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Aetna Student Health

Plan Design and Benefits Summary

Preferred Provider Organization (PPO)

Missouri University of Science & Technology - International Students

Policy Year: 2019 – 2020
Policy Number: 890441
www.aetnastudenthealth.com
(877) 375-7905

Special Missouri Notice

An enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical or religious beliefs.

Your group contract holder has not purchased an optional rider for elective abortions pursuant to VAMS section 376.805.

This is a brief description of the Student Health Plan. The Plan is available for University of Missouri System students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate of Coverage issued to you and may be viewed online at **www.aetnastudenthealth.com.** If there is a difference between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

Coverage Periods

Students: Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
Annual	**08/01/2019**	**07/31/2020**	**09/06/2019**
Fall	**08/01/2019**	**12/31/2019**	**09/06/2019**
Spring/Summer	**01/01/2020**	**07/31/2020**	**02/07/2020**
Summer	**06/01/2020**	**07/31/2020**	**06/05/2020**

Eligible Dependents: Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
Annual	**08/01/2019**	**07/31/2020**	**09/06/2019**
Fall	**08/01/2019**	**12/31/2019**	**09/06/2019**
Spring/Summer	**01/01/2020**	**07/31/2020**	**02/07/2020**
Summer	**06/01/2020**	**07/31/2020**	**06/05/2020**

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna) as well as the Missouri University of Science & Technology administrative fee.

Premium Rates				
Coverage Period	**Annual**	**Fall**	**Spring/Summer**	**Summer**
Student	**$2,065**	**$863**	**$1,202**	**$344**
Student & Spouse	**$4,130**	**$1,726**	**$2,404**	**$688**
Student & Child(ren)	**$4,130**	**$1,726**	**$2,404**	**$688**
Student, Spouse & Child(ren)	**$6,195**	**$2,589**	**$3,606**	**$1,032**

Student Coverage

Eligibility

All international students, scholars, Optional Practical Training (OPT) / Academic Training (AT) participants holding F or J visas who are engaged in international education or research activities outside their home country or country of regular domicile as non-resident aliens and who have not been awarded permanent residency are eligible for this coverage.

Distance learning students taking home study, correspondence or television courses are not eligible to enroll in the Plan.

If you withdraw from school within the first 31 days of a coverage period, you will not be covered under the Policy and the full premium will be refunded. After 31 days, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Enrollment

All F-1 students and J-1 visa students will be automatically enrolled in the mandatory health insurance provided through the University of Missouri. For academically enrolled students, charges for each insurance enrollment term will be applied to your student account. For students at the Applied Language Institute, payment is required at the beginning of each insurance term.

J-1 visa students whose spouse and/or children are living in the United States are required to carry health insurance for their dependents as well.

If you are participating as a research scholar or are on an OPT/AT you will enroll by completing enrollment forms located in the Office of International Affairs and providing a credit card number for payment.

Dependent Coverage

Eligibility

Covered students or research scholars may also enroll their lawful spouse and/or dependent children up to the age of 26.

Enrollment

To enroll a dependent(s) of a covered student or research scholar, please complete the Enrollment Form from the International Affairs Office or enroll online by visiting **www.aetnastudenthealth.com,** choose Missouri University of Science & Technology , click on View Your School and click on the Enroll link on the left hand side of the screen to complete the appropriate application.

Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan). The completed Enrollment Form and premium must be sent to Aetna Student Health. Please contact the Office of International Affairs at **(573) 341-6875** or customer service at **(877) 375-7905** to request an Enrollment Form.

Important note regarding coverage for a newborn infant or newly adopted child:
Your newborn child is covered on your health plan for the first 31 days from the moment of birth.

- To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31 day period.
- You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
- If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- When you tell us of the newborn's birth, we will send you the forms and instructions to enroll your newborn. We will also give you an additional ten (10) days from the date we provide these forms to enroll your newborn child. Your newborn will be covered for treatment of injury or illness, including medically diagnosed congenital defects and birth abnormalities.
- If your coverage ends during this 31 day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

A child that you, or that you and your spouse, civil union partner or domestic partner adopts or is placed with you for adoption, is covered on your plan for the first 31 days from the date of birth or the date of placement in your home, if a petition for adoption is filed within 30 days of the date of birth, or within 30 days from the date of placement in your home. The child will continue to be considered adopted unless she or he is removed from your home prior to issuance of a legal decree of adoption. Placement means "in the physical custody of the adoptive parent." Coverage includes the necessary care and treatment of medical conditions existing prior to the date of placement.

