



**Student Health Insurance**

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

**Schedule of benefits**

**Prepared exclusively for:**

|                                            |                                |
|--------------------------------------------|--------------------------------|
| <b>Policyholder:</b>                       | Queens University of Charlotte |
| <b>Policyholder number:</b>                | 252660                         |
| <b>Student policy effective date:</b>      | 08/01/2026                     |
| <b>Plan effective date:</b>                | 08/01/2026                     |
| <b>Plan issue date:</b>                    | 07/13/2026                     |
| <b>Actuarial value and metallic level:</b> | 85.24% - Gold                  |

**Underwritten by Aetna Life Insurance Company in the  
State of North Carolina**

## Schedule of benefits

---

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

### How to read your schedule of benefits

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

#### Important note:

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

### How to contact us for help

We are here to answer your questions.

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

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

## Important note about your cost sharing

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

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

Here's an example of how cost sharing works:

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

## Plan features

### Policy year deductibles

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

| Deductible type | In-network coverage          | Out-of-network coverage      |
|-----------------|------------------------------|------------------------------|
| Student         | \$350 per <b>policy year</b> | \$700 per <b>policy year</b> |

### Policy year deductible waiver

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

In-network care for:

- Preventive care and wellness
- Pediatric Dental Type A services
- Pediatric Vision Care Services
- Physician, specialist including Consultants Office visits (including Mental Health and Substance Abuse)
- Walk-in clinic visits (non-emergency visit)

In-network care and out-of-network care for:

- Well newborn nursery care
- Outpatient prescription drugs
- Urgent care
- Emergency room
- Ambulance

## Maximum out-of-pocket limits

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

| Maximum out-of-pocket type | In-network coverage     | Out-of-network coverage  |
|----------------------------|-------------------------|--------------------------|
| Student                    | \$6,000 per policy year | \$12,000 per policy year |

## Precertification covered service penalty

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

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

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

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 service**, and will not be applied to the out-of-network **policy year deductible** amount or the **maximum out-of-pocket limit**, if any.

## Covered services

### Coinsurance listed in the schedule of benefits

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

### 1. Preventive care and wellness

#### Routine physical exams

Performed at a **physician's** office

| Description                                                                                                                 | In-network coverage                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Out-of-network coverage                          |
|-----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Routine physical exam                                                                                                       | 100% (of the <b>negotiated charge</b> ) per visit<br><br>No <b>copayment</b> or <b>policy year deductible</b> applies                                                                                                                                                                                                                                                                                                                                                                                                    | 70% (of the <b>recognized charge</b> ) per visit |
| Routine physical exam limits for <b>covered persons</b> through age 21: maximum age and visit limits per <b>policy year</b> | 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 <b>physician</b> or Member Services by logging in to your <b>Aetna</b> website at <a href="https://www.aetnastudenthealth.com">https://www.aetnastudenthealth.com</a> or calling the toll-free number in the <i>How to contact us for help</i> section. |                                                  |
| Routine physical exam limits for <b>covered persons</b> age 22 and over: maximum visits per <b>policy year</b>              | 1 visit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                  |

#### Preventive care immunizations

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

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

## Well woman preventive visits

Routine gynecological exams (including Pap smears)

| Description                                                                              | In-network coverage                                                                                                                   | Out-of-network coverage                          |
|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Performed at a <b>physician</b> , obstetrician (OB), gynecologist (GYN) or OB/GYN office | 100% (of the <b>negotiated charge</b> ) per visit<br><br>No <b>copayment</b> or <b>policy year deductible</b> applies                 | 70% (of the <b>recognized charge</b> ) per visit |
| Well woman routine gynecological exam maximums                                           | Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. |                                                  |
| Maximum visits per <b>policy year</b>                                                    | 1 visit                                                                                                                               |                                                  |

## Preventive screening and counseling services

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

| Description                                                                     | In-network coverage                                                                                                                      | Out-of-network coverage                          |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Obesity and/or healthy diet counseling office visits                            | 100% (of the <b>negotiated charge</b> ) per visit<br><br>No <b>copayment</b> or <b>policy year deductible</b> applies                    | 70% (of the <b>recognized charge</b> ) per visit |
| Obesity and/or healthy diet counseling maximum visits                           | Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling. |                                                  |
| Misuse of alcohol and/or drugs counseling office visits                         | 100% (of the <b>negotiated charge</b> ) per visit<br><br>No <b>copayment</b> or <b>policy year deductible</b> applies                    | 70% (of the <b>recognized charge</b> ) per visit |
| Misuse of alcohol and/or drugs counseling maximum visits per <b>policy year</b> | 5 visits                                                                                                                                 |                                                  |
| Use of tobacco products counseling office visits                                | 100% (of the <b>negotiated charge</b> ) per visit<br><br>No <b>copayment</b> or <b>policy year deductible</b> applies                    | 70% (of the <b>recognized charge</b> ) per visit |
| Use of tobacco products counseling maximum visits per <b>policy year</b>        | 8 visits                                                                                                                                 |                                                  |

| Description                                                                         | In-network coverage                                                                                                   | Out-of-network coverage                          |
|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Sexually transmitted infection counseling office visits                             | 100% (of the <b>negotiated charge</b> ) per visit<br><br>No <b>copayment</b> or <b>policy year deductible</b> applies | 70% (of the <b>recognized charge</b> ) per visit |
| Sexually transmitted infection counseling maximum visits per <b>policy year</b>     | 2 visits                                                                                                              |                                                  |
| Genetic risk counseling for breast and ovarian cancer office visits                 | 100% (of the <b>negotiated charge</b> ) per visit<br><br>No <b>copayment</b> or <b>policy year deductible</b> applies | 70% (of the <b>recognized charge</b> ) per visit |
| Genetic risk counseling for breast and ovarian cancer age and frequency limitations | Not subject to any age or frequency limitations                                                                       |                                                  |

### Routine cancer screenings

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

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

#### Lung cancer screenings important note:

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

## Prenatal care

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

| Description                   | In-network coverage                                                                                                   | Out-of-network coverage                          |
|-------------------------------|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Preventive care services only | 100% (of the <b>negotiated charge</b> ) per visit<br><br>No <b>copayment</b> or <b>policy year deductible</b> applies | 70% (of the <b>recognized charge</b> ) per visit |

### Important note:

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

## Comprehensive lactation support and counseling services

Facility or office visits

| Description                                                                                                 | In-network coverage                                                                                                   | Out-of-network coverage                          |
|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Lactation counseling services                                                                               | 100% (of the <b>negotiated charge</b> ) per visit<br><br>No <b>copayment</b> or <b>policy year deductible</b> applies | 70% (of the <b>recognized charge</b> ) per visit |
| Lactation counseling services maximum visits per <b>policy year</b> either in a group or individual setting | 6 visits                                                                                                              |                                                  |

### Important note:

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

## Breast feeding durable medical equipment

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

### Important note:

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



## Family planning services – female contraceptives

### Counseling services

| Description                                                                                                     | In-network coverage                                                                                                   | Out-of-network coverage                          |
|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Female contraceptive counseling services office visit                                                           | 100% (of the <b>negotiated charge</b> ) per visit<br><br>No <b>copayment</b> or <b>policy year deductible</b> applies | 70% (of the <b>recognized charge</b> ) per visit |
| Contraceptive counseling services maximum visits per <b>policy year</b> either in a group or individual setting | 2 visits                                                                                                              |                                                  |

#### Important note:

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

### Contraceptives (prescription drugs and devices)

| Description                                                                                                                                | In-network coverage                                                                                                  | Out-of-network coverage                         |
|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| Female contraceptive <b>prescription drugs</b> and devices provided, administered, or removed, by a <b>provider</b> during an office visit | 100% (of the <b>negotiated charge</b> ) per item<br><br>No <b>copayment</b> or <b>policy year deductible</b> applies | 70% (of the <b>recognized charge</b> ) per item |

### Female voluntary sterilization

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

## 2. Physicians and other health professionals

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

| Description                                                                                                                                        | In-network coverage                                                                                                                                       | Out-of-network coverage                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Office hours visits (non-surgical and non-preventive care by a <b>physician</b> or <b>specialist</b> , includes <b>telemedicine</b> consultations) | \$35 <b>copayment</b> then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit<br><br>No <b>policy year deductible</b> applies | 70% (of the <b>recognized charge</b> ) per visit |

### Allergy testing and treatment

| Description                                                                              | In-network coverage                              | Out-of-network coverage                          |
|------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------|
| Allergy testing performed at a <b>physician</b> or <b>specialist</b> office              | 80% (of the <b>negotiated charge</b> ) per visit | 60% (of the <b>recognized charge</b> ) per visit |
| Allergy injections treatment performed at a <b>physician</b> or <b>specialist</b> office | 80% (of the <b>negotiated charge</b> ) per visit | 60% (of the <b>recognized charge</b> ) per visit |

### Physician and specialist – inpatient surgical services

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

### Physician and specialist – outpatient surgical services

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

### In-hospital non-surgical physician services

| Description                                                | In-network coverage                              | Out-of-network coverage                          |
|------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------|
| In- <b>hospital</b> non-surgical <b>physician</b> services | 80% (of the <b>negotiated charge</b> ) per visit | 60% (of the <b>recognized charge</b> ) per visit |

### Consultant services (non-surgical and non-preventive)

| Description                                                                                                            | In-network coverage                                                                                                                                       | Out-of-network coverage                          |
|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Office hours visits (non-surgical and non-preventive care by a consultant, includes <b>telemedicine</b> consultations) | \$35 <b>copayment</b> then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit<br><br>No <b>policy year deductible</b> applies | 70% (of the <b>recognized charge</b> ) per visit |

### Second surgical opinion

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

### Alternatives to physician office visits

#### Walk-in clinic visits (non-emergency visit)

| Description                                 | In-network coverage                                                                                                                                       | Out-of-network coverage                          |
|---------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| <b>Walk-in clinic</b> (non-emergency visit) | \$35 <b>copayment</b> then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit<br><br>No <b>policy year deductible</b> applies | 70% (of the <b>recognized charge</b> ) per visit |

#### Important note:

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

### 3. Hospital and other facility care

#### Hospital care (facility charges)

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

#### Preadmission testing

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

#### Anesthesia and related facility charges for a dental procedure

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

| Description                                                                                                                                                                                                                        | In-network coverage                                                                   | Out-of-network coverage                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| <p>Anesthesia and related facility charges for a dental procedure</p> <p>For covered dependents below the age of 9, or for a covered person with serious mental or physical condition, or with significant behavioral problems</p> | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

## Alternatives to hospital stays

### Outpatient surgery (facility charges)

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

### Home health care

| Description      | In-network coverage                              | Out-of-network coverage                          |
|------------------|--------------------------------------------------|--------------------------------------------------|
| Home health care | 80% (of the <b>negotiated charge</b> ) per visit | 60% (of the <b>recognized charge</b> ) per visit |

### Hospice care

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

#### Hospice care important note:

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

### Outpatient private duty nursing

Up to 8 hours equals one shift

| Description                     | In-network coverage                              | Out-of-network coverage                          |
|---------------------------------|--------------------------------------------------|--------------------------------------------------|
| Outpatient private duty nursing | 80% (of the <b>negotiated charge</b> ) per visit | 60% (of the <b>recognized charge</b> ) per visit |

### Skilled nursing facility

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

## 4. Emergency services and urgent care

### Emergency services

| Description                             | In-network coverage                                                                                                                                        | Out-of-network coverage              |
|-----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| Emergency room                          | \$150 <b>copayment</b> then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit<br><br>No <b>policy year deductible</b> applies | Paid the same as in-network coverage |
| Non-emergency care in an emergency room | Not covered                                                                                                                                                | Not covered                          |

#### Emergency services important note:

- **Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, or call Member Services for an address at 1-877-626-2308 and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.
- A separate emergency room **copayment** will apply for each visit to an emergency room. If you are admitted to a **hospital** as an inpatient right after a visit to an emergency room, your emergency room **copayment** will be waived and your inpatient **copayment** will apply.
- **Covered services** that are applied to the emergency room **copayment** cannot be applied to any other **copayment** under the plan. Likewise, a **copayment** that applies to other **covered services** under the plan cannot be applied to the emergency room **copayment**.
- Separate **copayment** amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These **copayment** amounts may be different from the emergency room **copayment**. They are based on the specific service given to you.
- Services given to you in the emergency room that are not part of the emergency room benefit may be subject to **copayment** amounts.

### Urgent care

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

## 5. Pediatric dental care

### Pediatric dental care

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

Dental benefits are subject to the medical plan's **policy year deductibles** and **maximum out-of-pocket limits** as explained on the schedule of benefits.

| Description                      | In-network coverage                                                                                                   | Out-of-network coverage                                                               |
|----------------------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Type A services                  | 100% (of the <b>negotiated charge</b> ) per visit<br><br>No <b>copayment</b> or <b>policy year deductible</b> applies | 70% (of the <b>recognized charge</b> ) per visit                                      |
| Type B services                  | 80% (of the <b>negotiated charge</b> ) per visit                                                                      | 60% (of the <b>recognized charge</b> ) per visit                                      |
| Type C services                  | 50% (of the <b>negotiated charge</b> ) per visit                                                                      | 50% (of the <b>recognized charge</b> ) per visit                                      |
| Orthodontic services             | 50% (of the <b>negotiated charge</b> ) per visit                                                                      | 50% (of the <b>recognized charge</b> ) per visit                                      |
| <b>Dental emergency services</b> | 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. |



| Benefit Group                                     | Benefit Description                                                                        | Frequency/Limitation           |
|---------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------|
| Diagnostic and Preventive Care (Type A Expenses): |                                                                                            |                                |
| Visits and Images                                 |                                                                                            |                                |
|                                                   | Periodic oral evaluation-established patient                                               | limited to 2 visits per year   |
|                                                   | Problem-focused examination                                                                | limited to 2 visits per year   |
|                                                   | Oral evaluation-child under 3                                                              | limited to 2 visits per year   |
|                                                   | Comprehensive oral evaluation                                                              | limited to 2 visits per year   |
|                                                   | Detailed and extensive oral evaluation - problem focused, by report                        | limited to 2 visits per year   |
|                                                   | Comprehensive periodontal evaluation - new or established patient                          | limited to 2 visits per year   |
|                                                   | Intraoral comprehensive image series, including bitewings                                  | limited to 1 set every 3 years |
|                                                   | Periapical 1st radiographic image                                                          |                                |
|                                                   | Periapical each additional radiographic image                                              |                                |
|                                                   | Intra-oral, occlusal radiographic image                                                    |                                |
|                                                   | Bitewing image - one image                                                                 | limited to 2 sets per year     |
|                                                   | Bitewing images - two images                                                               | limited to 2 sets per year     |
|                                                   | Bitewing image - three images                                                              | limited to 2 sets per year     |
|                                                   | Bitewing images - four images                                                              | limited to 2 sets per year     |
|                                                   | Vertical bitewing images                                                                   | limited to 2 sets per year     |
|                                                   | Panoramic radiographic image                                                               | limited to 1 set every 3 years |
|                                                   | 2D Cephalometric image                                                                     |                                |
|                                                   | 2D oral/facial photographic images                                                         |                                |
|                                                   | Intraoral tomosynthesis-comprehensive series of radiographic images                        | limited to 1 set every 3 years |
|                                                   | Intraoral tomosynthesis – bitewing radiographic image                                      | limited to 2 sets per year     |
|                                                   | Intraoral tomosynthesis – periapical radiographic image                                    |                                |
|                                                   | Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only | limited to 1 set every 3 years |
|                                                   | Intraoral tomosynthesis – bitewing radiographic image – image capture only                 | limited to 2 sets per year     |
|                                                   | Intraoral tomosynthesis – periapical radiographic image – image capture only               |                                |
|                                                   | Interpretation of diagnostic image                                                         |                                |
|                                                   | Testing for cracked tooth                                                                  |                                |
|                                                   | Diagnostic models                                                                          |                                |
|                                                   | Panoramic radiographic image – image capture only                                          |                                |
|                                                   | 2-D cephalometric radiographic image – image capture only                                  |                                |

