on the date the provider terminated their participation with Aetna. |

If you 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/coinsurance**
- Your **maximum out-of-pocket limit**

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

**The general rule**

When you get **eligible health services**:

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

And then

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

And then

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

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

**Important exception – when your plan pays all**

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

**Important exceptions – when you pay all**

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

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

In all these cases, the **provider** may require you to pay the entire charge. And 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
- Completion of a claim form
- Non-telemedicine telephone conversations with providers

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
- 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/coinsurance works**

Your **copayment/coinsurance** 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/coinsurance** you need to pay for specific eligible health services.

**How your maximum out-of-pocket limit works**

You will pay your **policy year deductible** and **copayments/coinsurance copayments** 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:

<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit a claim</td>
<td>• You should notify and request a claim form from us.</td>
<td>• You must send us notice and proof as soon as reasonably possible.</td>
</tr>
<tr>
<td></td>
<td>• The claim form will provide instructions on how to complete and where to</td>
<td>• If you are unable to complete a claim form, you may send us:</td>
</tr>
<tr>
<td></td>
<td>send the form(s).</td>
<td>- A description of services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Bill of charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Any medical documentation you received from your provider</td>
</tr>
<tr>
<td>Proof of loss (claim)</td>
<td>• A completed claim form and any additional information required by us.</td>
<td>• You must send us notice and proof as soon as reasonably possible.</td>
</tr>
<tr>
<td>Benefit payment</td>
<td>• Written proof must be provided for all benefits.</td>
<td>• Benefits will be paid as soon as the necessary proof to support the</td>
</tr>
<tr>
<td></td>
<td>• If any portion of a claim is contested by us, the uncontested portion of</td>
<td>claim is received.</td>
</tr>
<tr>
<td></td>
<td>the claim will be paid promptly after the receipt of proof of loss.</td>
<td></td>
</tr>
</tbody>
</table>

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. And 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 delay in getting medical care, in the opinion of the attending physician, could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. Or it could 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 review organization if the situation is eligible for external review.

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

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

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

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Urgent care claim</th>
<th>Pre-service claim</th>
<th>Post-service claim</th>
<th>Concurrent care claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial determination (us)</td>
<td>48 hours</td>
<td>15 days</td>
<td>30 days</td>
<td>24 hours for urgent request*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15 calendar days for non-urgent request</td>
</tr>
<tr>
<td>Extensions</td>
<td>None</td>
<td>15 days</td>
<td>15 days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Additional information request (us)</td>
<td>72 hours</td>
<td>15 days</td>
<td>30 days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Response to additional information request (you)</td>
<td>48 hours</td>
<td>45 days</td>
<td>45 days</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

*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 a select care provider and 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 the back of your ID card or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

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

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

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

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

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

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Urgent care claim</th>
<th>Pre-service claim</th>
<th>Post-service claim</th>
<th>Concurrent care claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal determinations at each level</td>
<td>36 hours</td>
<td>15 days</td>
<td>30 days</td>
<td>As appropriate to type of claim</td>
</tr>
<tr>
<td>Extensions</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

Exhaustion of appeals process
In most situations you must complete an appeal with us before you can take these other actions:
- Contact the Georgia Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Georgia Department of Insurance
- Appeal through an external 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 review process.
- We did not follow all of the claim determination and appeal requirements of the state of Georgia or Federal Department of Health and Human Services. But, you will not be able to proceed directly to external 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 review
External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO).

You have a right to external review only if:
- Our claim decision involved medical judgment
- We decided the service or supply is not medically necessary or not appropriate
- We decided the service or supply is experimental or investigational
- You have received an adverse determination
If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:
- To the Office of Insurance and Safety Fire Commissioner
- Within 120 calendar days of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

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

The Office of Insurance and Safety Fire Commissioner will:
- Contact the ERO that will conduct the review of your claim
- The ERO will:
  - Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
  - Consider appropriate credible information that you sent
  - Follow our contractual documents and your plan of benefits
  - Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

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

How long will it take to get an ERO decision?
We will tell you of the ERO decision not more than 45 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

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

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

For initial adverse determinations
Your provider tells us that a delay in your receiving health care services would:
- Jeopardize your life, health or ability to regain maximum function or
- Be much less effective if not started right away (in the case of experimental or investigational treatment)

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

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.
Recordkeeping
We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses
We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.
Coordination of benefits

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 a “plan” 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
- Medicare or other governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

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.