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

If you need information or have general questions on dependent enrollment, call Member Services at **(877) 375-7905**.

Medicare Eligibility Notice

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.

In-network Provider Network

Aetna Student Health offers Aetna’s broad network of In-network Providers. You can save money by seeing In-network Providers because Aetna has negotiated special rates with them, and because the Plan’s benefits are better.

If you need care that is covered under the Plan but not available from an In-network Provider, contact Member Services for assistance at the toll-free number on the back of your ID card. In this situation, Aetna may issue a pre-approval for you to receive the care from an Out-of-network Provider. When a pre-approval is issued by Aetna, the benefit level is the same as for In-network Providers.

Precertification

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

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 additional details on requirements in the Certificate of Coverage.

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

Aetna will not retroactively reduce or terminate a previously approved service or supply unless:

- Such authorization is based on a material misrepresentation or omission about the treated or cause of the health condition or
- The plan terminated before services are provided; or
- Coverage terminated before the services were provided.

Precertification call

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

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

Access to Obstetrical and Gynecological (Ob/Gyn) Care

You do not need pre-certification from Aetna or from any other person (including a Primary Care Provider) in order to obtain access or make an appointment to receive obstetrical or gynecological care from a health care professional in Aetna's Network who specializes in obstetrics or gynecology. The health care professional, however, may recommend certain elective medical procedures that may require pre-certification. Preventive care services do not require pre-certification.

Please see the "Pre-certification" provision in the Certificate of Coverage for a list of services under the Plan that require pre-certification. Please see the Schedule of Benefits for any penalty or benefit reduction that may apply to your coverage when pre-certification is not obtained for the listed services or supplies when received from a non-preferred care provider.

We will provide a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 30 days as long as you remain enrolled in the plan.

If you require an extension to the services that have been 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.

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

What if you don't obtain the required precertification?

If you don't obtain the required precertification:

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

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

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

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

Coordination of Benefits (COB)

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

Here's how COB works

- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid
- We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable submitted expenses

For more information about the Coordination of Benefits provision, including determining which plan is primary and which is secondary, you may call the Member Services telephone number shown on your ID card. A complete description of the Coordination of Benefits provision is contained in the Policy issued to The University of Missouri System and may be viewed online at **www.aetnastudenthealth.com**.

Missouri University of Science & Technology – Student Health Services (SHS)

The Missouri University of Science & Technology Student Health Services (SHS) is the University's campus health facility located at 910 W. 10th Street, just 2 blocks west of the Student Design Center. Student Health is primarily a walk-in, acute care clinic with short wait times. Student Health does not replace your primary care or specialist provider, but can assist in care while you are a student on the S&T campus. The student health fee covers your visits to SHS but is not insurance. Out-of-pocket costs are generally low for medications, labs, procedures, and xrays. Student Health does not bill your Aetna insurance but can assist you should you need to use it to see an outside provider/specialist or need other imaging modalities. Please refer to our website for details regarding our services:
https://studenthealth.mst.edu/ourservices/

Description of Benefits

The Plan excludes coverage for certain services (referred to as exceptions in the certificate of coverage) and has limitations on the amounts it will pay. While this Plan Design and Benefit Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Certificate of Coverage issued to you, go to **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

This Plan will pay benefits in accordance with any applicable Missouri Insurance Law(s).

Metallic Level: Gold, tested at 81.90%

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

Policy year deductible	In-network coverage	Out-of-network coverage
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$400 per policy year	$800 per policy year
Spouse	$400 per policy year	$800 per policy year
Each child	$400 per policy year	$800 per policy year
Family	None	None
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network care for Preventive care and wellness, Family planning services - female contraceptives, and Pediatric Dental Services. • In-network care and out-of-network care for immunizations for children under five years of age, Prescribed Medicines Expense, and Pediatric Vision Services.		

Maximum out-of-pocket limits **Maximum out-of-pocket limit per policy year**		
Student	$6,350 per policy year	None
Spouse	$6,350 per policy year	None
Each child	$6,350 per policy year	None
Family	$12,700 per policy year	None

Precertification covered benefit penalty
This only applies to out-of-network coverage: The certificate of coverage contains a complete description of the precertification program. You will find details on precertification requirements in the *Medical necessity and precertification requirements* section. Failure to precertify your eligible health services when required will result in the following benefit penalties: • A **$500** benefit penalty will be applied separately to each type of eligible health services. The additional percentage or dollar amount of the recognized charge which you may pay as a penalty for failure to obtain precertification is not a covered benefit and will not be applied to the policy year deductible amount or the maximum out-of-pocket limit, if any.