| Benefit Group     | Benefit Description                                                             | Frequency/Limitation                                        |
|-------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------|
|                   | Intraoral – occlusal radiographic image – image capture only                    |                                                             |
|                   | Intraoral – periapical radiographic image – image capture only                  |                                                             |
|                   | Intraoral – bitewing radiographic image – image capture only                    |                                                             |
|                   | Intraoral – comprehensive series of radiographic images – image capture only    | limited to 1 set every 3 years                              |
|                   | Prophylaxis (cleaning) - Adult                                                  | limited to 2 treatments per year                            |
|                   | Prophylaxis (cleaning) - Child                                                  | limited to 2 treatments per year                            |
|                   | Topical fluoride varnish                                                        | limited to 2 courses of treatment every 12 months           |
|                   | Topical application of fluoride                                                 | limited to 2 courses of treatment every 12 months           |
|                   | Sealants, per tooth                                                             | limited to 1 application every 3 years for permanent molars |
|                   | Sealant repair, per tooth                                                       |                                                             |
|                   | Resin infiltration of lesion                                                    | limited to 1 per tooth every 3 years                        |
|                   | Application of hydroxyapatite regeneration medicament – per tooth               | limited to 1 per tooth every 3 years                        |
|                   | Palliative treatment of dental pain - per visit                                 |                                                             |
| Space Maintainers |                                                                                 |                                                             |
|                   | Space maintainers (Includes all adjustments within 6 months after installation) |                                                             |
|                   | Space Maintainer - Fixed - unilateral, per quadrant                             |                                                             |
|                   | Space Maintainer - Fixed Bilateral, Maxillary                                   |                                                             |
|                   | Space Maintainer - Fixed Bilateral, Mandibular                                  |                                                             |
|                   | Space Maintainer - Removable, Unilateral, per quadrant                          |                                                             |
|                   | Space Maintainer - Removable Bilateral, Maxillary                               |                                                             |
|                   | Space Maintainer - Removable Bilateral, Mandibular                              |                                                             |
|                   | Re-cement or re-bond bilateral space maintainer - maxillary                     |                                                             |
|                   | Re-cement or re-bond bilateral space maintainer - mandibular                    |                                                             |
|                   | Re-cement or re-bond unilateral space maintainer - per quadrant                 |                                                             |
|                   | Removal of fixed unilateral space maintainer - per quadrant                     |                                                             |

| Benefit Group                             | Benefit Description                                                                                         | Frequency/Limitation |
|-------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------------------|
|                                           | Removal of fixed bilateral space maintainer - maxillary                                                     |                      |
|                                           | Removal of fixed bilateral space maintainer - mandibular                                                    |                      |
| Basic Restorative Care (Type B Expenses): |                                                                                                             |                      |
| Visits and Images                         |                                                                                                             |                      |
|                                           | Consultation (by other than the treating provider)                                                          |                      |
|                                           | Office visit after regularly scheduled hours                                                                |                      |
|                                           | Treatment of complications (post surgical) unusual circumstances, by report                                 |                      |
| Images, Pathology, Drugs                  |                                                                                                             |                      |
|                                           | Extra-oral first 2D projection radiographic image                                                           |                      |
|                                           | Extra-oral posterior dental radiographic image                                                              |                      |
|                                           | Extra-oral posterior dental radiographic image – image capture only                                         |                      |
|                                           | Photobiomodulation therapy - first 15 minute increment, or any portion thereof                              |                      |
|                                           | Therapeutic drug injection, by report                                                                       |                      |
|                                           | Infiltration of a sustained release therapeutic drug - per quadrant                                         |                      |
| Oral Surgery                              |                                                                                                             |                      |
|                                           | Extraction - coronal remnants - primary tooth                                                               |                      |
|                                           | Extraction, erupted tooth or exposed root (elevation and/or forceps removal)                                |                      |
|                                           | Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth                      |                      |
|                                           | Removal of impacted tooth - soft tissue                                                                     |                      |
|                                           | Removal of impacted tooth - partially bony                                                                  |                      |
|                                           | Removal of impacted tooth - completely bony                                                                 |                      |
|                                           | Removal of impacted tooth - completely bony with unusual surgical complications                             |                      |
|                                           | Removal of residual tooth roots (cutting procedure)                                                         |                      |
|                                           | Coronectomy – intentional partial tooth removal, impacted teeth only                                        |                      |
|                                           | Oroantral fistula closure                                                                                   |                      |
|                                           | Tooth re-implantation and/or stabilization                                                                  |                      |
|                                           | Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization) |                      |

| Benefit Group | Benefit Description                                                                                                   | Frequency/Limitation                                                                                |
|---------------|-----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
|               | Exposure of an unerupted tooth                                                                                        |                                                                                                     |
|               | Placement of device to facilitate eruption of impacted tooth                                                          |                                                                                                     |
|               | Excisional biopsy of minor salivary glands                                                                            |                                                                                                     |
|               | Incision and drainage of abscess - intraoral soft tissue                                                              |                                                                                                     |
|               | Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) |                                                                                                     |
|               | Incision and drainage of abscess - extraoral soft tissue                                                              |                                                                                                     |
|               | Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) |                                                                                                     |
|               | Alveoplasty, in conjunction with extractions-four or more teeth or tooth spaces, per quadrant                         |                                                                                                     |
|               | Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces, per quadrant                              |                                                                                                     |
|               | Alveoplasty, not in conjunction with extraction - four or more teeth or tooth spaces, per quadrant                    |                                                                                                     |
|               | Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces, per quadrant                          |                                                                                                     |
|               | Removal of lateral exostosis (maxilla or mandible)                                                                    |                                                                                                     |
|               | Removal of torus palatinus                                                                                            |                                                                                                     |
|               | Removal of torus mandibularis                                                                                         |                                                                                                     |
|               | Suture of small wounds up to 5 cm                                                                                     |                                                                                                     |
|               | Bone replacement graft for ridge preservation - per site                                                              |                                                                                                     |
|               | Buccal / labial frenectomy (frenulectomy)                                                                             |                                                                                                     |
|               | Lingual frenectomy (frenulectomy)                                                                                     |                                                                                                     |
|               | Excision of hyperplastic tissue - per arch                                                                            |                                                                                                     |
|               | Excision of pericoronal gingiva                                                                                       |                                                                                                     |
| Periodontics  |                                                                                                                       |                                                                                                     |
|               | Periodontal scaling and root planing, four or more teeth per quadrant                                                 | limited to 4 separate quadrants every 2 years                                                       |
|               | Periodontal scaling and root planing, one to three teeth per quadrant                                                 | limited to once per quadrant every 2 years                                                          |
|               | Periodontal maintenance procedures following active therapy                                                           | limited to 4 in 12 months, combined with prophylaxis after completion of active periodontal therapy |
|               | Collection and application of autologous blood concentrate product                                                    | limited to 1 in 36 months                                                                           |

| Benefit Group         | Benefit Description                                                                                                                                                          | Frequency/Limitation |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
|                       | Occlusal adjustment limited - non ortho related                                                                                                                              |                      |
|                       | Occlusal adjustment full mouth                                                                                                                                               |                      |
| Endodontics           |                                                                                                                                                                              |                      |
|                       | Pulp cap - direct (excluding final restoration)                                                                                                                              |                      |
|                       | Pulp cap - indirect (excluding final restoration)                                                                                                                            |                      |
|                       | Therapeutic pulpotomy (excluding final restoration)                                                                                                                          |                      |
|                       | Partial pulpotomy for apexogenesis                                                                                                                                           |                      |
|                       | Pulpal therapy (resorbable filling) - anterior, primary tooth                                                                                                                |                      |
|                       | Pulpal therapy (resorbable filling) - posterior, primary tooth                                                                                                               |                      |
|                       | Pulpal regeneration - initial visit                                                                                                                                          |                      |
|                       | Pulpal regeneration - interim medication replacement                                                                                                                         |                      |
|                       | Pulpal regeneration - completion of treatment                                                                                                                                |                      |
|                       | Retrograde filling - per root                                                                                                                                                |                      |
| Restorative Dentistry |                                                                                                                                                                              |                      |
|                       | Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges.<br>(Multiple restorations in 1 surface will be considered as a single restoration.) |                      |
|                       | Amalgam - one surface, primary or permanent                                                                                                                                  |                      |
|                       | Amalgam - two surfaces, primary or permanent                                                                                                                                 |                      |
|                       | Amalgam - three surfaces, primary or permanent                                                                                                                               |                      |
|                       | Amalgam - four or more surfaces, primary or permanent                                                                                                                        |                      |
|                       | Resin-based composite - one surface, anterior                                                                                                                                |                      |
|                       | Resin-based composite - two surfaces, anterior                                                                                                                               |                      |
|                       | Resin-based composite - three surfaces, anterior                                                                                                                             |                      |
|                       | Resin-based composite - four or more surfaces, anterior                                                                                                                      |                      |
|                       | Resin-based composite crown - anterior                                                                                                                                       |                      |
|                       | Resin-based composite - one surface, posterior                                                                                                                               |                      |
|                       | Resin-based composite - two surfaces, posterior                                                                                                                              |                      |

| Benefit Group  | Benefit Description                                                                                                               | Frequency/Limitation                                                                                                      |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
|                | Resin-based composite - three surfaces, posterior                                                                                 |                                                                                                                           |
|                | Resin-based composite - four or more surfaces, posterior                                                                          |                                                                                                                           |
|                | Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant |                                                                                                                           |
|                | Pins:                                                                                                                             |                                                                                                                           |
|                | Pin retention—per tooth, in addition to restoration                                                                               |                                                                                                                           |
|                | Crowns (when tooth cannot be restored with a filling material):                                                                   |                                                                                                                           |
|                | Prefabricated stainless steel crown - primary teeth                                                                               |                                                                                                                           |
|                | Prefabricated stainless steel crown - permanent teeth                                                                             |                                                                                                                           |
|                | Prefabricated resin crown                                                                                                         |                                                                                                                           |
|                | Placement of interim direct restoration                                                                                           |                                                                                                                           |
|                | Prefabricated porcelain/ceramic crown - primary tooth                                                                             |                                                                                                                           |
|                | Recementation or Re-bond:                                                                                                         |                                                                                                                           |
|                | Recement or re-bond Inlay, onlay, veneer or partial coverage restoration                                                          |                                                                                                                           |
|                | Recement or re-bond indirectly fabricated or prefabricated post and core                                                          |                                                                                                                           |
|                | Recement or re-bond crown                                                                                                         |                                                                                                                           |
|                | Excavation of a tooth resulting in the determination of non-restorability                                                         |                                                                                                                           |
|                | Recement implant/abutment supported crown                                                                                         |                                                                                                                           |
|                | Recement implant/abutment supported fixed partial denture                                                                         |                                                                                                                           |
|                | Recement fixed partial denture retainers                                                                                          |                                                                                                                           |
| Prosthodontics |                                                                                                                                   |                                                                                                                           |
|                | Dentures and Partials                                                                                                             |                                                                                                                           |
|                | Adjustment to complete denture - maxillary                                                                                        | (Adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture) |
|                | Adjustment to complete denture - mandibular                                                                                       | (Adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture) |
|                | Adjustment to partial denture - maxillary                                                                                         | (Adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture) |

| <b>Benefit Group</b> | <b>Benefit Description</b>                                         | <b>Frequency/Limitation</b>                                                                                               |
|----------------------|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
|                      | Adjustment to partial denture - mandibular                         | (Adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture) |
|                      | Repairs:                                                           |                                                                                                                           |
|                      | Repair broken complete denture base, mandibular                    |                                                                                                                           |
|                      | Repair broken complete denture base, maxillary                     |                                                                                                                           |
|                      | Replace missing or broken tooth - complete denture - per tooth     |                                                                                                                           |
|                      | Repair resin partial denture base, mandibular                      |                                                                                                                           |
|                      | Repair resin partial denture base, maxillary                       |                                                                                                                           |
|                      | Repair cast partial framework, mandibular                          |                                                                                                                           |
|                      | Repair cast partial framework, maxillary                           |                                                                                                                           |
|                      | Repair or replace broken retentive/clasping materials - per tooth  |                                                                                                                           |
|                      | Replace missing or broken teeth – partial denture- per tooth       |                                                                                                                           |
|                      | Add tooth to existing partial denture - per tooth                  |                                                                                                                           |
|                      | Add clasp to existing partial denture – per tooth                  |                                                                                                                           |
|                      | Replace all teeth and acrylic on cast metal framework - maxillary  |                                                                                                                           |
|                      | Replace all teeth and acrylic on cast metal framework - mandibular |                                                                                                                           |
|                      | Tissue conditioning, per denture - maxillary                       |                                                                                                                           |
|                      | Tissue conditioning, per denture - mandibular                      |                                                                                                                           |
|                      | Add metal substructure to acrylic full denture, per arch           |                                                                                                                           |
|                      | Rebase, complete maxillary denture                                 |                                                                                                                           |
|                      | Rebase, complete mandibular denture                                |                                                                                                                           |
|                      | Rebase partial maxillary denture                                   |                                                                                                                           |
|                      | Rebase partial mandibular denture                                  |                                                                                                                           |
|                      | Rebase hybrid prosthesis                                           |                                                                                                                           |
|                      | Reline complete maxillary denture - direct                         |                                                                                                                           |
|                      | Reline complete mandibular denture - direct                        |                                                                                                                           |
|                      | Reline maxillary partial denture - direct                          |                                                                                                                           |
|                      | Reline mandibular partial denture - direct                         |                                                                                                                           |
|                      | Reline complete maxillary denture - indirect                       |                                                                                                                           |
|                      | Reline complete mandibular denture - indirect                      |                                                                                                                           |

| <b>Benefit Group</b>                        | <b>Benefit Description</b>                                                                                                     | <b>Frequency/Limitation</b>             |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
|                                             | Reline maxillary partial denture - indirect                                                                                    |                                         |
|                                             | Reline mandibular partial denture - indirect                                                                                   |                                         |
|                                             | Soft liner for complete or partial removable denture – indirect                                                                |                                         |
|                                             | Fixed partial denture repair necessitated by restorative material failure                                                      |                                         |
| General Anesthesia and Intravenous Sedation |                                                                                                                                |                                         |
|                                             | Evaluation for deep sedation or general anesthesia                                                                             |                                         |
|                                             | Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof                         |                                         |
|                                             | Administration of deep sedation/general anesthesia - each subsequent 15 minute increment, or any portion thereof               |                                         |
|                                             | Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof        |                                         |
|                                             | Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof        |                                         |
|                                             | Intravenous moderate (conscious) sedation/anesthesia – first 15 minutes                                                        |                                         |
|                                             | Administration of moderate sedation-intravenous - each subsequent 15 minute increment, or any portion thereof                  |                                         |
|                                             | Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof           |                                         |
|                                             | Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof |                                         |
| Major Restorative Care (Type C Expenses):   |                                                                                                                                |                                         |
| Periodontics                                |                                                                                                                                |                                         |
|                                             | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bound spaces, per quadrant                              | limited to 1 per quadrant every 3 years |
|                                             | Gingivectomy or gingivoplasty - one to three teeth per quadrant                                                                | limited to 1 per quadrant every 3 years |
|                                             | Gingivectomy or gingivoplasty, to allow access for restorative procedure, per tooth                                            | limited to 1 per quadrant every 3 years |
|                                             | Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant             | limited to 1 per quadrant every 3 years |



| Benefit Group | Benefit Description                                                                                                                                                                        | Frequency/Limitation                    |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
|               | Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant                                                                         | limited to 1 per quadrant every 3 years |
|               | Crown lengthening clinical - hard tissue                                                                                                                                                   |                                         |
|               | Osseous surgery (including flap and closure) - four or more contiguous teeth                                                                                                               | limited to 1 per quadrant every 3 years |
|               | Osseous surgery (including flap and closure) - one to three teeth per quadrant                                                                                                             | limited to 1 per site every 3 years     |
|               | Bone replacement graft - retained natural tooth - first site in quadrant                                                                                                                   | Limited to 1 every 3 years              |
|               | Pedicle soft tissue graft procedures                                                                                                                                                       |                                         |
|               | Autogenous connective tissue graft procedure                                                                                                                                               |                                         |
|               | Non-autogenous connective soft tissue graft                                                                                                                                                |                                         |
|               | Free soft tissue graft procedure (including donor surgical sites)                                                                                                                          |                                         |
|               | Free soft tissue graft procedure (including donor surgical sites) each additional tooth, each additional contiguous tooth, implant or edentulous tooth position in same graft site         |                                         |
|               | Autogenous connective tissue graft procedure (including donor and recipient surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site     |                                         |
|               | Non-autogenous connective tissue graft procedure (including donor and recipient surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site |                                         |
|               | Debridement, full mouth to enable a comprehensive periodontal evaluation and diagnosis                                                                                                     | limited to 1                            |
| Endodontics   |                                                                                                                                                                                            |                                         |
|               | Root canal therapy, including images:                                                                                                                                                      |                                         |
|               | Endodontic therapy, anterior tooth (excluding final restoration)                                                                                                                           |                                         |
|               | Endodontic therapy, premolar tooth (excluding final restoration)                                                                                                                           |                                         |
|               | Endodontic therapy, molar tooth (excluding final restoration)                                                                                                                              |                                         |
|               | Retreatment of previous root canal therapy, including images:                                                                                                                              |                                         |
|               | Retreatment of previous root canal therapy - anterior tooth                                                                                                                                |                                         |
|               | Retreatment of previous root canal therapy - premolar tooth                                                                                                                                |                                         |