<table>
<thead>
<tr>
<th>If you are covered as a:</th>
<th>Primary plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-dependent or Dependent</td>
<td>The plan covering you as a student.</td>
<td>The plan covering you as a dependent.</td>
</tr>
</tbody>
</table>

Exception to the rule above when you are eligible for Medicare

If you or your spouse has Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us:
- **Online**: Log on to your Aetna Navigator® secure website at www.aetnastudenthealth.com. Select Find a Form, then select Your Other Health Plans
- **By phone**: Call the Member Services toll-free number on the back of your ID card
### COB rules for dependent children

<table>
<thead>
<tr>
<th>Child of:</th>
<th>The “birthday rule” applies. The plan of the parent whose birthday* (month and day only) falls earlier in the calendar year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Parents who are married or living together</td>
<td><em>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)</em>.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child of:</th>
<th>The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other spouse’s plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Parents separated or divorced or not living together</td>
<td>The plan of the other parent. But if that parent has no coverage, then his/her spouse’s plan is primary.</td>
</tr>
<tr>
<td>• With court-order</td>
<td>Primary and secondary coverage is based on the birthday rule.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child of:</th>
<th>The order of benefit payments is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Parents separated or divorced or not living together and there is no court-order</td>
<td>• The plan of the custodial parent pays first</td>
</tr>
<tr>
<td>• Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)</td>
<td>• The plan of the spouse of the custodial parent (if any) pays second</td>
</tr>
<tr>
<td>• The plan of the noncustodial parents pays next</td>
<td>• The plan of the spouse of the noncustodial parent (if any) pays last</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Longer or shorter length of coverage</th>
<th>If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other rules do not apply</td>
<td>If none of the above rules apply, the plans share expenses equally.</td>
</tr>
</tbody>
</table>

---

*Same birthdays--the plan that has covered a parent longer is primary.
### How are benefits paid?

<table>
<thead>
<tr>
<th>Plan</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary plan</strong></td>
<td>The primary plan pays your claims as if there is no other health plan involved.</td>
</tr>
<tr>
<td><strong>Secondary plan</strong></td>
<td>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. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.</td>
</tr>
</tbody>
</table>
| **Benefit reserve**| Each family member has a separate benefit reserve for each policy year. The benefit reserve:  
• 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.

You are eligible for Medicare when you are covered under it by reason of:
- Age
- Disability or
- End stage renal disease

You are also eligible for Medicare even if you are not covered if you:
- Refused it
- Dropped it or
- Did not make a proper request for it

When you are eligible for 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 will pay as if you are covered by Medicare and coordinates benefits with the benefits Medicare would have paid had you enrolled in Medicare. At no time, will this plan be the primary plan, which means that the plan will never pay benefits before Medicare pays benefits. This plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid had you been covered.
This plan is secondary to Medicare in all other circumstances.

<table>
<thead>
<tr>
<th>How are benefits paid?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>We are primary</td>
<td>We pay your claims as if there is no Medicare coverage.</td>
</tr>
<tr>
<td>Medicare is primary</td>
<td>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.</td>
</tr>
</tbody>
</table>

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 website at www.aetnastudenthealth.com Select Find a Form, then select Your Other Health Plans.
- **By phone:** Call the Member Services toll-free number on the back of 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 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 prorata basis, when we receive your application within 90 days from the date of the withdrawal.

When will your continuation of coverage plan end?
Your coverage and your dependent’s coverage under the continuation of coverage plan will end:

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

If your continuation of coverage plan ends because you withdraw from school for reasons other than entering the armed forces, we will not refund your premium contributions. You are covered for your elected time period and the premium contribution that you paid.

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

See the Continuation of coverage for other reasons section to learn how you can extend your coverage.
When will coverage end for any dependents?
Coverage for your dependent will end if:

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

In addition, coverage for your domestic partner 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 dependents if you die?
Coverage for dependents may continue for some time after your death. See the Special coverage options after your plan coverage ends section for more information.