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

Eligible health services	**In-network coverage**	**Out-of-network coverage**
Preventive care and wellness		
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Covered persons through age 21: Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna secure website at **www.aetnastudenthealth.com** or calling the toll-free number on your ID card.	
Covered persons age 22 and over: Maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care and wellness (continued)		
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit Covered 100% for children up to 5 years of age. Deductible & coinsurance applies thereafter.
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician or Member Services by logging onto your Aetna secure website at **www.aetnastudenthealth.com** or calling the toll-free number on your ID card.	
Child health supervision services		
	Covered according to the type of benefit incurred and the place where the service is received	Covered according to the type of benefit incurred and the place where the service is received
Well baby/child exams		
Limited to: Covered persons through age 22	Covered according to the type of benefit incurred and the place where the service is received	Covered according to the type of benefit incurred and the place where the service is received
Maximum visits per policy year	• Limited to 7 exams in the first 12 months • Limited to 3 exams in the second 12 months • Limited to 3 exams in the third 12 months Limited to 1 exam thereafter per policy year benefit maximum	
Early intervention for infants and toddlers (First Steps)		
Early intervention services office visit for children from birth to age 3	Covered according to the type of benefit incurred and the place where the service is received	Covered according to the type of benefit incurred and the place where the service is received
Well woman preventive visits **Routine gynecological exams (including Pap smears)**		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Maximum visits per policy year	1 visits	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care and wellness (continued)		
Preventive screening and counseling services		
Obesity and/or healthy diet counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Maximum visits per policy year (This maximum applies only to covered persons age 22 and older.)	26 visits. However, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.	
Misuse of alcohol and/or drugs counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Maximum visits per policy year	5 visits	
Use of tobacco products counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Maximum visits per policy year	8 visits	
Depression screening counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
Sexually transmitted infection counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Age and frequency limitations	Not subject to any age or frequency limitations	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services (continued)		
Lead poisoning screening	Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Routine cancer screenings performed at a physician's office, specialist's office or facility		
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging onto your Aetna secure website at **www.aetnastudenthealth.com** or calling the toll-free number on your ID card.	
Mammogram maximums	Age 35 and older; subject to any family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force and • The comprehensive guidelines supported by the Health Resources and Services Administration; or • State law (where stricter). For details, contact your physician or Member Services by logging onto your Aetna secure member website at **www.aetnastudenthealth.com** or calling the toll-free number on your ID card in the *How to contact us for help* section.	
Lung cancer screening maximums	1 screening every 12 months*	
***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		

Eligible health services	In-network coverage	Out-of-network coverage
Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
Preventive care services only	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Important note: You should review the *Maternity care and Well newborn nursery care* sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services - facility or office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Important note: Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section.		
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	70% (of the recognized charge) per item
Family planning services –contraceptives		
Contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	
Contraceptives (prescription drugs and devices)		
Contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	70% (of the recognized charge) per item

Eligible health services	In-network coverage	Out-of-network coverage
Family planning services (continued)		
Voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	70% (of the recognized charge)
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Physicians and other health professionals		
Physician and specialist services		
Office hours visits (non-surgical and non-preventive care by a physician and specialist) Includes telemedicine consultations	$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Allergy injections treatment performed at a physician's, or specialist office	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Allergy sera and extracts administered via injection at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Physician and specialist - inpatient surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon	80% (of the negotiated charge)	50% (of the recognized charge)
Anesthetist	80% (of the negotiated charge)	50% (of the recognized charge)
Surgical assistant	80% (of the negotiated charge)	50% (of the recognized charge)

