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Aetna Student Health
Plan Design and Benefits Summary

Missouri University of Science & Technology - Domestic Students

Policy Year: 2017 - 2018
Policy Number: 890430
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 governing this insurance, including definitions, are contained in the Master Policy issued to the University of Missouri System and may be viewed online at **www.aetnastudenthealth.com**. If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits.

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	**08/15/2017**	**08/14/2018**	**09/08/2017**
Fall	**08/15/2017**	**01/09/2018**	**09/08/2017**
Spring/Summer	**01/10/2018**	**08/14/2018**	**02/09/2018**
Summer	**06/01/2018**	**08/14/2018**	**06/08/2018**

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	**08/15/2017**	**08/14/2018**	**09/08/2017**
Fall	**08/15/2017**	**01/09/2018**	**09/08/2017**
Spring/Summer	**01/10/2018**	**08/14/2018**	**02/09/2018**
Summer	**06/01/2018**	**08/14/2018**	**06/08/2018**

Rates

Premium Rates				
Coverage Period	Annual	Fall	Spring/Summer	Summer
Student	**$2,907**	**$1,179**	**$1,728**	**$597**
Student & Spouse	**$5,814**	**$2,358**	**$3,456**	**$1,194**
Student & Child(ren)	**$5,814**	**$2,358**	**$3,456**	**$1,194**
Student, Spouse & Child(ren)	**$8,721**	**$3,537**	**$5,184**	**$1,791**

Student Coverage

Eligibility

All registered students taking credit hours including graduate students and graduate students holding assistantships are eligible to enroll in the Plan. Online degree-seeking students are also eligible to enroll in the Plan.

Distance learning students taking home study, correspondence or television courses are not eligible to enroll in the Plan. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

Enrollment

Students can enroll online at **www.aetnastudenthealth.com/mst** and click on the Enroll: Student Health Insurance Plan link in the center or to right of the Welcome page to complete the appropriate application.

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 the dependent(s) of a covered student, please complete the Enrollment Form by visiting **www.aetnastudenthealth.com/mst** and click on the Enroll: Student Health Insurance Plan link in the center or to right of the Welcome page. 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 customer service at **(877) 375-7905** to request an Enrollment Form.

Medicare Eligibility

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

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

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

Preferred Provider Network

Aetna Student Health offers Aetna's broad network of Preferred Providers. You can save money by seeing Preferred 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 a Preferred 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 a Non- Preferred Provider. When a pre-approval is issued by Aetna, the benefit level is the same as for Preferred Providers.

Pre-certification Program

Some services have to be pre-certified by Aetna beforehand if you want the Plan to cover them. Preferred Providers are responsible for requesting pre-certification for their services. You are responsible for requesting pre-certification if you seek care from a Non-Preferred Provider for any of the services listed in the Schedule of Benefits section of the Certificate.

If you want the Plan to cover a service from a Non-Preferred Provider that requires pre-certification, you must call Aetna at the number on your ID card. After Aetna receives a request for pre-certification, we will review the reasons for your planned treatment and determine if benefits are available.

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.

If you do not secure pre-certification for the below listed inpatient covered medical services and supplies obtained from a non-preferred provider your covered medical expenses will be subject to a **$500** per service, treatment, procedure, visit, or supply benefit reduction.

Pre-certification for the following inpatient services or supplies is needed:

- All inpatient maternity and newborn care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- Inpatient Confinements (surgical and non-surgical); hospital, skilled nursing facility, rehabilitation facility, residential treatment facility for mental disorders and substance abuse, hospice care;
- Inpatient mental disorders treatment;
- Inpatient substance abuse treatment.

Pre-certification DOES NOT guarantee the payment of benefits for your inpatient stays

Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Certificate of Coverage. The Certificate of Coverage also includes information regarding your eligibility criteria, notification guidelines, and benefit coverage.

Pre-certification of non-emergency admissions

Non-emergency admissions must be requested at least **fifteen (15) days** prior to the date they are scheduled to be admitted.

Pre-certification of immediate post-stabilization or post-evaluation admission after receiving emergency services

Emergency admissions must be requested within **twenty-four (24) hours** or as soon as reasonably possible after the admission.

Aetna will notify you of an emergency care claim authorization decision for immediate post-evaluation or post-stabilization services as soon as possible, but not later than 60 minutes of receiving a request. If the authorization is not made within 30 minutes, such services will be deemed approved.

Pre-certification of urgent admissions

Urgent admissions must be requested before you are scheduled to be admitted.