| Benefit Group | Benefit Description                                                                                                                                                                                                                                                   | Frequency/Limitation             |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
|               | Retreatment of previous root canal therapy - molar tooth                                                                                                                                                                                                              |                                  |
|               | Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)                                                                                                                                                 |                                  |
|               | Apexification/recalcification - interim medication replacement                                                                                                                                                                                                        |                                  |
|               | Apexification/recalcification - final visit (includes completed root canal - apical closure/calcific repair of perforations, root resorption, etc.)                                                                                                                   |                                  |
|               | Pulpal regeneration - initial visit                                                                                                                                                                                                                                   |                                  |
|               | Pulpal regeneration - interim medications replacement                                                                                                                                                                                                                 |                                  |
|               | Pulpal regeneration - completion of treatment                                                                                                                                                                                                                         |                                  |
|               | Apicoectomy - anterior                                                                                                                                                                                                                                                |                                  |
|               | Apicoectomy - premolar (first root)                                                                                                                                                                                                                                   |                                  |
|               | Apicoectomy - molar (first root)                                                                                                                                                                                                                                      |                                  |
|               | Apicoectomy - each additional root                                                                                                                                                                                                                                    |                                  |
|               | Root amputation - per root                                                                                                                                                                                                                                            |                                  |
|               | Surgical repair of root resorption - anterior                                                                                                                                                                                                                         |                                  |
|               | Surgical repair of root resorption – premolar                                                                                                                                                                                                                         |                                  |
|               | Surgical repair of root resorption – molar                                                                                                                                                                                                                            |                                  |
|               | Hemisection (including any root removal), not including root canal therapy                                                                                                                                                                                            |                                  |
| 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) |                                  |
|               | Inlay - metallic - one surface                                                                                                                                                                                                                                        | limited to 1 tooth every 5 years |
|               | Inlay - metallic - two surfaces                                                                                                                                                                                                                                       | limited to 1 tooth every 5 years |
|               | Inlay - metallic - three or more surfaces                                                                                                                                                                                                                             | limited to 1 tooth every 5 years |
|               | Onlay - metallic - two surfaces                                                                                                                                                                                                                                       | limited to 1 tooth every 5 years |
|               | Onlay - metallic - three surfaces                                                                                                                                                                                                                                     | limited to 1 tooth every 5 years |
|               | Onlay - metallic - four or more surfaces                                                                                                                                                                                                                              | limited to 1 tooth every 5 years |
|               | Inlay - porcelain/ceramic - one surface                                                                                                                                                                                                                               | limited to 1 tooth every 5 years |
|               | Inlay - porcelain/ceramic - two surfaces                                                                                                                                                                                                                              | limited to 1 tooth every 5 years |
|               | Inlay - porcelain/ceramic - three or more surfaces                                                                                                                                                                                                                    | limited to 1 tooth every 5 years |
|               | Onlay - porcelain/ceramic - two surfaces                                                                                                                                                                                                                              | limited to 1 tooth every 5 years |
|               | Onlay - porcelain/ceramic - three surfaces                                                                                                                                                                                                                            | limited to 1 tooth every 5 years |

| <b>Benefit Group</b> | <b>Benefit Description</b>                                 | <b>Frequency/Limitation</b>      |
|----------------------|------------------------------------------------------------|----------------------------------|
|                      | Onlay - porcelain/ceramic - four or more surfaces          | limited to 1 tooth every 5 years |
|                      | Inlay - composite/resin - one surface                      | limited to 1 tooth every 5 years |
|                      | Inlay - composite/resin - two surfaces                     | limited to 1 tooth every 5 years |
|                      | Inlay - composite/resin - three surfaces                   | limited to 1 tooth every 5 years |
|                      | Onlay - composite/resin - two surfaces                     | limited to 1 tooth every 5 years |
|                      | Onlay - composite/resin - three surfaces                   | limited to 1 tooth every 5 years |
|                      | Onlay - composite/resin - four or more surfaces            | limited to 1 tooth every 5 years |
|                      | Crowns (limited to 1 tooth every 5 years)                  | limited to 1 tooth every 5 years |
|                      | Crown - resin-based composite (indirect)                   | limited to 1 tooth every 5 years |
|                      | Crown - resin with high noble metal                        | limited to 1 tooth every 5 years |
|                      | Crown - resin with predominantly base metal                | limited to 1 tooth every 5 years |
|                      | Crown - resin with noble metal                             | limited to 1 tooth every 5 years |
|                      | Crown - porcelain/ceramic                                  | limited to 1 tooth every 5 years |
|                      | Crown - porcelain fused to high noble metal                | limited to 1 tooth every 5 years |
|                      | Crown - porcelain fused to predominantly base metal        | limited to 1 tooth every 5 years |
|                      | Crown - porcelain fused to noble metal                     | limited to 1 tooth every 5 years |
|                      | Crown - porcelain fused to titanium and titanium alloys    | limited to 1 tooth every 5 years |
|                      | Crown - 3/4 cast high noble metal                          | limited to 1 tooth every 5 years |
|                      | Crown - 3/4 cast predominantly base metal                  | limited to 1 tooth every 5 years |
|                      | Crown - 3/4 cast noble metal                               | limited to 1 tooth every 5 years |
|                      | Crown - 3/4 porcelain/ceramic                              | limited to 1 tooth every 5 years |
|                      | Crown - full cast high noble metal                         | limited to 1 tooth every 5 years |
|                      | Crown - full cast predominantly base metal                 | limited to 1 tooth every 5 years |
|                      | Crown - full cast noble metal                              | limited to 1 tooth every 5 years |
|                      | Crown - titanium and titanium alloys                       | limited to 1 tooth every 5 years |
|                      | Core build-up, including any pins when required            |                                  |
|                      | Post and core in addition to crown, indirectly fabricated  |                                  |
|                      | Each additional cast indirectly fabricated post same tooth |                                  |
|                      | Prefabricated post and core in addition to crown           |                                  |
|                      | Each additional prefabricated post - same tooth            |                                  |
|                      | Labial veneer (resin laminate) - direct                    |                                  |
|                      | Labial veneer (resin laminate) - indirect                  | limited to 1 tooth every 5 years |
|                      | Labial veneer (porcelain laminate)                         | limited to 1 tooth every 5 years |

| Benefit Group  | Benefit Description                                                                                                                            | Frequency/Limitation       |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
|                | <b>Repairs:</b>                                                                                                                                |                            |
|                | Crown repair necessitated by restorative material failure                                                                                      |                            |
|                | Inlay repair necessitated by restorative material failure                                                                                      |                            |
|                | Onlay repair necessitated by restorative material failure                                                                                      |                            |
|                | Veneer repair necessitated by restorative material failure                                                                                     |                            |
| Prosthodontics |                                                                                                                                                |                            |
|                | Dentures and partial dentures:<br>(Replacement of existing dentures or partial dentures / bridges) (limited to 1 every 5 years)                |                            |
|                | 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 |
|                | Upper partial denture - resin base, including retentive/clasping materials, rests, and teeth)                                                  | limited to 1 every 5 years |
|                | Lower partial denture - resin base, including retentive/clasping materials, rests, and teeth)                                                  | limited to 1 every 5 years |
|                | Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)            | limited to 1 every 5 years |
|                | Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)           | limited to 1 every 5 years |
|                | Immediate maxillary partial denture – resin base (including any retentive/clasping materials, rests and teeth)                                 | limited to 1 every 5 years |
|                | Immediate mandibular partial denture – resin base (including any retentive/clasping materials, rests and teeth)                                | limited to 1 every 5 years |
|                | Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)  | limited to 1 every 5 years |
|                | Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | limited to 1 every 5 years |
|                | Maxillary partial denture - flexible base (including any clasps, rests and teeth)                                                              | limited to 1 every 5 years |

| <b>Benefit Group</b> | <b>Benefit Description</b>                                                                                                            | <b>Frequency/Limitation</b> |
|----------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
|                      | Mandibular partial denture - flexible base (including any clasps, rests and teeth)                                                    | limited to 1 every 5 years  |
|                      | Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)                                           | limited to 1 every 5 years  |
|                      | Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)                                          | limited to 1 every 5 years  |
|                      | Interim partial denture (including retentive/clasping materials, rests and teeth), maxillary                                          |                             |
|                      | Interim partial denture (including retentive/clasping materials, rests and teeth), mandibular                                         |                             |
|                      | Removable unilateral partial denture one piece cast metal (including retentive/clasping material, rest and teeth), maxillary          | limited to 1 every 5 years  |
|                      | Removable unilateral partial denture one piece cast metal (including retentive/clasping material, rest and teeth), mandibular         | limited to 1 every 5 years  |
|                      | Removable unilateral partial denture - one piece flexible base (including retentive/clasping material, rest and teeth) - per quadrant | limited to 1 every 5 years  |
|                      | Removable unilateral partial denture - one piece resin (including retentive/clasping material, rests and teeth) - per quadrant        | limited to 1 every 5 years  |
|                      | Implant Services:                                                                                                                     |                             |
|                      | Endosteal implant - surgical placement                                                                                                | 1 every 5 years             |
|                      | Surgical placement of interim implant body for transitional prosthesis: endosteal implant                                             | 1 every 5 years             |
|                      | Subperiosteal implant                                                                                                                 | 1 every 5 years             |
|                      | Transosseous mandibular implant                                                                                                       | 1 every 5 years             |
|                      | Implant connecting bar                                                                                                                | 1 every 5 years             |
|                      | Modification of a prefabricated abutment may be necessary                                                                             | 1 every 5 years             |
|                      | Created by a laboratory process, specific for an individual application                                                               | 1 every 5 years             |
|                      | Abutment supported porcelain/ceramic crown                                                                                            | 1 every 5 years             |
|                      | Abutment supported porcelain fused to metal crown (high noble metal)                                                                  | 1 every 5 years             |
|                      | Abutment supported porcelain fused to metal crown (predominately base metal)                                                          | 1 every 5 years             |
|                      | Abutment supported porcelain fused to metal crown (noble metal)                                                                       | 1 every 5 years             |

| <b>Benefit Group</b> | <b>Benefit Description</b>                                                                                                                                                                                                     | <b>Frequency/Limitation</b> |
|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
|                      | Abutment supported cast metal crown (high noble metal)                                                                                                                                                                         | 1 every 5 years             |
|                      | Abutment supported cast metal crown (predominately base metal)                                                                                                                                                                 | 1 every 5 years             |
|                      | Abutment supported cast noble metal crown (noble metal)                                                                                                                                                                        | 1 every 5 years             |
|                      | Implant supported porcelain/ceramic crown                                                                                                                                                                                      | 1 every 5 years             |
|                      | Implant supported crown - porcelain fused to high noble alloys                                                                                                                                                                 | 1 every 5 years             |
|                      | Implant supported crown high noble alloys                                                                                                                                                                                      | 1 every 5 years             |
|                      | Abutment supported retainer - for porcelain/ceramic fixed partial denture (FPD)                                                                                                                                                | 1 every 5 years             |
|                      | Abutment supported retainer - porcelain fused to high noble metal fixed partial denture (FPD)                                                                                                                                  | 1 every 5 years             |
|                      | Abutment supported retainer - for porcelain fused to predominately base metal fixed partial denture (FPD)                                                                                                                      | 1 every 5 years             |
|                      | Abutment supported retainer - for porcelain fused to noble metal fixed partial denture (FPD)                                                                                                                                   | 1 every 5 years             |
|                      | Abutment supported retainer - for cast high noble metal fixed partial denture (FPD)                                                                                                                                            | 1 every 5 years             |
|                      | Abutment supported retainer - for cast predominately base metal fixed partial denture (FPD)                                                                                                                                    | 1 every 5 years             |
|                      | Abutment supported retainer - for cast noble metal fixed partial denture (FPD)                                                                                                                                                 | 1 every 5 years             |
|                      | Implant supported - for ceramic fixed partial dental retainer (FPD)                                                                                                                                                            | 1 every 5 years             |
|                      | Implant supported retainer for FPD - porcelain fused to high noble alloys                                                                                                                                                      | 1 every 5 years             |
|                      | Implant supported retainer for metal fixed partial denture (FPD) - high noble alloys                                                                                                                                           | 1 every 5 years             |
|                      | Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments                                                                             | 1 every 5 years             |
|                      | Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths: includes cleaning of the implant surfaces, without flap entry and closure |                             |
|                      | Implant supported crown - porcelain fused to predominantly base alloys                                                                                                                                                         | 1 every 5 years             |

| <b>Benefit Group</b> | <b>Benefit Description</b>                                                                                                                                    | <b>Frequency/Limitation</b> |
|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
|                      | Implant supported crown - porcelain fused to predominantly noble alloys                                                                                       | 1 every 5 years             |
|                      | Implant supported crown - porcelain fused to titanium and titanium alloys                                                                                     | 1 every 5 years             |
|                      | Implant supported crown - predominately base alloys                                                                                                           | 1 every 5 years             |
|                      | Implant supported crown - noble alloys                                                                                                                        | 1 every 5 years             |
|                      | Implant supported crown - titanium and titanium alloys                                                                                                        | 1 every 5 years             |
|                      | Accessing and retorquing loose implant screw - per screw                                                                                                      | 1 every 5 years             |
|                      | Repair of implant/abutment supported prosthesis                                                                                                               | 1 every 5 years             |
|                      | Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment | 1 every 5 years             |
|                      | Abutment supported crown - titanium and titanium alloys                                                                                                       | 1 every 5 years             |
|                      | Remove broken implant retaining screw                                                                                                                         | 1 every 5 years             |
|                      | Abutment supported crown - porcelain fused to titanium and titanium alloys                                                                                    | 1 every 5 years             |
|                      | Implant supported retainer - porcelain fused to predominately base alloys                                                                                     | 1 every 5 years             |
|                      | Implant supported retainer for FPD - porcelain fused to noble alloys                                                                                          | 1 every 5 years             |
|                      | Implant removal, by report                                                                                                                                    | 1 every 5 years             |
|                      | Debridement of peri-implant defect                                                                                                                            | 1 every 5 years             |
|                      | Debridement and osseous contouring of peri-implant defect                                                                                                     | 1 every 5 years             |
|                      | Bone graft for repair of peri-implant defect                                                                                                                  | 1 every 5 years             |
|                      | Bone graft at time of implant placement                                                                                                                       | 1 every 5 years             |
|                      | Removal of implant body not requiring bone removal or flap elevation                                                                                          | 1 every 5 years             |
|                      | Implant/abutment supported removable denture for completely edentulous arch - maxillary                                                                       | 1 every 5 years             |
|                      | Implant/abutment supported removable denture for completely edentulous arch - mandibular                                                                      | 1 every 5 years             |
|                      | Implant/abutment supported removable denture for partially edentulous arch - maxillary                                                                        | 1 every 5 years             |
|                      | Implant/abutment supported removable denture for partially edentulous arch - mandibular                                                                       | 1 every 5 years             |

| <b>Benefit Group</b> | <b>Benefit Description</b>                                                                                                              | <b>Frequency/Limitation</b> |
|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
|                      | Implant/abutment supported fixed denture for completely edentulous arch – maxillary                                                     | 1 every 5 years             |
|                      | Implant/abutment supported fixed denture for completely edentulous arch – mandibular                                                    | 1 every 5 years             |
|                      | Implant/abutment supported fixed denture for partially edentulous arch – maxillary                                                      | 1 every 5 years             |
|                      | Implant/abutment supported fixed denture for partially edentulous arch – mandibular                                                     | 1 every 5 years             |
|                      | Implant/abutment supported interim fixed denture for edentulous arch – mandibular                                                       |                             |
|                      | Implant/abutment supported interim fixed denture for edentulous arch – maxillary                                                        |                             |
|                      | Implant supported retainer - porcelain fused to titanium and titanium alloys                                                            | 1 every 5 years             |
|                      | Implant supported retainer for metal full partial denture (FPD) - predominantly base alloys                                             | 1 every 5 years             |
|                      | Implanted supported retainer for metal full partial denture (FPD) - noble alloys                                                        | 1 every 5 years             |
|                      | Implant supported retainer for metal full partial denture (FPD) - titanium and titanium alloys                                          | 1 every 5 years             |
|                      | Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments | 1 every 5 years             |
|                      | Radiographic/Surgical Implant Index, By Report                                                                                          | 1 every 5 years             |
|                      | Replacement of an implant screw                                                                                                         | 1 every 5 years             |
|                      | Abutment support retainer crown for FPD titanium and titanium alloys                                                                    | 1 every 5 years             |
|                      | Abutment supported retainer - porcelain fused to titanium and titanium alloys                                                           | 1 every 5 years             |
|                      | Pontics - Fixed partial denture:                                                                                                        |                             |
|                      | Pontic - cast high noble metal                                                                                                          | 1 every 5 years             |
|                      | Pontic - cast predominantly base metal                                                                                                  | 1 every 5 years             |
|                      | Pontic - cast noble metal                                                                                                               | 1 every 5 years             |
|                      | Pontic - titanium                                                                                                                       | 1 every 5 years             |
|                      | Pontic - porcelain fused to high noble metal                                                                                            | 1 every 5 years             |
|                      | Pontic - porcelain fused to predominantly base metal                                                                                    | 1 every 5 years             |
|                      | Pontic - porcelain fused to noble metal                                                                                                 | 1 every 5 years             |