Eligible health services	In-network coverage	Out-of-network coverage
Physician and specialist - outpatient surgical services		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Anesthetist	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Surgical assistant	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
In-hospital non-surgical physician services		
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Consultant services (non-surgical and non-preventive)		
Office hours visits (non-surgical and non-preventive care) (includes telemedicine consultations)	$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
Second surgical opinion	Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Second opinion - cancer		
Second opinion - cancer	Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes **intensive** care For physician charges, refer to the *Physician and specialist – inpatient surgical services* benefit	$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission	50% (of the recognized charge) per admission
Preadmission testing	Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Alternatives to hospital stays		
Outpatient surgery (facility charges)		
Facility charges for surgery performed in the outpatient department of a hospital or surgery center For physician charges, refer to the *Physician and specialist - outpatient surgical services* benefit	80% (of the negotiated charge)	50% (of the recognized charge)
Home health care		
Outpatient	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Outpatient private duty nursing	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Hospice care		
Inpatient facility (room and board and other miscellaneous services and supplies)	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Outpatient	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Skilled nursing facility		
Inpatient facility (room and board and miscellaneous inpatient care services and supplies) Subject to semi-private room rate unless intensive care unit is required Room and board includes intensive care	$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission	50% (of the recognized charge) per admission
Emergency services and urgent care		
Emergency services		
Hospital emergency room	$100 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered

Important note:

- As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply.
- Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance.
- Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you.
- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.

Eligible health services	In-network coverage	Out-of-network coverage
Urgent care		
Urgent medical care provided by an urgent care provider	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Non-urgent use of urgent care provider	Not covered	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	70% (of the recognized charge) per visit
Type B services	70% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Dental emergency treatment	Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Specific conditions		
Birthing center (facility charges)		
Inpatient (room and board and other miscellaneous services and supplies)	Paid at the same cost-sharing as hospital care.	Paid at the same cost-sharing as hospital care.
Diabetic services and supplies (including equipment and training)		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred

Eligible health services	In-network coverage	Out-of-network coverage
Impacted wisdom teeth		
Impacted wisdom teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Accidental injury to sound natural teeth		
Accidental injury to sound natural teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Anesthesia and related facility charges fora dental procedure		
Anesthesia and related facility charges for a dental procedure	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Anesthesia and hospital charges for dental care		
Anesthesia and hospital charges for dental care	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment		
TMJ and **CMJ** treatment	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Dermatological treatment		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Maternity care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred

Eligible health services	In-network coverage	Out-of-network coverage
Maternity care (continued)		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	50% (of the recognized charge) No policy year deductible applies
Note: *The per admission copayment amount and/or policy year deductible for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.*		
Pregnancy complications		
Inpatient (room and board and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive careunit required Room and board includes intensive care	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Family planning services – other		
Voluntary sterilization for males Inpatient physician or specialist surgical services	100% (of the negotiated charge) No policy year deductible applies	70% (of the recognized charge)
Voluntary sterilization for males Outpatient physician or specialist surgical services	100% (of the negotiated charge) No policy year deductible applies	70% (of the recognized charge)
Gender Reassignment (Sex Change) Treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Autism spectrum disorder		
Autism spectrum disorder diagnosis and testing	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Autism spectrum disorder treatment (includes physician and specialist office visits, diagnosis and testing)	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred

Eligible health services	In-network coverage	Out-of-network coverage
Autism spectrum disorder (continued)		
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder The copayment or coinsurance for any physical therapy and occupational therapy services under this benefit will be no greater than a physician's office visit copay	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred
Mental health treatment		
Mental health treatment – inpatient		
Inpatient hospital mental disorders treatment (room and board and other miscellaneous hospital services and supplies) Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Mental disorder room and board intensive care	$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission	50% (of the recognized charge) per admission
Mental health treatment - outpatient		
Outpatient mental disorders treatment office visits to a physician or behavioral health provider (includes telemedicine consultations)	$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
Other outpatient mental disorders treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive Outpatient Program	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Substance abuse related disorders treatment-inpatient		
Inpatient hospital substance abuse detoxification (room and board and other miscellaneous hospital services and supplies) Inpatient hospital substance abuse rehabilitation (room and board and other miscellaneous hospital services and supplies) Inpatient residential treatment facility substance abuse (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Substance abuse room and board intensive care	$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission	50% (of the recognized charge) per admission
Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation		
Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine consultations)	$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
Other outpatient substance abuse services Partial hospitalization treatment Intensive Outpatient Program	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Reconstructive surgery and supplies		
Reconstructive surgery and supplies (includes reconstructive breast surgery)	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred

Eligible health services	In-network coverage (IOE facility)	In-network coverage (Non-IOE facility)	Out-of-network coverage
Transplant services			
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.
Maximum Benefit for donor searches for bone marrow/ stem cell transplants for a covered Transplant procedure	$30,000 per transplant		
Maximum Benefit for Dose intensive chemotherapy/autologous bone marrow transplants for stem cell transplants for breast cancer treatment incurred while covered under any Aetna or Aetna-affiliated plan:	$100,000 per transplant		
Human Leukocyte Antigen Testing for A, B and DR Antigens:	Covered according to the type of benefit incurred and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.		