Pre-certification of prenatal care and delivery

Prenatal care medical services must be requested as soon as possible after the attending physician confirms pregnancy. Delivery medical services, which exceed the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery, must be requested within **twenty-four (24) hours** of the birth or as soon thereafter as possible.

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.

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

The student health insurance plan is designed to work with your campus student health center. Out-of-pocket costs are generally lower at the student health center and the location is ideal for students to seek care.

The Missouri University of Science & Technology Student Health Services (SHS) is the University's on campus health facility. The SHS is committed to providing quality health care for all students. The SHS offers services such as medical care and counseling services and other wellness services and it's all in the Student Health Complex.

Here are some of the services offered:

- Shots (immunizations)
- Physicals
- Well woman exams
- Counseling Services
- Sick visits

Call **(573) 341-4284** to set up an appointment.

Description of Benefits

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. While this Plan Design and Benefits 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 Master Policy issued to University of Missouri System, you may access it online at **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits. All coverage is based on Recognized Charges unless otherwise specified.

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

Metallic Level: Gold, Tested at 81.07%

DEDUCTIBLE	Preferred Care and Non-Preferred Care	
The policy year deductible is waived for Preferred Care covered medical expenses that apply to Preventive Care Expense benefits. In compliance with Missouri state mandate(s) the policy year deductible is also waived for: • Immunizations for children under five years of age. Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible. ***Annual Deductible does not apply to these services**	Individual: $300 per Policy Year	
COINSURANCE	**Preferred Care**	**Non-Preferred Care**
Coinsurance is both the percentage of covered medical expenses that the plan pays, and the percentage of covered medical expenses that you pay. The percentage that the plan pays is referred to as "plan coinsurance" or the "payment percentage," and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.	Covered Medical Expenses are payable at the plan coinsurance percentage specified below, after any applicable Deductible.	

OUT-OF-POCKET MAXIMUMS	Preferred Care	Non-Preferred Care
Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year. The following expenses do not apply toward meeting the plan's preferred and non-preferred care out-of-pocket limits: • Non-covered medical expenses; and • Expenses that are not paid or pre-certification benefit reductions or penalties because a required pre-certification for the service(s) or supply was not obtained from Aetna.	Individual Out-of-Pocket: $6,350 per Policy Year Family Out-of-Pocket: $12,700 per Policy Year	Individual Out-of-Pocket: N/A Family Out-of-Pocket: N/A
INPATIENT HOSPITALIZATION BENEFITS	**Preferred Care**	**Non-Preferred Care**
Room and Board Expense The covered room and board expense does not include any charge in excess of the daily room and board maximum.	After a $200 Copay per admission, 80% of the Negotiated Charge	50% of the Recognized Charge for a semi-private room
Intensive Care The covered room and board expense does not include any charge in excess of the daily room and board maximum.	After a $200 Copay per admission, 80% of the Negotiated Charge	50% of the Recognized Charge
Miscellaneous Hospital Expense Includes but not limited to: operating room, laboratory tests/X rays, oxygen tent, drugs, medicines and dressings.	80% of the Negotiated Charge	50% of the Recognized Charge
Licensed Nurse Expense Includes charges incurred by a covered person who is confined in a hospital as a resident bed patient and requires the services of a registered nurse or licensed practical nurse.	80% of the Negotiated Charge	50% of the Recognized Charge
Well Newborn Nursery Care	80% of the Negotiated Charge*	50% of the Recognized Charge*
Non-Surgical Physicians Expense Includes hospital charges incurred by a covered person who is confined as an inpatient in a hospital for a surgical procedure for the services of a physician who is not the physician who may have performed surgery on the covered person.	80% of the Negotiated Charge	50% of the Recognized Charge
SURGICAL EXPENSES	**Preferred Care**	**Non-Preferred Care**
Surgical Expense (Inpatient and Outpatient) When injury or sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, covered medical expenses only include expenses incurred for the most expensive procedure.	80% of the Negotiated Charge	50% of the Recognized Charge
Anesthesia Expense (Inpatient and Outpatient) If, in connection with such operation, the covered person requires the services of an anesthetist who is not employed or retained by the hospital in which the operation is performed, the expenses incurred will be Covered Medical Expenses. Includes anesthesia for certain dental services listed under the Anesthesia and Hospital Charges for Dental Care section of the Certificate of Coverage.	80% of the Negotiated Charge	50% of the Recognized Charge
Assistant Surgeon Expense (Inpatient and Outpatient)	80% of the Negotiated Charge	50% of the Recognized Charge