Why would we end your coverage?
We will give you 30 days advance written notice if we end your coverage because:

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

We may immediately end your 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 plan

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

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

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

Continuation of coverage for other reasons

To request an extension of coverage, just call the Member Services toll-free number on the back of your ID card.

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

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

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

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

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

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

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

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

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

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

- When you are discharged. Coverage will not end if you are transferred to another hospital or a skilled nursing facility.
- When you no longer need inpatient care.
- When you become covered by another health benefits plan.
- 3 months of coverage.
How can you extend coverage for your disabled child beyond the plan age limits?
You have the right to extend coverage for your 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.

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 the back of your ID card.
General provisions – other things you should know

We gathered a number of provisions here. They talk about several different things, so we call this part “General provisions – other things you should know”.

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 discretion.

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 Core providers and in-network providers are not our employees or agents.

Coverage and services

Your coverage can change
Your coverage is defined by the student health insurance policy (student policy). This document may have amendments or riders too. Under certain circumstances, we or the policyholder or the law may change your plan. Only Emory 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
No legal action may be taken by you against Aetna for any expense or bill until you complete the appeal process. See the When you disagree – An Appeal section. And you cannot take any action until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.
Physical examinations and evaluations
At our expense, we have the right to have a **physician** of our choice examine you. This will be done at all reasonable times while certification or a claim for benefits is pending or under review.

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

Things that would be important to keep are:
- Names of **physicians, dental providers** and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes
You or the **policyholder** may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won’t make a change if the mistake happened more than 1 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 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 use it and share it with others as 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 the back of your ID card.

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

**Effect of benefits under other plans**

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

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

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

**Actual charge**
The standard office charge established by a provider for services and supplies that are covered benefits under the plan and that the provider gives to you.

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

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

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

**Biosimilar prescription drug**
A biological prescription drug that is highly similar to a U.S. Food and Drug Administration (FDA) – licensed reference biological prescription drug notwithstanding minor differences in clinically inactive components, and for which there are no clinically meaningful differences between the highly similar biological prescription drug and the reference biological prescription drug in terms of the safety, purity, and potency of the drug. As defined in accordance with U.S. Food and Drug Administration (FDA) regulations.

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

**Brand-name prescription drug**
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 1 year 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:

- Needle stick pricks
- Exposure to blood and body fluid
- Exposure to highly contagious pathogens
Coinsurance
Coinsurance is both the percentage of eligible health services that the plan pays and what you pay. The specific percentage that we have to pay for eligible health services is listed in the schedule of benefits.

Copayments or copayments/coinsurance
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 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 benefits
Eligible health services that meet the requirements for coverage under the terms of this plan, including:
- They are medically necessary
- You received precertification and/or a referral from student health services, if required

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

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

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 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 you and your dependent’s coverage begins under this certificate of coverage as noted in Aetna’s records.

Elective treatment:
Services and supplies provided to you when there is no evidence of pathology, dysfunction, or illness in any part of your body. Examples of elective treatment are:
- Breast reduction
- Sub mucous resection and/or other surgical correction for deviated nasal septum, other than treatment of covered acute purulent sinusitis

Eligible health services
The health care services and supplies and outpatient prescription drugs listed in the Eligible health services under your plan section and not carved out or limited in the Exceptions section 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 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 Generic 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 abuse
- Residential treatment facility for mental disorders
- Extended care facility
- Intermediate care facility
- Skilled nursing facility

**Hospital stay**
This is your stay of 18 or more hours in a row as a resident bed patient in a hospital.

**Illness**
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 retailor 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.

**Infertile or infertility**
A disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (or 6 months for women age 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:
- Delivered by an appropriately licensed or credentialed practitioner
- Designed to address a mental disorder or substance abuse issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring

**Jaw joint disorder**
This is:
- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint
- A Myofascial Pain Dysfunction (MPD) of the jaw or
- 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.