Eligible health services	In-network coverage	Out-of-network coverage
Treatment of infertility		
Basic infertility services Inpatient and outpatient care - basic infertility	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.
Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge)	50% (of the recognized charge)
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge)	50% (of the recognized charge)
Chemotherapy		
Chemotherapy **Important Note:** Coverage for orally administered anti-cancer medication will be provided under the same terms and conditions as intravenously administered or injected anti-cancer medication.	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Outpatient infusion therapy		
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.
Outpatient radiation therapy		
Outpatient radiation therapy	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Outpatient respiratory therapy		
Respiratory therapy	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Transfusion or kidney dialysis of blood		
Transfusion or kidney dialysis of blood	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.
Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Pulmonary rehabilitation	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Short-term rehabilitation and habilitation therapy services		
Outpatient physical, occupational, speech, and cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services The copayment or coinsurance for any physical therapy and occupational therapy services will be no greater than a physician's office visit copay	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Maximum visits per policy year	Unlimited	
Chiropractic Care		
Chiropractic Treatment	80% per visit	50% per visit
Speech and hearing disorders		
Speech and hearing disorders	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.
Diagnostic testing for learning disabilities		
Diagnostic testing for learning disabilities	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.

Eligible health services	In-network coverage	Out-of-network coverage
Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit or the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.
Other services and supplies		
Acupuncture in lieu of anesthesia	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.
Emergency ground, air, and water ambulance	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.
Cancer clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.
Durable medical equipment	80% (of the negotiated charge) per item	50% (of the recognized charge) per item

Eligible health services	In-network coverage	Out-of-network coverage
Other services and supplies (continued)		
Enteral formulas and nutritional supplements	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
Osteoporosis (non-preventive care)	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.
Prosthetic devices		
Prosthetic devices	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
Cochlear implants	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
Hearing aids and exams		
Hearing aid exams	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Hearing aid exam maximum	One hearing exam every policy year	
Hearing aids	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
Hearing aids maximum per ear	One hearing aid per ear every policy year	
Podiatric (foot care) treatment		
Physician and Specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.

Eligible health services	In-network coverage	Out-of-network coverage
Vision care		
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year	1 visit	
Pediatric comprehensive low vision evaluations		
Performed by a legally qualified ophthalmologist or optometrist	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.	Covered according to the type of benefit and the place where the service is received. Refer to the specific cost-sharing in this schedule of benefits that applies to the type of expense that you incurred.
Maximum	One comprehensive low vision evaluation every policy year	
Pediatric vision care services and supplies		
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	70% (of the recognized charge) per item No policy year deductible applies
Maximum number of eyeglass frames per policy year	One set of eyeglass frames	
Maximum number of prescription lenses per policy year	One pair of prescription lenses	
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year	1 visit	
Optical devices	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maximum number of optical devices per policy year	One optical device	
***Important note**: Refer to the 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.		

Outpatient prescription drugs

Outpatient prescription drug copayment waiver for risk reducing breast cancer

The outpatient prescription drug copayment will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.

Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs

The outpatient 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 outpatient prescription drug copayment will apply after those two regimens per policy year have been exhausted.

Outpatient prescription drug copayment waiver for contraceptives

The outpatient 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 drug or device for that method paid at 100%.

The outpatient prescription drug copayment will 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.

Eligible health services	In-network coverage	Out-of-network coverage
Preferred generic prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$15 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered

Eligible health services	In-network coverage	Out-of-network coverage
Preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$35 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$35 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$70 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Non-preferred generic prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Non-preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a retail pharmacy For each 30-day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure website at **www.aetnastudenthealth.com** or calling the toll-free number on the back of your ID card.	
Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30-day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure website at **www.aetnastudenthealth.com** or calling the toll-free number on the back of your ID card.	
Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30-day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna secure website at **www.aetnastudenthealth.com** or calling the toll-free number on the back of your ID card.	
Tobacco cessation prescription drugs and over-the-counter drugs ***(Other than preventive care)***		
For each fill up to a 30-day supply filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug.

The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:

CVS Health
ATTN: Aetna PA
1300 E Campbell Road
Richardson, TX 75081

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

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

In this section we tell you about the exceptions and exclusions that apply to your plan.