| <b>Benefit Group</b> | <b>Benefit Description</b>                                                                                                                                                                                 | <b>Frequency/Limitation</b> |
|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
|                      | Pontic - porcelain fused to titanium and titanium alloys                                                                                                                                                   | 1 every 5 years             |
|                      | Pontic - porcelain/ceramic                                                                                                                                                                                 | 1 every 5 years             |
|                      | Pontic - resin with high noble metal                                                                                                                                                                       | 1 every 5 years             |
|                      | Pontic - resin with predominantly base metal                                                                                                                                                               | 1 every 5 years             |
|                      | Pontic - resin with noble metal                                                                                                                                                                            | 1 every 5 years             |
|                      | Inlays/Onlays-Fixed partial denture:                                                                                                                                                                       |                             |
|                      | Retainer - cast metal for resin bonded fixed prosthesis                                                                                                                                                    | 1 every 5 years             |
|                      | Retainer - porcelain/ceramic for resin bonded fixed prosthesis                                                                                                                                             | 1 every 5 years             |
|                      | Inlay - porcelain/ceramic, two surfaces                                                                                                                                                                    | 1 every 5 years             |
|                      | Inlay - cast high noble metal, two surfaces                                                                                                                                                                | 1 every 5 years             |
|                      | Inlay - cast high noble metal, three or more surfaces                                                                                                                                                      | 1 every 5 years             |
|                      | Inlay - cast predominately base metal, two surfaces                                                                                                                                                        | 1 every 5 years             |
|                      | Inlay - cast predominately base metal, three or more surfaces                                                                                                                                              | 1 every 5 years             |
|                      | Inlay - cast noble metal, two surfaces                                                                                                                                                                     | 1 every 5 years             |
|                      | Inlay - cast noble metal, three or more surfaces                                                                                                                                                           | 1 every 5 years             |
|                      | Onlay - porcelain/ceramic, two surfaces                                                                                                                                                                    | 1 every 5 years             |
|                      | Onlay - cast high noble metal, three or more surfaces                                                                                                                                                      | 1 every 5 years             |
|                      | Onlay - cast predominately base metal, three or more surfaces                                                                                                                                              | 1 every 5 years             |
|                      | Onlay - cast noble metal, three or more surfaces                                                                                                                                                           | 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.) |                             |
|                      | Crowns-Fixed partial dentures:                                                                                                                                                                             |                             |
|                      | Retainer crown - porcelain/ceramic                                                                                                                                                                         | limited to 1 every 5 years  |
|                      | Retainer crown - porcelain fused to high noble metal                                                                                                                                                       | limited to 1 every 5 years  |
|                      | Retainer crown - porcelain fused to predominantly base metal                                                                                                                                               | limited to 1 every 5 years  |
|                      | Retainer crown - porcelain fused to noble metal                                                                                                                                                            | limited to 1 every 5 years  |
|                      | Retainer crown - porcelain fused to titanium and titanium alloys                                                                                                                                           | limited to 1 every 5 years  |
|                      | Retainer crown - high noble metal (3/4 cast)                                                                                                                                                               | limited to 1 every 5 years  |
|                      | Retainer crown - predominantly base metal (3/4 cast)                                                                                                                                                       | limited to 1 every 5 years  |

| <b>Benefit Group</b> | <b>Benefit Description</b>                                                | <b>Frequency/Limitation</b>                                     |
|----------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------|
|                      | Retainer crown - noble metal (3/4 cast)                                   | limited to 1 every 5 years                                      |
|                      | Retainer crown - porcelain/ceramic (3/4 cast)                             | limited to 1 every 5 years                                      |
|                      | Retainer crown - 3/4 titanium and titanium alloys                         | limited to 1 every 5 years                                      |
|                      | Retainer crown - high noble metal (full cast)                             | limited to 1 every 5 years                                      |
|                      | Retainer crown - predominantly base metal (full cast)                     | limited to 1 every 5 years                                      |
|                      | Retainer crown - noble metal (full cast)                                  | limited to 1 every 5 years                                      |
|                      | Stress breaker                                                            |                                                                 |
|                      | Pediatric partial denture, fixed                                          | limited to 1 every 5 years                                      |
|                      | Removable appliance therapy                                               |                                                                 |
|                      | Fixed appliance therapy                                                   |                                                                 |
|                      | Cleaning and inspection of removable complete denture, maxillary          |                                                                 |
|                      | Cleaning and inspection of removable complete partial denture, mandibular |                                                                 |
|                      | Cleaning and inspection of removable complete partial denture, maxillary  |                                                                 |
|                      | Cleaning and inspection of removable complete denture, mandibular         |                                                                 |
|                      | Cleaning and inspection of occlusal guard – per appliance                 |                                                                 |
|                      | Occlusal guard adjustment                                                 | Not eligible within first 6 months after placement of appliance |
|                      | Occlusal guard - hard appliance, full arch                                |                                                                 |
|                      | Occlusal guard - soft appliance, full arch                                |                                                                 |
|                      | Occlusal guard - hard appliance, partial arch                             |                                                                 |
| Orthodontic Care     |                                                                           |                                                                 |
|                      | Limited orthodontic treatment of the primary dentition                    |                                                                 |
|                      | Limited orthodontic treatment of the transitional dentition               |                                                                 |
|                      | Limited orthodontic treatment of the adolescent dentition                 |                                                                 |
|                      | Comprehensive orthodontic treatment of the transitional dentition         |                                                                 |
|                      | Comprehensive orthodontic treatment of the adolescent dentition           |                                                                 |
|                      | Comprehensive treatment of the adult dentition                            |                                                                 |
|                      | Comprehensive orthodontic treatment with orthognathic surgery             |                                                                 |
|                      | Pre-orthodontic treatment examination                                     |                                                                 |
|                      | Periodic orthodontic treatment visit                                      |                                                                 |

| <b>Benefit Group</b> | <b>Benefit Description</b>                                                            | <b>Frequency/Limitation</b> |
|----------------------|---------------------------------------------------------------------------------------|-----------------------------|
|                      | Periodic orthodontic treatment visit associated with orthognathic surgery             |                             |
|                      | Orthodontic retention (removal of appliances, construction and placement of retainer) |                             |
|                      | Repair of orthodontic appliance - maxillary                                           |                             |
|                      | Repair of orthodontic appliance - mandibular                                          |                             |
|                      | Re-cement or re-bond fixed retainer - maxillary                                       |                             |
|                      | Re-cement or re-bond fixed retainer - mandibular                                      |                             |
|                      | Repair of fixed retainer, includes reattachment - maxillary                           |                             |
|                      | Repair of fixed retainer, includes reattachment - mandibular                          |                             |
|                      | 3D printing of a 3D dental surface scan                                               |                             |
|                      | 3D intraoral surface scan – direct                                                    |                             |

## 6. Specific conditions

### Birth center (facility charges)

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

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

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

### Voluntary sterilization for males

| Description                                          | In-network coverage            | Out-of-network coverage        |
|------------------------------------------------------|--------------------------------|--------------------------------|
| Inpatient physician or specialist surgical services  | 80% (of the negotiated charge) | 70% (of the recognized charge) |
| Outpatient physician or specialist surgical services | 60% (of the negotiated charge) | 60% (of the recognized charge) |

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

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

### Impacted wisdom teeth

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

### Accidental injury to sound natural teeth

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

## Dermatological treatment

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

## Maternity care

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

## Well newborn nursery care

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

### Important note:

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

## Gender affirming treatment

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

## Autism spectrum disorder

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

| Description               | In-network coverage                                                                   | Out-of-network coverage                                                               |
|---------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Applied behavior analysis | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

## Behavioral health

### Mental health treatment – inpatient

| Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | In-network coverage                                                                                                                                  | Out-of-network coverage                                                                                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Inpatient <b>hospital mental health disorders</b> treatment (<b>room and board</b> and other miscellaneous <b>hospital</b> services and supplies)</p> <p>Inpatient <b>residential treatment facility mental health disorders</b> treatment (<b>room and board</b> and other miscellaneous <b>residential treatment facility</b> services and supplies)</p> <p>Subject to <b>semi-private room rate</b> unless <b>intensive care unit</b> is required</p> <p><b>Mental health disorder room and board</b> intensive care</p> | <p>80% (of the <b>negotiated charge</b>) per admission</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p> | <p>60% (of the <b>recognized charge</b>) per admission</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p> |

### Mental health treatment – outpatient

| Description                                                                                                                                                                   | In-network coverage                                                                                                                                                                                                                                       | Out-of-network coverage                                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Outpatient <b>mental health disorders</b> office visits to a <b>physician</b> or <b>behavioral health provider</b></p> <p>(Includes <b>telemedicine</b> consultations)</p> | <p>\$35 <b>copayment</b> then the plan pays 100% (of the balance of the <b>negotiated charge</b>) per visit</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p> <p>No <b>policy year deductible</b> applies</p> | <p>70% (of the <b>recognized charge</b>) per visit</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p> |

| Description                                                                                                         | In-network coverage                              | Out-of-network coverage                          |
|---------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------|
| Other outpatient <b>mental health disorders</b> treatment (includes skilled behavioral health services in the home) | 80% (of the <b>negotiated charge</b> ) per visit | 60% (of the <b>recognized charge</b> ) per visit |
| Partial hospitalization treatment                                                                                   |                                                  |                                                  |
| Intensive outpatient program                                                                                        |                                                  |                                                  |

#### Substance related disorders treatment – inpatient

| Description                                                                                                                                                                      | In-network coverage                                                                 | Out-of-network coverage                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| Inpatient <b>hospital substance related disorders detoxification (room and board</b> and other miscellaneous <b>hospital</b> services and supplies)                              | 80% (of the <b>negotiated charge</b> ) per admission                                | 60% (of the <b>recognized charge</b> ) per admission                                |
| Inpatient <b>hospital substance related disorders</b> rehabilitation ( <b>room and board</b> and other miscellaneous <b>hospital</b> services and supplies)                      | Coverage is provided under the same terms, conditions as any other <b>illness</b> . | Coverage is provided under the same terms, conditions as any other <b>illness</b> . |
| Inpatient <b>residential treatment facility substance related disorders (room and board</b> and other miscellaneous <b>residential treatment facility</b> services and supplies) |                                                                                     |                                                                                     |
| Subject to <b>semi-private room rate</b> unless <b>intensive care unit</b> is required                                                                                           |                                                                                     |                                                                                     |
| <b>Substance related disorders room and board</b> intensive care                                                                                                                 |                                                                                     |                                                                                     |

## Substance related disorders treatment – outpatient

### Detoxification and rehabilitation

| Description                                                                                                                                                                | In-network coverage                                                                                                                                                                                                                                  | Out-of-network coverage                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| Outpatient <b>substance related disorders</b> office visits to a <b>physician</b> or <b>behavioral health provider</b><br><br>(Includes <b>telemedicine</b> consultations) | \$35 <b>copayment</b> then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit<br><br>Coverage is provided under the same terms, conditions as any other <b>illness</b> .<br><br>No <b>policy year deductible</b> applies | 70% (of the <b>recognized charge</b> ) per visit<br><br>Coverage is provided under the same terms, conditions as any other <b>illness</b> . |
| Other outpatient <b>substance related disorder</b> services<br><br>Partial hospitalization treatment<br><br>Intensive outpatient program                                   | 80% (of the <b>negotiated charge</b> ) per visit<br><br>Coverage is provided under the same terms, conditions as any other <b>illness</b> .                                                                                                          | 60% (of the <b>recognized charge</b> ) per visit<br><br>Coverage is provided under the same terms, conditions as any other <b>illness</b> . |

## Obesity surgery

| Description                                                                              | In-network coverage                                                                   | Out-of-network coverage                                                               |
|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Obesity <b>surgery</b> – inpatient and outpatient facility and <b>physician</b> services | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

## Reconstructive surgery and supplies

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

## Transplant services

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



### Transplant services – travel and lodging

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

### Infertility Services

#### Basic infertility

| Description                                                                                                       | In-network coverage                                                                   | Out-of-network coverage                                                               |
|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Treatment of basic <b>infertility</b>                                                                             | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Maximum number of ovulation induction cycles per <b>policy year</b> while on medications to stimulate the ovaries | 3 attempts                                                                            |                                                                                       |

## 7. Specific therapies and tests

### Outpatient diagnostic testing

#### Diagnostic complex imaging services

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

#### Diagnostic lab work and radiological services

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

### Chemotherapy

| Description  | In-network coverage                              | Out-of-network coverage                          |
|--------------|--------------------------------------------------|--------------------------------------------------|
| Chemotherapy | 80% (of the <b>negotiated charge</b> ) per visit | 60% (of the <b>recognized charge</b> ) per visit |

### Outpatient infusion therapy

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

### Outpatient radiation therapy

| Description                  | In-network coverage                              | Out-of-network coverage                          |
|------------------------------|--------------------------------------------------|--------------------------------------------------|
| Outpatient radiation therapy | 80% (of the <b>negotiated charge</b> ) per visit | 60% (of the <b>recognized charge</b> ) per visit |

### Specialty prescription drugs

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

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

### Outpatient respiratory therapy

| Description         | In-network coverage                              | Out-of-network coverage                          |
|---------------------|--------------------------------------------------|--------------------------------------------------|
| Respiratory therapy | 80% (of the <b>negotiated charge</b> ) per visit | 60% (of the <b>recognized charge</b> ) per visit |

### Transfusion or kidney dialysis of blood

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

### Short-term cardiac and pulmonary rehabilitation services

#### Cardiac rehabilitation

| Description            | In-network coverage                              | Out-of-network coverage                          |
|------------------------|--------------------------------------------------|--------------------------------------------------|
| Cardiac rehabilitation | 80% (of the <b>negotiated charge</b> ) per visit | 60% (of the <b>recognized charge</b> ) per visit |

#### Pulmonary rehabilitation

| Description              | In-network coverage                              | Out-of-network coverage                          |
|--------------------------|--------------------------------------------------|--------------------------------------------------|
| Pulmonary rehabilitation | 80% (of the <b>negotiated charge</b> ) per visit | 60% (of the <b>recognized charge</b> ) per visit |

### Short-term rehabilitation and habilitation therapy services

| Description                                                                       | In-network coverage                              | Out-of-network coverage                          |
|-----------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------|
| Outpatient physical, occupational, speech, and cognitive therapies                | 80% (of the <b>negotiated charge</b> ) per visit | 60% (of the <b>recognized charge</b> ) per visit |
| Combined for short-term rehabilitation services and habilitation therapy services |                                                  |                                                  |
| Maximum visits per <b>policy year</b>                                             | Unlimited                                        |                                                  |

**Chiropractic services**

| <b>Description</b>                    | <b>In-network coverage</b>                       | <b>Out-of-network coverage</b>                   |
|---------------------------------------|--------------------------------------------------|--------------------------------------------------|
| Chiropractic services                 | 80% (of the <b>negotiated charge</b> ) per visit | 60% (of the <b>recognized charge</b> ) per visit |
| Maximum visits per <b>policy year</b> | 30                                               |                                                  |

**Diagnostic testing for learning disabilities**

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

## 8. Other services

### Ambulance service

| Description                                                                                         | In-network coverage                              | Out-of-network coverage              |
|-----------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------|
| Emergency ground, air, and water <b>ambulance</b><br><br>(Includes non-emergency <b>ambulance</b> ) | 100% (of the <b>negotiated charge</b> ) per trip | Paid the same as in-network coverage |

### Clinical trials

| Description                     | In-network coverage                                                                   | Out-of-network coverage                                                               |
|---------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Experimental or investigational | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Routine patient costs           | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

### Durable medical equipment (DME)

| Description                      | In-network coverage                             | Out-of-network coverage                         |
|----------------------------------|-------------------------------------------------|-------------------------------------------------|
| <b>Durable medical equipment</b> | 80% (of the <b>negotiated charge</b> ) per item | 60% (of the <b>recognized charge</b> ) per item |

### Nutritional support

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

### Orthotic devices

| Description                                          | In-network coverage                             | Out-of-network coverage                         |
|------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| Orthotic devices                                     | 80% (of the <b>negotiated charge</b> ) per item | 60% (of the <b>recognized charge</b> ) per item |
| Orthotic devices to correct positional plagiocephaly | 1 per lifetime                                  |                                                 |

## Prosthetic devices

| Description                                                                            | In-network coverage                             | Out-of-network coverage                         |
|----------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| Cochlear implants<br><br>Coverage is limited to <b>covered persons</b> age 18 and over | 80% (of the <b>negotiated charge</b> ) per item | 60% (of the <b>recognized charge</b> ) per item |
| Cranial prosthetics (Medical wigs)                                                     | 80% (of the <b>negotiated charge</b> ) per item | 80% (of the actual <b>charge</b> ) per item     |
| Prosthetic devices                                                                     | 80% (of the <b>negotiated charge</b> ) per item | 60% (of the <b>recognized charge</b> ) per item |

## Hearing aids

| Description                  | In-network coverage                                       | Out-of-network coverage                         |
|------------------------------|-----------------------------------------------------------|-------------------------------------------------|
| Hearing aids                 | 80% (of the <b>negotiated charge</b> ) per item           | 60% (of the <b>recognized charge</b> ) per item |
| Hearing aids maximum per ear | One hearing aid per ear every 36 month consecutive period |                                                 |