**Maximum out-of-pocket limit**
The maximum out-of-pocket amount for payment of copayments/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**
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 of the American Psychiatric Association*. It is a syndrome characterized by clinically significant disturbance in a person’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 a select care provider and an in-network provider has agreed to accept
- The amount we agree to pay directly to a select care provider and in-network provider or third party vendor (including any administrative fee in the amount paid)

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

Prescription drug coverage from a select care or in-network pharmacy

Select care pharmacy
Reach out to Student health services for information.

In-network pharmacy
This is the amount Aetna has established for each prescription drug obtained from an in-network pharmacy under this plan. This negotiated charge may reflect amounts Aetna has 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 Aetna.

The negotiated charge does not reflect any amount Aetna, an affiliate, or a third party vendor, may receive under a rebate arrangement between Aetna, an affiliate or a third party vendor and a drug manufacturer for any prescription drug, including prescription drugs on the preferred drug guide.

Aetna may receive rebates from the manufacturers of prescription drugs and may receive or pay additional amounts from or to third parties underprice 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 a select care dental provider or an in-network dental provider and does not appear in the directory for your plan.

Out-of-network pharmacy
A pharmacy that is not a select care pharmacy or an in-network pharmacy, 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 select care provider or in-network provider or National Advantage Program (NAP) provider and does not appear in the directory for your plan.
Partial hospitalization treatment
A plan of clinical treatment such as medical, psychiatric, nursing, counseling, or therapeutic services to treat mental disorders and substance abuse.

The clinical treatment must be provided:
- No more than 5 days per week
- For a minimum of 4 hours each treatment day

The clinical treatment must be:
- Provided by a behavioral health provider with the appropriate license or credentials
- Designed to address a mental disorder or substance abuse issue and may include:
  - Group, individual, family or multi-family group psychotherapy
  - Psycho-educational services
  - Adjunctive services such as medication monitoring
- For services delivered according to accepted medical practice for the condition of the person

Pharmacy
An establishment where prescription drugs are legally dispensed. This includes a select care and in-network retail and specialty pharmacy and 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 abuse and mental disorders.

Mental disorders includes related substance abuse disorders.

Psychiatrist
A psychiatrist generally provides evaluation and treatment of mental, emotional, or behavioral disorders.
Recognized charge
The amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider’s full charge.

In all cases, the recognized charge is based on the Geographic area where you receive the service or supply.

Except as otherwise specified below, the recognized charge for each service or supply is the lesser of what the provider bills and:

- For professional services and for other services or supplies not mentioned below: 105% of the Medicare allowable rate
- For services of hospitals and other facilities: 140% of the Medicare allowable rate
- For prescription drugs: 100% of the Average wholesale price (AWP)
- For dental expenses: 80th percentile of the prevailing charge rate
- For emergency services, the greatest of standards A, B and C:
  - Standard A. The median of the amounts we have negotiated with Core providers or in-network providers for the emergency service furnished. In determining that median amount, we will treat the amount negotiated with each select care provider or in-network provider as a separate amount even if the same amount is paid to more than one provider. This standard does not apply if we have not negotiated per-service amounts with Core providers or in-network providers.
  - Standard B. The amount that would be calculated using the same method the plan generally uses to determine the recognized charge for out-of-network services and supplies, as specified above.
  - Standard C. The amount that would be paid under Medicare (Part A or Part B of title XVIII of the Social Security Act) for those emergency services.

Special terms used
Average wholesale price (AWP), Geographic area, Medicare allowable rates, are defined as follows:

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
The Geographic area made up of 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 allowable rates
Except as specified below, these are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 90-180 days of receiving them from CMS. If Medicare does not have a rate, we will determine the rate as follows:

- Use the same method CMS uses to set Medicare rates
- Look at what other providers charge
- Look at how much work it takes to perform a service
- Look at other things as needed to decide what rate is reasonable for a particular service or supply
Prevailing charge rates
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 90-180 days after receiving them from FAIR Health. If the Fair Health database becomes unavailable, we have the right to substitute an alternative database that we believe is comparable.

R.N.
A registered nurse.

Referral
This is an oral, written or electronic authorization made by student health services to direct you to a provider for medically necessary services and supplies.