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

General exceptions and exclusions

Acupuncture therapy

- Maintenance treatment
- Acupuncture when provided for the following conditions:
  - Acute low back pain
  - Addiction
  - AIDS
  - Amblyopia
  - Allergic rehinitis
  - Asthma
  - Autism spectrum disorders
  - Bell's Palsy
  - Burning mouth syndrome
  - Cancer-related dyspnea
  - Carpal tunnel syndrome
  - Chemotherapy-induced leukopenia
  - Chemotherapy-induced neuopathic pain
  - Chronic pain syndrome (e.g., RSD, facial pain)
  - Chronic obstructive pulmonary disease
  - Diabetic peripheral neuropathy
  - Dry eyes
  - Erectile dysfunction
  - Facial spasm

- Fetal breech presentation
- Fibromyalgia
- Fibrotic contractures
- Glaucoma
- Hypertension
- Induction of labor
- Infertility(e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
- Insomnia
- Irritable bowel syndrome
- Menstrual cramps/dysmenorrhea
- Mumps
- Myofascial pain
- Myopia
- Neck pain/cervical spondylosis
- Obesity
- Painful neuropathies
- Parkinson's disease
- Peripheral arterial disease (e.g., intermittent claudication)
- Phantom leg pain
- Polycystic ovary syndrome
- Post-herpetic neuralgia
- Psoriasis
- Psychiatric disorders (e.g., depression)
- Raynaud's disease pain
- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

Air or space travel

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

This exclusion does not apply if:

- You are traveling solely as a fare-paying passenger
- You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
- You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
  - o The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved

- o You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the policyholder performing duties for the policyholder

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

Ambulance services
- Non-emergency transport by fixed wing air ambulance
- Non-emergency ambulance transports

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

Artificial organs
- Any device that would perform the function of a body organ.

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

Blood and body fluid exposure
- Services and supplies provided for the treatment of an illness that results from your clinical related injury as these are covered elsewhere in the student policy

Blood, blood plasma, synthetic blood, blood derivatives or substitutes except as specifically provided in the *Eligible health services under your plan* section.
Examples of these are:
- The provision of blood to the hospital, other than blood derived clotting factors
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered

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

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

Clinical trial therapies (routine patient costs)
- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)
- In-network coverage limited to benefits for routine patient services provided within the network

Cartilage transplants
- Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

Cornea or cartilage transplants
- Cornea (corneal graft with amniotic membrane)
- Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

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

Counseling
- Marriage, religious, family, career, social adjustment, pastoral, or financial counseling

Court-ordered services and supplies
- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

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

Dermatological treatment
- Cosmetic treatment and procedures

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

- Prosthetic restoration of dental implants
- Dental implants

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

Durable medical equipment (DME)

Examples of these items are:

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

Early intensive behavioral interventions

Examples of these services are:

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

Educational services

Examples of these services are:

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

Elective treatment or elective surgery

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

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Emergency services and urgent care

- Non-emergency services in a hospital emergency room facility
- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

Facility charges

For care, services or supplies provided in:

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

Family planning services - other

- Voluntary termination of pregnancy
- Reversal of voluntary sterilization procedures, including related follow-up care
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

Felony

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

Foot care

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

Gender reassignment (sex change) treatment

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

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

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

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

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

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

Incidental surgeries
- Charges made by a physician for incidental surgeries

These are non-medically necessary surgeries performed during the same procedure as a medically necessary surgery.

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

Mandatory no-fault laws

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

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 and Autism Spectrum Disorder. See the *Eligible health services under your plan – Habilitation therapy services* and the *Eligible health services under your plan – Autism Spectrum Disorders* section

Maternity and related prenatal care

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Medical supplies – outpatient disposable

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

Medicare

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

Mental health treatment

- Mental health services conditions that are not included in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders
- School and/or education service including special educational, remedial education, wilderness treatment programs, or any such related or similar programs
- Mental health services provided in conjunction with school, vocation, work or recreational activities

Motor vehicle accidents

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

Non-medically necessary services and supplies

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

Nutritional supplements

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

Obesity (bariatric) surgery and weight management

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Eligible health services under your plan – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
  - Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Oral and maxillofacial treatment (mouth, jaws and teeth)

- Dental implants

Organ removal

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

Other primary payer

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

Outpatient infusion therapy

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

Outpatient prescription or non-prescription drugs and medicines

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

Outpatient surgery and physician surgical services

- A stay in a hospital (Hospital stays are covered in the *Eligible health services under your plan – 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