## Podiatric (foot care) treatment

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

## Vision care

### Pediatric vision care

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

#### Pediatric routine vision exams (including refraction)

| Description                                                     | In-network coverage                                                                               | Out-of-network coverage                          |
|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Performed by a legally qualified ophthalmologist or optometrist | 100% (of the <b>negotiated charge</b> ) per visit<br><br>No <b>policy year deductible</b> applies | 70% (of the <b>recognized charge</b> ) per visit |
| Maximum visits per <b>policy year</b>                           | 1 visit                                                                                           |                                                  |

#### Pediatric comprehensive low vision evaluations

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

**Pediatric vision care services and supplies**

| Description                                                                                                                                                                                                | In-network coverage                                                                                                 | Out-of-network coverage                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Office visit for fitting of contact lenses                                                                                                                                                                 | 100% (of the <b>negotiated charge</b> ) per visit<br><br>No <b>policy year deductible</b> applies                   | 70% (of the <b>recognized charge</b> ) per visit                                      |
| Eyeglass frames, <b>prescription</b> lenses or <b>prescription</b> contact lenses                                                                                                                          | 100% (of the <b>negotiated charge</b> ) per item<br><br>No <b>policy year deductible</b> applies                    | 70% (of the <b>recognized charge</b> ) per item                                       |
| Maximum number of eyeglass frames per <b>policy year</b>                                                                                                                                                   | One set of eyeglass frames                                                                                          |                                                                                       |
| Maximum number of <b>prescription</b> lenses per <b>policy year</b>                                                                                                                                        | One pair of <b>prescription</b> lenses                                                                              |                                                                                       |
| Maximum number of <b>prescription</b> contact lenses per <b>policy year</b><br>(includes non-conventional <b>prescription</b> contact lenses and aphakic lenses prescribed after cataract <b>surgery</b> ) | Daily disposable: up to 3 month supply<br>Extended wear disposable: up to 6 month supply<br>Non-disposable: one set |                                                                                       |
| Optical devices                                                                                                                                                                                            | Covered according to the type of benefit and the place where the service is received.                               | Covered according to the type of benefit and the place where the service is received. |
| Maximum number of optical devices per <b>policy year</b>                                                                                                                                                   | One optical device                                                                                                  |                                                                                       |

**Pediatric vision care important note:**

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

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

## 9. Outpatient prescription drugs

### Plan features

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

### Policy year deductible and copayment waiver for risk reducing breast cancer

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

### Policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs

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

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

### Policy year deductible and copayment waiver for contraceptives

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

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

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

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



### Preferred generic prescription drugs (including specialty drugs)

| Description                                                                                | In-network coverage                                                                                                                                              | Out-of-network coverage                                                                                                                                          |
|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| For each fill up to a 30 day supply filled at a <b>retail pharmacy</b>                     | <p>\$20 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>negotiated charge</b>)</p> <p>No <b>policy year deductible</b> applies</p> | <p>\$20 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>recognized charge</b>)</p> <p>No <b>policy year deductible</b> applies</p> |
| More than a 30 day supply but less than a 91 day supply filled at a <b>retail pharmacy</b> | <p>\$60 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>negotiated charge</b>)</p> <p>No <b>policy year deductible</b> applies</p> | <p>\$60 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>recognized charge</b>)</p> <p>No <b>policy year deductible</b> applies</p> |

### Non-preferred generic prescription drugs (including specialty drugs)

| Description                                                                                | In-network coverage                                                                                                                                               | Out-of-network coverage                                                                                                                                           |
|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| For each fill up to a 30 day supply filled at a <b>retail pharmacy</b>                     | <p>\$70 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>negotiated charge</b>)</p> <p>No <b>policy year deductible</b> applies</p>  | <p>\$70 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>recognized charge</b>)</p> <p>No <b>policy year deductible</b> applies</p>  |
| More than a 30 day supply but less than a 91 day supply filled at a <b>retail pharmacy</b> | <p>\$210 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>negotiated charge</b>)</p> <p>No <b>policy year deductible</b> applies</p> | <p>\$210 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>recognized charge</b>)</p> <p>No <b>policy year deductible</b> applies</p> |

### Preferred brand-name prescription drugs (including specialty drugs)

| Description                                                                                | In-network coverage                                                                                                                                         | Out-of-network coverage                                                                                                                                     |
|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| For each fill up to a 30 day supply filled at a <b>retail pharmacy</b>                     | \$40 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>negotiated charge</b> )<br><br>No <b>policy year deductible</b> applies  | \$40 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>recognized charge</b> )<br><br>No <b>policy year deductible</b> applies  |
| More than a 30 day supply but less than a 91 day supply filled at a <b>retail pharmacy</b> | \$120 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>negotiated charge</b> )<br><br>No <b>policy year deductible</b> applies | \$120 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>recognized charge</b> )<br><br>No <b>policy year deductible</b> applies |

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

| Description                                                                                | In-network coverage                                                                                                                                         | Out-of-network coverage                                                                                                                                     |
|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| For each fill up to a 30 day supply filled at a <b>retail pharmacy</b>                     | \$70 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>negotiated charge</b> )<br><br>No <b>policy year deductible</b> applies  | \$70 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>recognized charge</b> )<br><br>No <b>policy year deductible</b> applies  |
| More than a 30 day supply but less than a 91 day supply filled at a <b>retail pharmacy</b> | \$210 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>negotiated charge</b> )<br><br>No <b>policy year deductible</b> applies | \$210 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>recognized charge</b> )<br><br>No <b>policy year deductible</b> applies |

#### Diabetic insulin important note:

Your cost share will not exceed \$25 per 30 day supply of a covered preferred **prescription** insulin drug filled at an **in-network pharmacy**.

### Anti-cancer drugs taken by mouth

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

### Contraceptives (birth control)

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

| Description                                                                                                                  | In-network coverage                                                                     | Out-of-network coverage                                                                 |
|------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| For each fill up to a 12 month supply of generic and OTC drugs and devices filled at a <b>retail pharmacy</b>                | 100% (of the <b>negotiated charge</b> )<br><br>No <b>policy year deductible</b> applies | 100% (of the <b>recognized charge</b> )<br><br>No <b>policy year deductible</b> applies |
| For each fill up to a 12 month supply of <b>brand-name prescription drugs</b> and devices filled at a <b>retail pharmacy</b> | Paid according to the type of drug per the schedule of benefits, above                  | Paid according to the type of drug per the schedule of benefits, above                  |

### Preventive care drugs and supplements

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

### Risk reducing breast cancer prescription drugs

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

## Tobacco cessation prescription and over-the-counter drugs

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

### Outpatient prescription drugs important note:

#### Dispense As Written (DAW)

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

## General coverage provisions

This section provides detailed explanations about these features:

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

## Policy year deductible provisions

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

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

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

## Individual

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

## Copayments

### In-network coverage

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

### Out-of-network coverage

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

## Coinsurance

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

## Maximum out-of-pocket limits provisions

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

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

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments**, **coinsurance** and **policy year deductibles** for **covered services** during the **policy year**. This plan has an individual **maximum out-of-pocket limit**.

### Individual

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

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

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

## Medical and outpatient prescription drugs

### In-network care

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

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

- All costs for non-covered services

### Out-of-network care

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

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

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

## Calculations; determination of recognized charge; determination of benefits provisions

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



**Student Health Insurance  
Preferred Provider Organization (PPO)  
Medical and Outpatient Prescription Drug Plan**

**Certificate of Coverage**

**Prepared exclusively for:**

|                                       |                                |
|---------------------------------------|--------------------------------|
| <b>Policyholder:</b>                  | Queens University of Charlotte |
| <b>Policyholder number:</b>           | 252660                         |
| <b>Student policy effective date:</b> | 08/01/26                       |
| <b>Plan effective date:</b>           | 08/01/26                       |
| <b>Plan issue date:</b>               | 07/13/26                       |

**Underwritten by Aetna Life Insurance Company**

- **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.
- **THIS CERTIFICATE IS NOT MEDICARE SUPPLEMENT CERTIFICATE.** If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.
- **Read your policy carefully. This is a legal contract between the policyholder and Aetna.**
- **Important Cancellation Information – Please Read The Provision Entitled, “When coverage ends”, Found On Page 73.**
- **NOTICE:** Your actual expenses for **covered services** may exceed the stated **copayment/coinsurance** amount because actual **provider** charges may not be used to determine the plan and your payment obligations.

# Welcome

---

Thank you for choosing **Aetna**®.

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

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

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

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

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

Welcome to your **Aetna** plan.



## Table of contents

---

|                                                        |                                          |
|--------------------------------------------------------|------------------------------------------|
| Let's get started!                                     | 4                                        |
| Who the plan covers                                    | 8                                        |
| Medical necessity and precertification requirements    | 10                                       |
| Covered services and exclusions                        | 13                                       |
| What your plan doesn't cover – general exclusions      | 54                                       |
| Who provides the care                                  | 60                                       |
| What the plan pays and what you pay                    | 62                                       |
| Claims procedures                                      | 64                                       |
| Complaints, claim decisions, and appeal procedures     | 67                                       |
| When coverage ends                                     | 73                                       |
| Special coverage options after your plan coverage ends | 74                                       |
| General provisions – other things you should know      | 75                                       |
| Glossary                                               | 79                                       |
| Discount programs                                      | 94                                       |
| 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 the **covered student**
- When we say “us”, “we”, and “our”, we mean **Aetna**
- Some words appear in **bold** type and we define them in the *Glossary* section

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

### What your plan does – providing covered services

Your plan provides **covered services** for which your plan has the obligation to pay.

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

### How your plan works – starting and stopping coverage

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

Your coverage typically ends when you are no longer a student. 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.

### Covered services

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

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

- They are listed in the **Covered services and exclusions** section.
- They are not carved out in the *What your plan doesn't cover – general exclusions* section.
- They are not beyond any limits in the schedule of benefits.
- They are **medically necessary**. See the *Medical necessity and precertification requirements* and the *Glossary* for more information.
- They are not prohibited by law. See *Services not permitted by law* in the *What your plan doesn't cover – general exclusions* section for more information.

### Paying for covered services – the general requirements

There are several general requirements for the plan to pay any part of the expense for a service. They are:

- The expense is for a **covered service**
- You get the care from an **in-network provider** or **out-of-network provider**
- You or your **provider precertifies** the service when required

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

## Paying for covered services – sharing the expense

Generally your plan and you will share the expense of your **covered 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 the schedule of benefits.

## Disagreements

We know that people sometimes see things differently.

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

For more information see the *Complaints, claim decisions, and appeal procedures* section.

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

Your in-network coverage helps you:

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

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

## School health services

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

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

You may go directly to **in-network providers** for **covered services**.

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

## Aetna's network of providers

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

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

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

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

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

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

Your out-of-network coverage:

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

You will find details on:

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

## Surprise bill

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

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

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

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

Ancillary services mean any professional services including:

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

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

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

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

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

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

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

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

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

## How to contact us for help

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

- Calling our Member Services at the toll-free number 1-877-626-2308
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156
- Visiting <https://www.aetnastudenthealth.com> to register and access your **Aetna** website

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

## Your ID card

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

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

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

## Who the plan covers

---

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

You will find information in this section about:

- Who is eligible?
- When you can join the plan
- Special times you can join the plan

### Who is eligible?

All full-time traditional undergraduates taking 12 credit hours or more, international students in one credit hour or more, athletes (including graduate athletes), and students in the BSN and ABSN nursing programs are automatically enrolled in Queens Healthcare Insurance Plan at registration, and the premium will be added to the Student's tuition fees, unless proof of comparable coverage is furnished and a waiver is approved.

### Medicare eligibility

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

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

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

### When you can join the plan

As a student you can enroll yourself:

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

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

### Notification of change in status

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

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

## Special times you 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 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 you are a victim of domestic abuse or spousal abandonment and you don't want to be enrolled in the perpetrator's health plan.

We must receive your completed enrollment information from you within 60 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.

#### Late enrollment

If we receive your enrollment application and **premium** contribution more than 60 days after the date you become eligible, coverage will only become effective if, and when:

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

## Medical necessity and precertification requirements

---

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

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

### Medically necessary; medical necessity

**Covered services** under the plan must be **medically necessary**. 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 a service is **medically necessary**.

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

### Precertification

You need **precertification** from us for some **covered services**.

#### Precertification for medical services and supplies

##### In-network care

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

##### Out-of-network care

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

##### Precertification call

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

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



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

#### **Written notification of precertification decisions**

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

#### **Inpatient and outpatient precertification**

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

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

If **precertification** determines that the **stay** or outpatient services and supplies are not **covered services**, 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 *Complaints, claim decisions, and appeal procedures* section.

#### **What if you don't obtain the required precertification?**

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

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

#### **What types of services and supplies require precertification?**

**Precertification** is required for the following types of services and supplies:

##### **Inpatient –**

- Gender affirming treatment
- Obesity (bariatric) **surgery**
- **Stays** in a **hospice facility**
- **Stays** in a **hospital**
- **Stays** in a rehabilitation facility
- **Stays** in a **residential treatment facility** for treatment of **mental health disorders** and **substance related disorders**
- **Stays** in a **skilled nursing facility**

### Outpatient –

- Certain **prescription drugs** and devices
- **Cosmetic** and reconstructive **surgery**
- Gender affirming treatment
- Home health care
- **Hospice care**
- Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
- Non-emergency transportation by airplane
- Obesity (bariatric) **surgery**
- Private duty nursing services

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

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

See *Medically Necessary, Medical Necessity* above and the “**medically necessary, medical necessity**” definition in the *Glossary* section for more information on what we consider when making a **precertification** decision.

For certain drugs covered under your medical plan or **prescription drug** plan, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs. The **medical necessity** requirements are in the *Glossary* section, where we define “**medically necessary, medical necessity**”.

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

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

### Requesting a medical exception

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

- Contact Member Services at the toll-free number 1-877-626-2308
- Log in to your **Aetna** website at <https://www.aetnastudenthealth.com>
- Submit the request in writing to CVS Health, ATTN: **Aetna** PA, 1300 E Campbell Road, Richardson, TX 75081

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

## Covered services and exclusions

---

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

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

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

For example:

- **Physician** care generally is covered but **physician** care for **cosmetic surgery** is never covered. This is an exclusion.
- Home health care is generally covered but may only be covered up to a set number of visits per year. This is a limitation. You can find out about limitations for **covered services** in the schedule of benefits.
- Your **provider** may recommend services that are considered **experimental, investigational, or unproven** services. But an **experimental, investigational, or unproven** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of **covered services** below.

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

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

### Important note:

- We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **medically necessary, experimental, investigational, or unproven**. They are subject to change. You can find these bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>. You can also contact us. See the *How to contact us for help* section for how.
- We cover **medically necessary**, sex-specific **covered services**, regardless of identified gender.

## 1. Preventive care and wellness

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

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

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

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

- Diagnostic testing for the treatment or diagnosis of a medical condition will not be covered under the preventive care and wellness benefit. For those types of tests and treatment, you will pay the cost sharing specific to **covered services** for diagnostic testing and treatment.
- Gender-specific preventive care and wellness benefits include **covered services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.
- To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging in to your **Aetna** website at <https://www.aetnastudenthealth.com> or by calling the toll-free number in the *How to contact us for help* section. This information can also be found at the <https://www.healthcare.gov> website.

## Routine physical exams

**Covered 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 age 30 and older
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial **hospital** checkup

## Preventive care immunizations

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

The following is not covered under this benefit:

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

## Well woman preventive visits

**Covered services** include your routine:

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

## Preventive screening and counseling services

**Covered 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**  
**Covered 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**  
**Covered 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**  
**Covered 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**  
**Covered services** include the counseling services to help you prevent or reduce sexually transmitted infections.
- **Genetic risk counseling for breast and ovarian cancer**  
**Covered services** include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

## Routine cancer screenings

**Covered services** include the following routine cancer screenings:

- Breast cancer screenings including initial screening mammograms, and if necessary to complete the screening process, additional imaging (e.g., MRI, ultrasound, mammography) and pathology evaluation
  - For low dose mammograms:
    - One or more mammograms per year, as recommended by a **physician**, for any woman who is determined to be at risk for breast cancer
    - One baseline mammogram for any woman 35 through 39 years of age, inclusive
    - A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a **physician**
    - A mammogram every year for any woman 50 years of age or older
- Cervical cancer screenings
- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Colorectal screenings
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Ovarian cancer screenings
- Lung cancer screenings
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

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
- Recently published American Cancer Society or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

## Prenatal care

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

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

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

**Important note:**

You should review the benefit under *Covered services and exclusions – Maternity care and Well newborn nursery care* section of this certificate of coverage for more information on coverage for pregnancy expenses under this plan.