Residential treatment facility (mental disorders)
- An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by Aetna or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating mental disorders:
- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)

Residential treatment facility (substance abuse)
An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for substance abuse residential treatment programs. And is credentialed by Aetna or accredited by one of the following agencies, commissions or committees for the services being provided:
- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)
In addition to the above requirements, an institution must meet the following for **substance abuse** residential treatment programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a **physician**
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

In addition to the above requirements, for **substance abuse detoxification** programs within a residential setting:

- An **R.N.** must be onsite 24 hours per day for 7 days a week within a residential setting
- Residential care must be provided under the direct supervision of a **physician**

**Respite care**
This is care provided to you when you have a **terminal illness** for the sole purpose of providing temporary relief to your family (or other care givers) from the daily demands of caring for you.

**Retail pharmacy**
A community **pharmacy** that dispenses outpatient **prescription drugs** at retail prices.

**Room and board**
A facility’s charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

**Student health services**
Any:
- Organization
- Facility
- Clinic
- Pharmacy

that is operated, maintained, or supported by the **policyholder** (or other entity under contract to the the **policyholder**) which provides health care services to **covered students** and their **covered dependents**. **Student health services** will either provide or coordinate the care provided to **covered students**.

**Select care**
**Eligible health services** provided by a **select care provider**.

**Select care dental provider**
A dental provider that that is affiliated with, or has an agreement or arrangement with, or is otherwise designated by, the policyholder’s student health services to provide services and supplies to covered students.

**Select care pharmacy**
A retailor specialty pharmacy that is affiliated with, or has an agreement or arrangement with, or is otherwise designated by, the policyholder’s student health services to provide services and supplies to covered students.
Select care provider
A health professional or pharmacy that is affiliated with, or has an agreement or arrangement with, the the policyholder’s student health services. It can also mean a health professional or pharmacy designated by the policyholder to provide services and supplies to covered students.

Self-injectable Drug(s)
These are prescription drugs that are intended for you to self-administer by injection to a specific part of your body to treat certain chronic medical conditions.

Semi-private room rate
An institution’s room and board charge for most beds in rooms with 2 or more beds. If there are no such rooms, Aetna will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service area
The geographic area where in-network providers for this plan are located.

Skilled nursing facility
A facility specifically licensed as a skilled nursing facility by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation hospitals, and portions of a rehabilitation hospital and a hospital designated for skilled or rehabilitation therapy services.

Skilled nursing facility does not include institutions that provide only:
- Minimal care
- Custodial care services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of mental disorders or substance abuse.

Skilled nursing services
Services provided by an R.N. or L.P.N. within the scope of his or her license.

Sound Natural Teeth
These are natural teeth. If there is a filling in a tooth, the major portion of the tooth must be present. A tooth cannot be decayed, abscessed, or defective. Sound natural teeth are not capped teeth, implants, crowns, bridges, or dentures.

Specialist
A physician who practices in any generally accepted medical or surgical sub-specialty and is board-certified.
Specialty prescription drugs
These are prescription drugs that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

You can access the list of these specialty prescription drugs by calling the Member Services toll-free number on your ID card or by logging on to your Aetna Navigator® secure website at www.aetnastudenthealth.com. The list also includes biosimilar prescription drugs.

Specialty pharmacy
This is a pharmacy designated by Aetna as a 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. These documents are:

- The student application
- The student policy
- The certificate of coverage
- The schedule of benefits
- The enrollment form
- Any riders, endorsement, inserts, attachments, and amendments to the student policy, the certificate of coverage, or the schedule of benefits

Substance abuse
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a mental disorder that are a focus of attention or treatment. Or an addiction to nicotine products, food or caffeine intoxication.

Surgery center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient surgery services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).
**Surgery, surgeries or surgical procedures**
The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as:
- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution or
- Otherwise physically changing body tissues and organs

**Telemedicine**
A telephone or internet-based consult with a **provider** that has contracted with **Aetna** to offer these services.

**Terminal illness**
A medical prognosis that you are not likely to live more than 6-24 months.

**Therapeutic drug class**
A group of drugs or medications that have a similar or identical mode of action. They could be used for the treatment of the same or similar **illness** or **injury**.

**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**
**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)


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)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat identifikasyon 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 연락 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

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)