Pediatric dental care

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *Eligible health services under your plan* 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 or
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces that are determined not to be medically necessary mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services under your plan – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in the *Eligible health services under your plan – Pediatric dental care* section
- 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 *Eligible health services under your plan – Pediatric dental care* section
- 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

Personal care, comfort or convenience items

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

Preventive care and wellness

- Services for diagnosis or treatment of a suspected or identified illness or injury
- Exams given during your stay for medical care
- Services not given by a physician or under his or her direction
- Psychiatric, psychological, personality or emotional testing or exams
- Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods or devices
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Female voluntary sterilization procedures that were not billed separately by the provider or were not the primary purpose of a confinement

Prosthetic devices

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

Riot

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

Routine exams

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

Services provided by a family member

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

Sexual dysfunction and enhancement

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

Sinus surgery

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

Sleep apnea

- Any services or supplies given by providers for the treatment of obstructive sleep apnea and sleep disorders

Specialty prescription drugs

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

Sports

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

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for the purpose of enhancing 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 given by providers that are not contracted with Aetna as telemedicine providers
- Services given when you are not present at the same time as the provider
- Services including:
  - Telephone calls for behavioral health services
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

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

Tobacco cessation

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

Transplant services
- 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

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 a proper claim is submitted by the hospital or other facility and such benefits have not already been paid directly to you prior to Aetna's receipt of a proper claim from the hospital or facility

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

Vision Care
Pediatric vision care services and supplies
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

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

Adult vision care services and supplies
Your plan does not cover adult vision care services and supplies, except as described in the *Eligible health services under your plan – Other services* section.
- Special supplies such as non-prescription sunglasses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a hospital or other facility for health care
- Eye exams for contact lenses or their fitting

- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Wilderness Treatment Programs
- Wilderness treatment programs (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)

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

Exceptions and exclusions that apply to outpatient prescription drugs

Abortion drugs

Any services related to the dispensing, injection or application of a drug

Biological sera

Compounded prescriptions
- Compound prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones

Cosmetic drugs
- Medications or preparations used for cosmetic purposes

Devices, products and appliances, except those that are specially covered

Dietary supplements including medical foods

Drugs or medications
- Administered or entirely consumed at the time and place it is prescribed or dispensed
- Which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
- That is therapeutically equivalent or therapeutically alternative to a covered outpatient prescription drug (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved)
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan while an inpatient of a healthcare facility
- Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by Aetna's Pharmacy and Therapeutics Committee

- That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the share or appearance of a sex organ
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies

Duplicative drug therapy (e.g. two antihistamine drugs)

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

Immunizations related to work

Immunization agents

Implantable drugs and associated devices except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* sections.

Infertility
- Injectable prescription drugs used primarily for the treatment of infertility.

Injectables
- Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us
- Needles and syringes, except for those used for self-administration of an injectable drug
- 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. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as specifically provided in the *Eligible health services under your plan – Diabetic equipment, supplies and education* section.

Prescription drugs:
- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this rider.
- Dispensed by a mail order pharmacy that include prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the preferred drug guide.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not medically necessary, or otherwise improper, and drugs obtained for use by anyone other than the person identified on the ID card.

Refills

- Refills dispensed more than one year from the date the latest prescription order was written.

Replacement of lost or stolen prescriptions

Test agents except diabetic test agents

Tobacco cessation

- Tobacco cessation products unless recommended by the United States Preventive Services Task Force (USPSTF)

We reserve the right to exclude:

- A manufacturer's product when a same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the preferred drug guide.
- Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our preferred drug guide.

The University of Missouri System Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

Sanctioned Countries

If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license. For more information, visit **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), **CRCoordinator@aetna.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their aff

TTY: 711

To access language services at no cost to you, call 1-877-375-7905 .

Para acceder a los servicios de idiomas sin costo, llame al 1-877-375-7905. (Spanish)

如欲使用免費語言服務，請致電 1-877-375-7905 。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-877-375-7905 . (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-375-7905 . (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-375-7905 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-375-7905 . (Arabic)

Pou jwenn sèvis lang gratis, rele 1-877-375-7905 . (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-375-7905. (Italian)

言語サービスを無料でご利用いただくには、1-877-375-7905 までお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 1-877-375-7905 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-375-7905 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-375-7905. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-375-7905. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-375-7905 . (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-375-7905 . (Vietnamese)