**Comprehensive lactation support and counseling services**

**Covered 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**

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

**Breast pump**

**Covered services** include:

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

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

**Breast pump supplies and accessories**

**Covered 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**

**Covered services** include family planning services such as:

**Counseling services**

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

**Contraceptives**

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

**Voluntary sterilization**

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

**Important note:**

See the following sections for more information:

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

The following are not preventive **covered services**:

- Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care. These services are covered, just not under this benefit- see *Outpatient surgery*.
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods or devices, except for male condoms prescribed by a **provider**



## 2. Physicians and other health professionals

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

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

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

If you have been diagnosed with a serious or chronic degenerative, disabling, or life-threatening **illness** or disease, either of which requires specialized **covered services**, you may choose a **specialist** with expertise in treating the **illness** or disease as your primary **physician** who will be responsible for and capable of providing and coordinating your specialized care with the plan.

If we determine that your specialized care is not appropriately coordinated by that **specialist** we may deny coverage to that **specialist** for your specialized care.

#### Important note:

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

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

### Allergy testing and treatment

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

- Allergy testing
- Allergy injections treatment

The following are not covered under this benefit:

- Allergy sera and extracts administered via injection

### Physician and specialist – inpatient surgical services

**Covered services** include the services of:

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

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

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

we will pay for the one that costs the most.

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

### **Anesthetist**

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

### **Surgical assistant**

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

The following are not covered under this benefit:

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

## **Physician and specialist – outpatient surgical services**

**Covered services** include the services of:

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

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

### **Anesthetist**

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

### **Surgical assistant**

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

The following are not covered under this benefit:

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

## **In-hospital non-surgical physician services**

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

## **Consultant services (non-surgical and non-preventive)**

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

**Covered services** include treatment by the consultant.

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

**Important note:**

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

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

**Alternatives to physician and specialist office visits****Walk-in clinic (non-emergency visit)**

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

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

### 3. Hospital and other facility care

#### Hospital care (facility charges)

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

- Semi-private **room and board**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge.
- Services of **physicians** employed by the **hospital**.
- Administration of blood and blood products.

The following are not **covered services** :

- All services and supplies provided in:
  - Rest homes
  - Any place considered a person's main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

#### Preadmission testing

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

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

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

#### Anesthesia and related facility charges for a dental procedure

**Covered services** include:

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

for your dental procedure.

The following conditions must be met:

- Your **dental provider** cannot safely perform the oral **surgery** in a dental office setting, and
- You are a child age 9 or under, or
- You are developmentally disabled

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

## Alternatives to hospital stays

### Outpatient surgery (facility charges)

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

#### Important note:

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

The following are not covered under this benefit:

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

### Home health care

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

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

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

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

The following are not covered under this benefit:

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

## Hospice care

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

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

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a **hospice care agency** or **hospice care** provided in a **hospital**
- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** 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

**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

The following are not covered under this benefit:

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

## Outpatient private duty nursing

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

## Skilled nursing facility

**Covered 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**

## 4. Emergency services and urgent care

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

### Emergency services

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

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

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

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

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

For follow-up care, you are covered when:

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

### In case of a medical emergency

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

### Non-emergency condition

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

The following are not covered under this benefit:

- Non-emergency services in a **hospital** emergency room or an independent freestanding emergency department

## **Urgent care**

### **In case of an urgent condition**

#### **Urgent condition**

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

#### **Non-urgent care**

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

Examples of non-urgent care are:

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

The following is not covered under this benefit:

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



## 5. Pediatric dental care

**Covered services** include dental services and supplies provided by a **dental provider** as found in the *Pediatric dental care* section of the schedule of benefits.

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

### Dental emergencies

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

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

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

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

### Orthodontic treatment

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

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

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

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

## Replacements

The plan's "replacement rule" applies to:

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

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

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

## Missing teeth that are not replaced

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

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

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

## Getting an advance claim review

This only applies to 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.

### Pediatric dental care exclusions

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- **Cosmetic** services and supplies including:
  - Plastic **surgery**, reconstructive **surgery**, **cosmetic surgery**, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Covered services and exclusions* section
  - Facings on molar crowns and pontics will always be considered **cosmetic**
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Mouth guards, and other devices to protect, replace or reposition teeth
- Dental implants except when part of an approved treatment plan for a **covered service** described in *Covered services and exclusions- Reconstructive surgery and supplies*
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion

- Treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including **temporomandibular joint dysfunction** disorder (**TMJ**) and **craniomandibular joint dysfunction** disorder (**CMJ**) treatment, orthognathic **surgery**, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Covered services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another **covered service**
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a **provider**
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a **dental provider**

## 6. Specific conditions

### Birth center (facility charges)

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

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

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

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

**Covered 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
  - Nutritional counseling
- Equipment
  - External insulin pumps
  - Blood glucose meters without special features, unless required due to blindness
- Training
  - Self-management training provided by a health care **provider** certified in diabetes self-management training

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

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

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

**Covered services** include:

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

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

The following are not covered under this benefit:

- Dental implants

### **Impacted wisdom teeth**

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

### **Accidental injury to sound natural teeth**

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

The following are not covered under this benefit:

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

### **Dermatological treatment**

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

The following are not covered under this benefit:

- **Cosmetic** treatment and procedures

### **Maternity care**

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

After your child is born, **covered services** include:

- 48 hours of inpatient care in a **hospital** or birthing center after a vaginal delivery
- 96 hours of inpatient care in a **hospital** or birthing center after a cesarean delivery
- A shorter **stay** if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier
- The mother could be discharged earlier. If so, the plan will pay for 2 post-delivery home visits by a health care **provider**
- A postpartum visit by a health care **provider**, not more than 72 hours after discharge

## Well newborn nursery care

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

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

## Pregnancy complications

**Covered 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 treatment

**Covered services** include gender affirming treatment. The services must follow a specific treatment plan ordered by your **provider** and include:

- Behavioral health counseling
- Hormone therapy
- **Surgery** such as:
  - Breast removal or augmentation
  - Removal of testicles, uterus, ovaries
  - Genital reconstruction

## Autism spectrum disorder

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

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

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

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

## Behavioral health

### Mental health treatment

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

- **Inpatient room and board** at the **semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Other services and supplies related to your condition that are provided during your **stay** in a general medical **hospital**, **psychiatric hospital**, or **residential treatment facility**, including biofeedback.
- 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)
  - Individual, group and family therapies for the treatment of mental health
  - Other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are **homebound**
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - Observation
    - Peer counseling support by a peer support specialist (including **telemedicine** consultation)

### Substance related disorders treatment

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

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



- Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
  - You are **homebound**
  - Your **physician** orders them
  - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
  - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness**, or disease
- Ambulatory **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
- Observation
- Peer counseling support by a peer support specialist (including **telemedicine** consultation)

**Telemedicine important note:**

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

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

## Obesity surgery and services

Obesity **surgery** is a type of procedure performed on people to help lose excess weight and reduce the risk of potentially life-threatening, weight-related health problem. Your **physician** will determine whether you qualify for obesity **surgery**.

**Covered services** include:

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

The following are not **covered services**:

- Weight management treatment.
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate.
- Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

## Reconstructive surgery and supplies

**Covered 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 such as congenital defects and anomalies. 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.

Postmastectomy inpatient care and the decision whether to discharge you following the mastectomy is made by the attending **physician** in consultation you. The length of the postmastectomy **hospital stay** is based on your unique characteristics taking into consideration your health and medical history.

When you have a mastectomy, we will notify you in writing that reconstruction **surgery** is available, at your option, without regard to the lapse of time between the mastectomy and the reconstruction.

## Sexual dysfunction services

**Covered services** include services related to the diagnosis, treatment and correction of any underlying causes of **sexual dysfunction**. A “**sexual dysfunction**” means an inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. It includes:

- Female sexual arousal disorder
- Male erectile disorder
- Hypoactive sexual desire disorder

## Transplant services

**Covered services** include transplant services and organ donor search services provided by a **physician** and **hospital**.

This includes the following transplant types:

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

## Network of transplant facilities

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

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

### Important note:

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

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

## Travel and lodging expenses

If an **IOE patient** lives 100 or more miles from the **IOE facility**, **covered 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**. **Covered services** will be reimbursed by the plan and include coach class round-trip air, train, or bus travel and lodging costs.

The following are not covered under this benefit:

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

## Infertility services

### Basic infertility

**Covered services** include seeing a **provider**:

- To diagnose and evaluate the underlying medical cause of infertility.
- To do **surgery** to treat the underlying medical cause of infertility. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.
- For artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination

See the *Covered services and exclusions-Outpatient prescription drugs* section for information on coverage of infertility **prescription drugs**.

## Infertility services exclusions

The following are not covered under the infertility services benefit:

- All infertility services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Infertility medication. See the *Covered services and exclusions-Outpatient prescription drugs* section for information on coverage of infertility **prescription drugs**.
- All infertility services associated with or in support of an Advanced Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, and professional services
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers
  - Gestational carrier cycles
  - Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery).
- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- Infertility medication not injected by your **provider**, including but not limited to menopausal hormones, hCG, and GnRH agonists. See the *Covered services and exclusions-Outpatient prescription drugs* section for information on coverage of infertility **prescription drugs**.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when either partner has had voluntary sterilization **surgery**, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause).

## 7. Specific therapies and tests

### Outpatient diagnostic testing

#### Diagnostic complex imaging services

**Covered 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

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

### Chemotherapy

**Covered 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 services** for chemotherapy include anti-nausea **prescription drugs**.

### Outpatient infusion therapy

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

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

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

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

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

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

The following are not covered under this benefit:

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

## Outpatient radiation therapy

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

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

## Specialty prescription drugs

**Covered services** include **specialty prescription drugs** when they are:

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

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

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

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

## Outpatient respiratory therapy

**Covered 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

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

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

## Short-term cardiac and pulmonary rehabilitation services

**Covered services** include the cardiac and pulmonary rehabilitation services listed below.

### Cardiac rehabilitation

**Covered 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

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

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

## Short-term rehabilitation and habilitation therapy services

### Short-term rehabilitation therapy services

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

**Covered 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

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

**Covered 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**

**Covered services** include:

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

### **Chiropractic services**

**Covered 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**

**Covered services** include diagnostic testing for:

- Attention deficit disorder
- Attention deficit hyperactive disorder
- Dyslexia

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



## 8. Other services

### Ambulance services

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

#### Emergency

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

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

#### Non-emergency

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

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

The following are not **covered services**:

- Ambulance services for non-emergency transportation
- Ambulance services for routine transportation to receive outpatient or inpatient services

### Clinical trials

#### Routine patient costs

**Covered services** include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

#### Experimental or investigational therapies

**Covered services** include drugs, devices, treatments or procedures from a **provider** under an "approved clinical trial" only when you have cancer or a **terminal illness**. All of the following conditions must be met:

- Standard therapies have not been effective or appropriate
- We determine you may benefit from the treatment

An approved clinical trial is one that meets all of these requirements:

- The Food and Drug Administration (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, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar organization and:
  - It conforms to standards of the NCI or other applicable federal organization
  - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the protocols of that study

## Durable medical equipment (DME)

**Covered services** include the expense of renting or buying **DME** and accessories you need to operate the item from a **DME** supplier. Your plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase **DME**, that purchase is only eligible for coverage if you need it for long-term use.

Coverage includes:

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

We:

- Assume no responsibility
- Make no express or implied warranties

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

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

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

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

The following are not covered under this benefit:

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

## Nutritional support

**Covered services** include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

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

The following are not covered under this benefit:

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

## Orthotic devices

**Covered services** include mechanical supportive devices ordered by your **physician**. Coverage includes the treatment of:

- Weak or muscle deficient feet.
- Positional plagiocephaly

## Prosthetic devices

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

Prosthetic device means:

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

Coverage includes:

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

The following are not covered under this benefit:

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

## Hearing aids

**Covered services** include prescribed hearing aids and hearing aid services as described below.

Hearing aid means:

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

Hearing aid services are:

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

### Hearing aids alternate treatment rule

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

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

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

The following are not covered under this benefit:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 36 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- Cochlear implants
- 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

## Podiatric (foot care) treatment

**Covered 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 a **covered 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.

Coverage is also available under the *diabetic services and supplies* section.

The following are not covered under this benefit:

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

## Telemedicine

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

## Vision care

### Pediatric vision care

#### Routine vision exams

**Covered 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

**Covered services** include:

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

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

The following are not covered under this benefit:

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

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

## 9. Outpatient prescription drugs

### Prescription drugs

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

#### Important note:

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

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

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

**Covered services** are based on the drugs in the **drug guide**. The **drug guide** contains a formulary exclusions list. This list is subject to change. We exclude **prescription drugs** listed on the formulary exclusions list unless we approve a medical exception. See the *Requesting a medical exception* section for more information on medical exceptions or just contact us.

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

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

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

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

### Prescription drug synchronization

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

### How to access in-network pharmacies

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

## Pharmacy types

### Retail pharmacy

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

### Mail order pharmacy

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

### Specialty pharmacy

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

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

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

## How to access out-of-network pharmacies

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

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

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

## Other covered services

### Anti-cancer drugs taken by mouth

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

### Contraceptives (birth control)

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

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



**Preventive contraceptives important note:**

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

**Diabetic supplies**

**Covered services** include but are not limited to the following:

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

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

**Immunizations**

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

**Preventive care drugs and supplements**

**Covered services** include preventive care drugs and supplements, including OTC ones, as required by the ACA.

**Risk reducing breast cancer prescription drugs**

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

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

**Sexual enhancement or dysfunction prescription drugs**

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

**Tobacco cessation prescription and OTC drugs**

**Covered services** include FDA approved **prescription** and OTC drugs to help stop the use of tobacco products. You will need a **prescription** from your **provider** and must fill it at a network **pharmacy**.

**Outpatient prescription drug exclusions**

The following are not **covered services**:

- Abortion drugs used for elective termination of pregnancy except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones, unless we have approved a medical exception
- **Cosmetic** drugs including medication and preparations used for **cosmetic** purposes
- Devices, products and appliances unless listed as a **covered service**
- Dietary supplements including medical foods

- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided unless listed in the **drug guide** or we have approved a medical exception
  - Which do not require a **prescription** by law, even if a **prescription** is written, unless listed as a **covered service** or we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered **prescription drug**, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a **covered service**
  - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications unless listed as a **covered service**
  - That are drugs or growth hormones used to stimulate growth and prescribed only to treat idiopathic short stature
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as a **covered service**
- Immunizations related to travel or work
- Immunization or immunological agents unless listed as a **covered service**
- Implantable drugs and associated devices unless listed as a **covered service**
- Injectables including:
  - Any charges for the administration or injection of **prescription drugs**
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting, with the exception of Depo Provera and other **injectable drugs** for contraception, unless listed in the **drug guide** or we have approved a medical exception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription drugs:**
  - That are ordered by a **dentist** or prescribed by an oral surgeon in relation to the removal of teeth or **prescription drugs** for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- **Prescription drugs** indicated for the purpose of weight loss.
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents

- Tobacco cessation drugs unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

### **Where your schedule of benefits fits in**

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

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

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

### **How your copayment works**

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

## What your plan doesn't cover – general exclusions

---

### General exclusions

The following are not **covered services** under your plan:

#### Abortion

- Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

#### Abortion drugs

- Drugs used for elective termination of pregnancy except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

#### Acupuncture

- Acupuncture
- Acupressure

#### Blood and blood products

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

#### 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, including cosmetic drugs, medications, and preparations used for cosmetic purposes, except where described in the *Covered services and exclusions* section

#### Court-ordered services and supplies

This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a **covered service** under your plan

#### Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs.

Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- **Respite care**, adult or child day care, or convalescent care
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods

- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and **substance related disorder** treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function
    - Provide a place free from conditions that could make your physical or mental state worse

### Dental care for adults

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

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

### Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs, whether or not the program is part of a **residential treatment facility** or otherwise licensed institution
  - Job training
  - Job hardening programs
- Any services that are schooling related or similar programs
- Therapeutic programs within a school, vocational, work, or recreational setting.

### Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, sporting event, or to join in a sport or other recreational activity.

### **Experimental, investigational, or unproven**

- **Experimental, investigational, or unproven** drugs, devices, treatments or procedures unless otherwise covered under clinical trials

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

All services and supplies associated with GCIT including, but not limited to:

- The cost of the GCIT product.
- Any medical, surgical, professional, and facility charges directly related to GCIT. Examples include:
  - Anesthesia
  - Infusion
  - Lab and radiology
  - Nursing
  - **Physician** or **specialist** services

### **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 exams**

- Hearing exams performed for the evaluation and treatment of **illness, injury** or hearing loss.

### **Jaw joint disorder**

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

### **Maintenance care**

Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services.

### **Medical supplies – outpatient disposable**

- Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

### **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

### **Other primary payer**

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

### **Prescription or non-prescription drugs and medicines**

- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones, unless we have approved a medical exception
- Drugs or medications recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
- **Specialty prescription drugs** except as stated in the *Covered services and exclusions* section

### **Personal care, comfort or convenience items**

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

### **Routine exams and preventive services and supplies**

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

### **School health services**

- Services and supplies normally provided by the **policyholder's**:
  - **School health services**
  - Infirmary
  - **Hospital**
  - **Pharmacy**
- Services and supplies provided by **health professionals** who the **policyholder**:
  - Employs
  - Is affiliated with
  - Has an agreement or arrangement with
  - Otherwise designates

### **Services not permitted by law**

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

### **Services provided by a family member**

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

### **Sexual dysfunction and enhancement**

- Except where described in the *Covered services and exclusions* section, any treatment, **prescription drug**, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - **Surgery, prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

### **Strength and performance**

- Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

### **Students in mental health field**

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

### **Telemedicine**

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

### **Therapies and tests**

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound 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 *Covered services and exclusions – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Covered services and exclusions – Outpatient prescription drugs* section
  - Nicotine patches
  - Gum

### **Treatment in a federal, state, or governmental entity**

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



**Vision care for adults**

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

**Voluntary sterilization**

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

**Wilderness treatment programs**

Wilderness treatment programs, whether or not the program is part of a **residential treatment facility** or otherwise licensed institution

**Work related illness or injuries**

- Services or supplies for the treatment of an occupational **injury** or **illness** which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

**Important note:**

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

## Who provides the care

---

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

### School health services

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

### In-network providers

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

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

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

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

### Out-of-network providers

You also have access to **out-of-network providers**. This means you can receive **covered services** from an **out-of-network provider**. If you use an **out-of-network provider** to receive **covered 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

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

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

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

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

## What the plan pays and what you pay

---

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

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

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

### The general rule

When you get **covered services**:

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

And then

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

And then

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

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

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

### Important exception – when your plan pays all

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

### Important exceptions – when you pay all

You pay the entire expense for a **covered service**:

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

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

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

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

Instead:

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

And then

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

And then

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

And then

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

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

## Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the **negotiated charge** for in-network **covered services**
- 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 **covered services** per **policy year** before your plan begins to pay for **covered services**. Your schedule of benefits shows the **policy year deductible** amounts for your plan.

### How your copayment works

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

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

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

## Claim procedures

---

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

When a claim comes in, we decide and tell you how you and we will split the expense. We explain what you can do if you think we got it wrong in the *Complaints, claim decisions, and appeal procedures* section.

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

### Submit a claim

- You should notify and request a claim form from the **policyholder**. You must send us notice within 20 days, or as soon as reasonably possible
- We will provide the claim form within 15 days of notice and the claim form will provide instructions on how to complete and where to send the form
- If you are unable to complete a claim form, you may send us:
  - A description of services
  - A bill of charges
  - Any medical documentation you received from your **provider**

### Proof of loss (claim)

- Proof of loss is a completed claim form and any additional information required by us
- You or your **provider** must send us notice and proof within 12 months of the date you received services, unless you are legally unable to notify us
- If the claim form is not provided within 15 days of notice you are deemed to have complied with the proof of loss requirements

### Benefit payment

- Written proof must be provided for all benefits
- If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss
- Benefits will be paid as soon as the necessary proof to support the claim is received

## Types of claims and communicating our claim decisions

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

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.

For additional information on your options and rights related to health insurance, contact Health Insurance Smart NC at:

North Carolina Department of Insurance  
Albemarle Building  
325 N. Salisbury St.  
Raleigh, NC 27603  
855-408-1212 (toll free)  
919-807-6865 (fax)

### Noncertification

A noncertification determination by **Aetna** that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet **Aetna's** requirements for **medical necessity**, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of **emergency services** and the requested service is denied, reduced, or terminated. A noncertification is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in this **certificate of coverage**. A noncertification includes any situation in which **Aetna** determines whether a requested treatment is **experimental or investigational**, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision.

We have processes to review claims before and after payment to ensure the services billed meet one or more of the following:

- Our reimbursement policies
- Are free from fraud, waste, and abuse

When we review, we will evaluate submitted claim information and determine the accuracy of the procedure and diagnosis codes for the services billed. Sometimes, this review will change how we pay for the services and what we allow on a claim. This doesn't mean that a service isn't a **covered service**. It may mean that the claim should be submitted differently, or the services billed on the claim don't satisfy one of the items above.

We will tell you and your **provider** of our decision if we find any of the items above are not met.

### Urgent care claim

An urgent claim is one for which the **physician** treating you decides that a delay in getting medical care, could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 72 hours.

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. We will make a decision within 15 days.

### Post-service claim

A post service claim is a claim that involves health care services you have already received. We will make a decision within 30 days. If we ask you for additional information you have 90 days to provide your response.

### 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**. You must let us know you need this extension 24 hours before the original approval ends. We will make a decision within 24 hours for an urgent request. We will make a decision for a non-urgent request within 15 days.

**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 by mail 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.



## Complaints, claim decisions, and appeal procedures

---

### The difference between a complaint and an appeal

#### Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. See the *How to contact us for help* section for how. This is a complaint. A complaint will undergo a first-level and second-level review. A first-level grievance is made by you or your **provider**. We will determine if you may attend the first-level review. We will provide you with the name, address and telephone number of the reviewer within three business days of receiving your complaint. We will acknowledge quality of care complaints with 10 business days. 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 let you know if we need more information to make a decision. We will give you a written response within 30 calendar days of receiving the complaint and any additional information we requested.

You have the right to review all information relevant to your case.

If the decision is not in your favor, we will send the written decision issued in a first-level review shall contain:

- The professional qualifications and licensure of the person or persons reviewing the grievance.
- A statement of the reviewers' understanding of the grievance.
- The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the **covered person** to respond further to the insurer's position.
- A reference to the evidence or documentation used as the basis for the decision.
- A statement advising the covered person of his or her right to request a second-level review and a description of the procedure for submitting a second-level review request under this section.
- Notice of the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.

If you are not satisfied with the first-level review, you or your **provider** may initiate a second-level review. We will provide you with information about the process and your rights within 10 days of receiving your request with the following:

- The contact information including the name, address and telephone number of the grievance review coordinator for **Aetna**.
- The statement of **covered person's** rights, including:
  - The right to request and receive all information relevant to the case
  - The right to present his or her appear before the review panel
  - The right to send in supporting materials before and at the review meeting
  - The right to ask questions of any member of the review panel
  - The right to be helped or represented by a person of his or her choice including a family member, employer representative or attorney; and
- Notification that the Member's right to a full review does not depend on his or her attendance at the meeting.

The meeting will take place within 45 days of receiving your request. We will notify you of the date at least 15 days before the meeting. The outcome of the review will not be based on your attending the meeting. We will notify you in writing of the decision within seven business days following the meeting.

An urgent review may be initiated, whether or not the first-level review was urgent. An urgent second-level review will follow the same procedures, as outlined above. It will take place within four days of receiving all necessary information by conference call or writing. A valid complaint does not include exclusions, if the exclusion is clearly stated in the *What your plan doesn't cover – general exclusions* section.

You may contact the Health Insurance Smart NC division of the North Carolina Department of Insurance for any questions or assistance:  
1201 Mail Service Center  
Raleigh, NC 27699  
1-800-546-5664

## **Grievance**

A grievance is a written complaint submitted to Aetna by you or your designee about any of the following:

- A decision, policy or action related to availability, delivery, or quality of health care services
- A written complaint submitted by you about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care services in question is not a grievance if the exclusion of the specific service requested is clearly stated in the certificate of coverage
- Claims payment or handling; or reimbursement for services
- The contractual relationship between you and the health plan
- The outcome of an appeal of a noncertification under North Carolina general statute

## **Appeal**

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

## **Claim decisions and appeal procedures**

Your **provider** may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in the *What the plan pays and what you pay* section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

For any adverse benefit determination, you will receive an explanation of benefits in writing, as consistent with North Carolina law and this plan's policies. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don't agree, you can also appeal that decision. There are times you may skip the internal appeal process. But in most situations, you must complete the internal appeal process before you can take any other actions, such as an external review. Noncertifications are also included in an adverse benefit determination.

Another person may submit a complaint or 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 do this for you (even if it is your **provider**). You should fill out an authorized representative form to tell us. You can get this form by contacting us. See the *How to contact us for help* section for how. You can use an authorized representative at any time during the internal appeal process.

## **Appeal of an adverse benefit determination**

### **Urgent care or pre-service claim appeal**

If your claim is an urgent claim or a pre-service claim, you or your authorized representative may appeal without having to fill out an appeal form. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim (urgent, pre-service) it involves.

## Any other claim appeal

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 contacting us. See the *How to contact us for help* section for how. You can appeal in writing to the address on the notice of adverse benefit determination. A written appeal should 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

We will assign your appeal to someone who was not involved in making a decision about the claim. We will provide you with that person's contact information within three business days. You will receive a decision within 30 days for a post-service claim.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 30 days from the date you receive the notice of the first appeal decision.

At your last available internal appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision. This decision is called the final adverse benefit determination. You can respond to the information before we tell you what our final decision is.

## Exhaustion of appeals process

You have the option to complete the two levels of appeal with us before you can take these other actions:

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

You may choose to not have to complete the appeal 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 or the 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). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an ERO to review your case once the NCDOI establishes that your request is complete and eligible for review. You or someone you have authorized to represent you may request an external review.

**Aetna** will notify you in writing of your right to request an external review each time you:

- receive a noncertification decision, or
- receive an appeal decision upholding a noncertification decision, or
- receive a second-level grievance review decision upholding the original noncertification.

You have a right to external review of noncertification decision only if all the following conditions are met:

- You have received an adverse benefit determination
- Our claim decision involved medical judgment
- We decided the service or supply is not **medically necessary** or not appropriate, or we decided the service or supply is **experimental, investigational, or unproven**
- You had coverage with **Aetna** in effect when the noncertification decision was issued;
- The service for which the noncertification was issued appears to be a covered service under your policy
- You have exhausted **Aetna's** appeals process as described in the *Appeals of adverse benefit determinations* section

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

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination of the noncertification or final adverse benefit determination of the noncertification we send you. That notice also will describe the external review process. It will include a copy of the request for external review form with the final adverse determination. A covered person may file a request for an external review with the Commissioner within 120 days after the date of receipt of a notice of right to external review.

For a standard external review, you will be considered to have exhausted the external review process if you have:

- Completed **Aetna's** appeal process and received a written determination on the appeal from **Aetna**, or
- Filed an appeal and except to the extent that you have requested or agreed to a delay, have not received **Aetna's** written decision on appeal within 60 days of the date you can demonstrate that you submitted the request, or
- Received notification that **Aetna** has agreed to waive the requirement to exhaust the internal appeal process.

If your request for a standard external review is related to a retrospective noncertification (a noncertification which occurs after you have received the services in question), you will not be eligible to request a standard review until you have completed **Aetna's** internal appeal process and received a written final determination from **Aetna**.

If you wish to request a standard external review, you (or your representative) must make this request to NCDOI within 120 days of receiving **Aetna's** written notice of final determination that the services in question are not approved. When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of your request for a standard external review, the NCDI will notify you and your provider of whether your request is complete and whether it is accepted. If the NCDI notifies you that your request is incomplete, you must provide all requested additional information to the NCDI within 150 days of the date of **Aetna's** written notice of final determination. If the NCDI accepts your request, the acceptance notice will include:

- The name and contact information for the External Review Organization (ERO) assigned to your case;
- A copy of the information about your case that **Aetna** has provided to the NCDI;
- Notice that **Aetna** will provide you or your authorized representative with a copy of the documents and information considered in making the denial decision (which will also be sent to the ERO); and
- Notification that you may submit additional written information and supporting documentation relevant to the initial noncertification to the assigned ERO within 7 after receipt of the notice of acceptance.

If you choose to provide any additional information to the IRO, you must also provide that same information to **Aetna** at the same time using the same means of communication (e.g., you must fax the information to **Aetna** if you faxed it to the ERO). When faxing information to **Aetna**, send it to 1-xxx-xxx-xxxx. If you choose to mail your information, send it to:

**Aetna Life Insurance Company**

151 Farmington, Ave  
Hartford, CT, 06156

Please note that you may also provide this additional information to the NCDI within the 7-day deadline rather than sending it directly to the ERO and **Aetna**. The NCDI will forward this information to the ERO and **Aetna** within two business days of receiving your additional information.

The ERO will send you written notice of its determination within 45 days of the date the NCDI received your standard external review request. If the IRO's decision is to reverse the noncertification, **Aetna** will, reverse the noncertification decision within 3 business days of receiving notice of the ERO's decision, and provide coverage for the requested service or supply that was the subject of the noncertification decision. If you are no longer covered by **Aetna** at the time **Aetna** receives notice of the IRO's decision to reverse the noncertification, **Aetna** will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

An expedited external review of a noncertification decision may be available if you have a medical condition where the time required to complete either an expedited internal appeal or second level grievance review or a standard external review would reasonably be expected to seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. If you meet this requirement, you may make a written or verbal request to the NCDI for an expedited review after you:

- Receive a noncertification decision from **Aetna** AND file a request with **Aetna** for an expedited appeal, or
- Receive an appeal decision upholding a noncertification decision.

You may also make a request for an expedited external review if you receive an adverse second-level grievance review decision first level appeal decision concerning a noncertification of an admission, availability of care, continued stay or emergency care, but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review your request and determine whether it qualifies for expedited review. You and your provider will be notified within 2 days if your request is accepted for expedited external review. If your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if **Aetna's** appeals process was already completed, or (2) require the completion of **Aetna's** appeals process before you may make another request for an external review with the NCDOI. An expedited external review is not available for retrospective noncertifications.

The ERO will communicate its decision to you within 3 days of the date the NCDOI received your request for an expedited external review. If the ERO's decision is to reverse the noncertification, **Aetna** will, within one day of receiving notice of the ERO's decision, reverse the noncertification decision for the requested service or supply that is the subject of the noncertification decision. If you are no longer covered by **Aetna** at the time **Aetna** receives notice of the ERO's decision to reverse the noncertification, **Aetna** will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

The ERO's external review decision is binding on **Aetna** and you, except to the extent you may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same noncertification decision for which you have already received an external review decision.

For further information about External Review or to submit the request for external review form:

- Contact the North Carolina Department of Insurance:
  - Health Insurance Smart NC
    - By mail: 1201 Mail Service Center, Raleigh, NC 27699-1201
    - In person: Albemarle Building, 325 N. Salisbury Street, Raleigh, NC 27603
    - Phone: 855-408-1212 or Fax: 919-807-6865
    - Online: <https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-external-review>
- Within 6 months of the date you received the decision from us
- You must submit a signed medical authorization at the request of NCDOI
- With any other important information that supports your request

You must sign the External Review Request form. 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.

## **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.

## 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 your coverage ends, we will give you a written certification of creditable coverage when you ask us for one. See the *How to contact us for help* section. The certification will include your period of creditable coverage under the student policy. The student policy does not have any waiting or affiliation periods.

### When will your coverage end?

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

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

When your coverage ends, we will refund your premiums on a pro-rata basis.

### Withdrawal from classes – leave of absence

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

### Withdrawal from classes – other than leave of absence

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

### Why would we end your coverage?

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 for other reasons

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

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

Your coverage may be extended if you 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.



# General provisions – other things you should know

---

## Entire student policy

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

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

## Administrative provisions

### How you and we will interpret this certificate

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

### How we administer this plan

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

### Who's responsible to you

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

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

## Coverage and services

### Your coverage can change

Your coverage is defined by the **student policy**. This document may have amendments and riders too. Under certain circumstances, we, the **policyholder** or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive **precertification**, **prescription** quantity limits or your cost share if you are affected. Only we 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.

### Physical examinations and evaluations

At our expense, we have the right to have a **physician** of our choice examine you. This will be done at all reasonable times while certification or a claim for benefits is pending or under review.

## Records of expenses

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

Things that would be important to keep are:

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

## Honest mistakes and intentional deception

### Honest mistakes

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

### Intentional deception

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

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

We also may report fraud to criminal authorities.

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

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

- We will give you 30 days advance written notice of any rescission of coverage
- You have the right to an **Aetna** appeal
- You have the right to a third-party review conducted by an independent external review organization
- We will refund the **premium** less any claims paid.

## Incontestability

We will not use a statement you make to void this student policy after it has been in force for 2 years from its **effective date** or reinstatement.

We will use only a statement in writing that you or a **covered person** makes, to do any of the following:

- To void coverage of the **covered person**
- To deny coverage of the **covered person**
- To deny a claim for benefits by the **covered person**

We will not use a statement by a **covered person** to deny a claim for benefit more than 2 years after the statement was made.

## Some other money issues

### Legal action

No legal action at law or in equity can be brought to recover on this **student policy** until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 2 years from the date of the original claim payment.

### Assignment of benefits

When you see an **in-network provider**, they will usually bill us directly. When you see an **out-of-network provider**, we may choose to pay you or to pay the **provider** directly. To the extent allowed by law, we will not accept an assignment to an **out-of-network provider**.

### Financial sanctions exclusions

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 **covered services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). Visit <https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx> to find out more.

### Grace period

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

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

### Recovery of overpayments

We sometimes pay too much for **covered 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.

### Reinstatement

You may request that we reinstate the **student policy** and coverage after we end it. You must make the request within 30-60 days of the **termination date**. We will reinstate the **student policy** and coverage as of the **termination date** when we accept payment of all amounts due and you give us reasonable assurances that you can and will fulfill all of your obligations under the **student policy**.

We or an agent may:

- Require that you submit a reinstatement application and
- Issue to you a conditional receipt for the **premium** tendered.

We will reinstate the **student policy** and coverage when we approve the reinstatement application. We will notify you in writing if the application is disapproved.

If we do not notify you of an approval or disapproval of the application, then the **student policy** and coverage will be reinstated on the 45<sup>th</sup> day after the date we issued the conditional receipt.

The reinstated policy shall cover only losses occurring from an:

- **Illness** that begins more than 10 days after the date of the reinstatement
- Accidental **injury** occurring on or after the date of reinstatement

In all other respects, your and our rights and duties under the **student policy** survive termination and reinstatement of the **student policy**. You are subject to any provisions contained within the conditional receipt.

When we accept any **premium** connected with the reinstatement, it will be applied to a **premium** period where **premium** is due. It will not be applied to a period that is more than 60 days prior to the reinstatement date.

## Your health information

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

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

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

## Effect of benefits under other plans

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

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

## Effect of prior coverage - transferred business

Prior coverage means:

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

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

## Glossary A-M

---

### Accident or accidental

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

### Aetna®

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

### Behavioral health provider

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

### Brand-name prescription drug

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

### Calendar year

A period of 12 months beginning January 1<sup>st</sup> and ending on December 31<sup>st</sup>.

### Clinical related injury

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

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

### Coinsurance

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

### Copayments

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

### Cosmetic

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

### Covered person

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 services

The benefits, subject to varying cost shares, covered under the plan. These are:

- Described in the *Covered services* section
- Not listed as an exclusion in the *Covered services and exclusions* section or *What your plan doesn't cover – general exclusions* section
- Not beyond any limits in the schedule of benefits
- **Medically necessary**. See the *Medical necessity and precertification requirements* and the *Glossary* for more information
- Services that are not prohibited by law

## Covered student

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

## Craniomandibular joint dysfunction (CMJ)

This is a disorder of the jaw joint.

## Custodial care

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

## Dental emergency

Any dental condition that:

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

## Dental emergency services

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

## Dental provider

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

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

## Dentist

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

## Detoxification

The process of getting alcohol or other drugs out of an addicted person's system and getting them physically stable.

## Directory

The list of **in-network providers** for your plan. The most up-to-date **directory** for your plan appears at <https://www.aetnastudenthealth.com>. When searching from our online **provider directory**, you need to make sure that you are searching for **providers** that participate in your specific plan. **In-network providers** may only be considered for certain **Aetna** plans. When searching for **in-network dental providers**, you need to make sure you are searching under Pediatric Dental plan.

## Drug guide

A list of **prescription** and over-the-counter (OTC) drugs and devices established by **Aetna** or an affiliate. It does not include all **prescription** and OTC drugs and devices. This list can be reviewed and changed by **Aetna** or an affiliate. A copy of the **drug guide** is available at your request. You can also find it on the **Aetna** website at <https://www.aetnastudenthealth.com>.

## Durable medical equipment (DME)

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

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

## Effective date of coverage

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

## Emergency admission

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

## Emergency medical condition

A medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, , possessing an average knowledge of health and medicine, 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

Health care items and services furnished or required to screen for treatment given in an ambulance and a **hospital's** emergency room or an independent freestanding emergency department, including prehospital care and ancillary services routinely available to the emergency department. This includes evaluation of and treatment to stabilize the **emergency medical condition**. An "independent freestanding emergency department" means a health care facility that is geographically separate, distinct and licensed separately from a **hospital** and provides **emergency services**.

## Experimental, investigational, or unproven

A drug, device, procedure, supply, treatment, test, or technology is considered by us to be **experimental, investigational, or unproven** if any of the following apply:

- It hasn't been shown through well-conducted clinical trials or cohort studies published in peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which it's meant.
  - A well-conducted clinical trial means a randomized, controlled trial where the experimental intervention is compared to a control group receiving care according to best practice and study participants are randomly assigned to the experimental or control group.
  - A well-conducted cohort study means a prospective cohort study from more than one institution where the experimental intervention is compared to a group of subjects receiving care according to best practice and where the comparison group is well matched to the experimental intervention group.
- There isn't FDA approval or clearance to market it for the proposed use.
- A national medical society, dental society, or regulatory agency has written that it's **experimental, investigational, or unproven**, or mainly for research purposes.
- It's the subject of a Phase I, Phase II, or the experimental or research arm of a Phase III clinical trial. The FDA and Department of Health and Human Services define these.
- Written procedures or consent form used by a facility **provider** says it's **experimental, investigational, or unproven**.

### Important note:

We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **medically necessary, experimental, investigational, or unproven**. They are subject to change. You can find these bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>. You can also contact us. See the *How to contact us for help* section for how.

## Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product. It is considered to be as effective as the brand-name product and offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance



## Health professional

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

## Home health aide

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

## Home health care agency

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

## Home health care plan

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

## Homebound

This means that you are confined to your home because:

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

You are not **homebound** if:

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

## Hospice benefit period

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

## Hospice care

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

## Hospice care agency

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

## Hospice care program

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

## Hospice facility

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

## Hospital

An institution licensed as a **hospital** by applicable law and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can stay overnight for care. Or they can be treated and leave the same day. All **hospitals** must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

## Hospital stay

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

## Illness or illnesses

Poor health resulting from disease of the body or mind.

## In-network dental provider

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

## In-network pharmacy

A **retail pharmacy** or **specialty pharmacy** that has contracted with **Aetna**, an affiliate, or a third-party vendor, to provide outpatient **prescription drugs** to you.

## In-network provider

A **provider** listed in the **directory** for your plan. However, a NAP **provider** listed in the NAP directory is not an **in-network provider**.

## Injectable drug(s)

These are **prescription drugs** when an oral alternative drug is not available.

## Injury or injuries

Physical damage done to a person or part of their body.

## Institutes of Excellence™ (IOE) facility

A facility designated by **Aetna** in the **provider directory** as Institutes of Excellence **in-network provider** for specific services or procedures.

## Intensive care unit

A ward, unit, or area in a **hospital** which is set aside to provide continuous specialized or intensive care services to you because your **illness** or **injury** is severe enough to require such care.

## Jaw joint disorder

This is:

- A disorder of the jaw joint
- A Myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

## L.P.N.

A licensed practical nurse or a licensed vocational nurse.

## Maximum out-of-pocket limit

The maximum out-of-pocket amount for payment of **copayments** and **coinsurance** including any **policy year deductible**, to be paid by you per **policy year** for **covered services**.

## Medically necessary/Medical necessity

Health care services or supplies are those covered services or supplies that are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, **illness** or **injury**, or disease, and except as allowed under G.S. 58-3-255, not for **experimental or investigational**, or cosmetic purposes
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, **illness**, **injury**, disease, or its symptom
- Within generally accepted standards of medical care in the community
- Not solely for the convenience of the insured, the insured's family, **physician**, or other health care **provider**

Generally accepted standards of medical practice means:

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

### Important note:

We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **medically necessary, experimental, investigational, or unproven**. They are subject to change. You can find these bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>. You can also contact us. See the *How to contact us for help* section.

## Medicare

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

## Mental health disorder

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

## Glossary N-Z

---

### Negotiated charge

#### *Health coverage*

This is either:

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

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

For surprise billing, calculations will be made based on the median contracted rate.

We may enter into arrangements with **in-network providers** or others related to:

- The coordination of care for **covered persons**
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing

These arrangements will not change the **negotiated charge** under this plan.

#### *Prescription drug coverage from an in-network pharmacy*

#### **In-network pharmacy**

The amount we established for each **prescription drug** obtained from an **in-network pharmacy** under this plan. This **negotiated charge** may reflect amounts we agreed to pay directly to the **in-network pharmacy** or to a third-party vendor for the **prescription drug**, and may include a rebate, an additional service or risk charge set by us.

We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may change the **negotiated charge** under this plan.

### Non-preferred drug

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

### Out-of-network dental provider

A **dental provider** who is not an **in-network dental provider** and does not appear in the **directory** for your plan.

### Out-of-network pharmacy

A **pharmacy** that is not an **in-network pharmacy** or National Advantage Program (NAP) **provider** and does not appear in the **directory** for your plan.

### Out-of-network provider

A **provider** who is not an **in-network provider** or National Advantage Program (NAP) **provider** and does not appear in the **directory** for your plan.

## Pharmacy

An establishment where **prescription drugs** are legally dispensed. This includes an in-network **retail pharmacy** and **specialty pharmacy**. It also includes an out-of-network **retail pharmacy**.

## Physician

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

## 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 **covered services** per **policy year** before your plan starts to pay as listed in the schedule of benefits.

## Policyholder

The school named on the front page of the **student policy** and your certificate of coverage and schedule of benefits for the purpose of coverage under the **student policy**.

## Precertification, precertify

A requirement that you or your **physician** contact **Aetna** before you receive coverage for certain services.

## Preferred drug

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

## Preferred in-network pharmacy

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

## Premium

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

## Prescription

*As to hearing care:*

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

*As to **prescription drugs**:*

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

*As to vision care:*

A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

## Prescription drug

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

## Provider(s)

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

## Psychiatric hospital

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

## Recognized charge

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

The **recognized charge** depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

| SERVICE OR SUPPLY                                                        | RECOGNIZED CHARGE IS BASED ON:            |
|--------------------------------------------------------------------------|-------------------------------------------|
| Professional services and other services or supplies not mentioned below | 105% of the <b>Medicare</b> allowed rate  |
| Services of <b>hospitals</b> and other facilities                        | 140% of the <b>Medicare</b> allowed rate  |
| <b>Prescription drugs</b>                                                | 100% of the average wholesale price (AWP) |
| Dental expenses                                                          | 80% of the prevailing charge rate         |

### Important note:

If the **provider** bills less than the amount calculated using the method above, the **recognized charge** is what the **provider** bills.

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP **provider**. NAP **providers** are **out-of-network providers** and third-party vendors that have contracts with us but are not **in-network providers**. Claims for services received from a NAP **provider** and paid at the NAP contracted rate are not subject to the federal surprise bill law.

## Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- **Medicare** allowed rates are the rates CMS establishes for services and supplies provided to **Medicare** enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If **Medicare** does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set **Medicare** rates
  - What other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply

When the **recognized charge** is based on a percentage of the **Medicare** allowed rate, it is not affected by adjustments or incentives given to **providers** under **Medicare** programs.

- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.

### Our reimbursement policies

We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the **recognized charge**. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the **provider**

Our reimbursement policies are based on our review of:

- The Centers for **Medicare** and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and **dentists** practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

### Get the most value out of your benefits

We have online tools to help you decide whether to get care and if so, where. Log in to your **Aetna** website at <https://www.aetnastudenthealth.com>. The website contains additional information that can help you determine the cost of a service or supply.

### R.N.

A registered nurse.

### Residential treatment facility

A facility that provides **mental health disorder** services or **substance related disorder** services and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed **physician** for the level of care provided
- Maintains a written treatment plan prepared by a licensed **behavioral health provider** (**R.N.** or master's level) requiring full-time residence and participation

- Has a licensed **behavioral health provider (R.N. or master's level)** on-site 24 hours per day 7 days per week
- And is:
  - Credentialed by us, or
  - Certified by **Medicare**, or
  - Accredited by The Joint Commission (TJC); The Committee on Accreditation of Rehabilitation Facilities (CARF); The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP); or The Council on Accreditation (COA)

## Respite care

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

## Retail pharmacy

A community **pharmacy** that dispenses outpatient **prescription drugs**.

## Room and board

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

## School health services

The **policyholder's** school's student health center or a **provider** or organization that is identified as a **school health services provider**.

## 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.

## Sexual dysfunction

Any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder

## Skilled nursing facility

A facility that provides skilled nursing care and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed **physician** for the level of care provided
- Maintains a written treatment plan prepared by a licensed **provider (R.N. or master's level)** requiring full-time residence and participation
- Has a licensed **provider (R.N. or master's level)** on-site 24 hours per day 7 days per week
- And is:
  - Credentialed by us, or
  - Certified by **Medicare**, or
  - Accredited by The Joint Commission (TJC) or The Committee on Accreditation of Rehabilitation Facilities (CARF)



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

**Skilled nursing facility** does not include institutions that provide only:

- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services

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

### **Skilled nursing services**

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

### **Sound natural teeth**

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

### **Specialist**

A **physician** who practices in any generally accepted medical or surgical sub-specialty and is board-certified.

### **Specialty pharmacy**

A **pharmacy** that fills **prescriptions** for specialty drugs.

### **Specialty prescription drug**

An FDA-approved **prescription drug** that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:

- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

### **Stay**

A full-time inpatient confinement for which a **room and board** charge is made.

### **Step therapy**

A form of **precertification** where you must try one or more required drug(s) before a **step therapy** drug is covered. The required drugs have FDA approval, may cost less and treat the same condition. If you don't try the appropriate required drug first, you may need to pay full cost for the **step therapy** drug.

### **Student policy**

The **student policy** consists of several documents taken together. The list of documents can be found in the *Entire student policy* section of this certificate of coverage.

## Substance related disorder

The use of drugs, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association, that directly affect the brain's reward system in an amount or frequency that causes problems with normal activities.

## Surgery center

A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all **Medicare** accreditation standards (even if it does not participate in **Medicare**).

## Surgery, surgeries or surgical procedures

The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution or
- Otherwise physically changing body tissues and organs

## Telemedicine

A consultation between you and a **physician, specialist, behavioral health provider, or telemedicine provider** who is performing a clinical medical or behavioral health service by means of electronic communication.

## Temporomandibular joint dysfunction (TMJ)

This is a disorder of the jaw joint.

## Terminal illness

A medical prognosis that you are not likely to live more than 12 months.

## Urgent admission

This is an admission to the **hospital** due to an **illness** or **injury** that is severe enough to require a **stay** in a **hospital** within 2 weeks from the date the need for the **stay** becomes apparent.

## Urgent care facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition**.

## **Urgent condition**

An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

## **Walk-in clinic**

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near, or within a:

- Drug store
- **Pharmacy**
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- **Hospital**
- Outpatient department of a **hospital**
- **Physician's office**
- **Urgent care facility**

## Discount programs

---

### Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third-party service providers”. These third-party service **providers** may pay us so that they can offer you their services.

Third-party service **providers** are independent contractors. The third-party service **provider** is responsible for the goods or services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don’t pay the third-party service **providers** for the services they offer. You are responsible for paying for the discounted goods or services.

### Wellness and other incentives

#### Covered students only

We may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services, and to continue your participation in the **Aetna** plan through incentives. You and your **physician** can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, including but not limited to financial wellness programs, we may provide incentives based on your participation.

Incentives may include but are not limited to:

- Modifications to **copayment, coinsurance, or policy year deductible** amounts
- **Premium** discounts or rebates
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards or
- Any combination of the above.

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon your health status.

## State mandated benefits

---

### North Carolina state mandated benefit

**Covered services** include the following North Carolina mandated benefits:

- Access to nonformulary drugs
- Alcoholism and drug abuse treatment
- Anesthesia and Hospital charges for dental procedures for certain individuals
- Autism Spectrum Disorders
- Bone Mass Measurement
- Certain clinical trials
- Cervical cancer screening
- Colorectal cancer screening
- Congenital defects and anomalies
- Diabetes
- Emergency Services
- Hearing Aids
- Inpatient stays following a delivery of a baby
- Lymphedema
- Mammogram screening
- Mental Illness
- Newborn hearing screening
- Off label Prescription Drugs
- Ovarian cancer surveillance tests
- Prescription Drug Contraceptives or Devices
- Procedures involving any bone or joint of the jaw, face or head
- Prostate cancer screening
- Reconstructive breast surgery following a mastectomy

TTY: **711**

[illegible]

|            |                                                                                                           |
|------------|-----------------------------------------------------------------------------------------------------------|
| Ukrainian  | Щоб безкоштовні отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікаційній картці. |
| Vietnamese | Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý              |

# Aetna Life Insurance Company



## **Notice Concerning Coverage Limitations And Exclusions Under The North Carolina Life And Health Insurance Guaranty Association Act**

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies and Health Maintenance Organizations (HMOs) licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association  
4441 Six Forks Rd. Ste. 106-153  
Raleigh, North Carolina 27609-5729  
<https://www.nclifega.org>

North Carolina Department of Insurance, Consumer Services Division  
1201 Mail Service Center  
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.



## **COVERAGE**

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## **EXCLUSIONS FROM COVERAGE**

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange;
- They acquired rights to receive payments through a structured settlement factoring transactions.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered;
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

## **LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the association is obligated to pay out as follows:

- (1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
- (2) Except as provided in (3) (4) and (5) below, the guaranty association will pay a maximum of \$300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
- (3) The guaranty association will pay a maximum of \$500,000 with respect to a health benefit plan.
- (4) The guaranty association will pay a maximum of \$1,000,000 with respect to the payee of a structured settlement annuity.
- (5) The guaranty association will pay a maximum of \$5,000,000 to any one unallocated annuity contract holder.