OUTPATIENT EXPENSES	Preferred Care	Non-Preferred Care
Physician or Specialist Office Visit Expense Includes the charges made by the physician or specialist if a covered person requires the services of a physician or specialist in the physician's or specialist's office while not confined as an inpatient in a hospital.	After a $20 Copay per visit , 80% of the Negotiated Charge	50% of the Recognized Charge
Laboratory and X-ray Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Hospital Outpatient Department Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Therapy Expense Covered medical expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis: • Radiation therapy; • Inhalation therapy; • Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy; • Kidney dialysis; and • Respiratory therapy. **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	50% of the Recognized Charge
Pre-Admission Testing Expense Includes charges incurred by a covered person for pre-admission testing charges made by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery.	80% of the Negotiated Charge	50% of the Recognized Charge
Ambulatory Surgical Expense Covered medical expenses include expenses incurred by a covered person for outpatient surgery performed in an ambulatory surgical center. Covered medical expenses must be incurred on the day of the surgery or within 24 hours after the surgery.	80% of the Negotiated Charge	50% of the Recognized Charge
Walk-in Clinic Visit Expense	After a $20 Copay per visit, 80% of the Negotiated Charge	50% of the Recognized Charge

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
Emergency Room Expense Covered medical expenses incurred by a covered person for services received in the emergency room of a hospital while the covered person is not a full-time inpatient of the hospital. The treatment received must be emergency care for an emergency medical condition. There is no coverage for elective treatment, routine care or care for a non-emergency sickness. As to emergency care incurred for the treatment of an emergency medical condition or psychiatric condition, any expenses incurred for non-preferred care will be paid at the same cost-sharing level as if they had been incurred for preferred care. **Important Notice**: A separate hospital emergency room visit benefit copay applies for each visit to an emergency room for emergency care. If a covered person is admitted to a hospital as an inpatient immediately following a visit to an emergency room, the emergency room visit benefit deductible or copay is waived. Covered medical expenses that are applied to the emergency room visit benefit deductible or copay cannot be applied to any other benefit deductible or copay under the plan. Likewise, covered medical expenses that are applied to any of the plan's other benefit deductibles or copays cannot be applied to the emergency room visit benefit deductible or copay. Separate benefit deductibles or copays may apply for certain services rendered in the emergency room that are not included in the hospital emergency room visit benefit. These benefit deductibles or copays may be different from the hospital emergency room visit benefit deductible or copay, and will be based on the specific service rendered. Similarly, services rendered in the emergency room that are not included in the hospital emergency room visit benefit may be subject to coinsurance rates that are different from the coinsurance rate applicable to the hospital emergency room visit benefit. **Important Note:** Please note that Non-Preferred Care Providers do not have a contract with Aetna; the provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.	After a $100 Copay per visit (waived if admitted), 80% of the Negotiated Charge	Paid the same as the Preferred Care level of coverage.

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
Durable Medical and Surgical Equipment Expense Durable medical and surgical equipment would include: Artificial arms and legs; including accessories; • Arm, back, neck braces, leg braces; including attached shoes (but not corrective shoes); • Surgical supports; • Scalp hair prostheses required as the result of hair loss due to injury; sickness; or treatment of sickness; and • Head halters.	80% of the Negotiated Charge	50% of the Recognized Charge

PREVENTIVE CARE EXPENSES

Preventive Care is services provided for a reason other than to diagnose or treat a suspected or identified sickness or injury and rendered in accordance with the guidelines provided by the following agencies:

- 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 uspreventiveservicestaskforce.org.
- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents http://brightfutures.aap.org/.
- For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration http://www.hrsa.gov/index.html.

PREVENTIVE CARE EXPENSES	Preferred Care	Non-Preferred Care
Routine Physical Exam Includes routine vision & hearing screenings given as part of the routine physical exam.	100% of the Negotiated Charge*	70% of the Recognized Charge
Preventive Care Immunizations Covered 100% for children up to 5 years of age. Deductible and coinsurance applies thereafter.	100% of the Negotiated Charge*	70% of the Recognized Charge*
Well Woman Preventive Visits Routine well woman preventive exam office visit, including Pap smears.	100% of the Negotiated Charge*	70% of the Recognized Charge
Preventive Care Screening and Counseling Services for Sexually Transmitted Infections Includes the counseling services to help a covered person prevent or reduce sexually transmitted infections.	100% of the Negotiated Charge*	70% of the Recognized Charge
Preventive Care Screening and Counseling Services for Obesity and/or Healthy Diet Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.	100% of the Negotiated Charge*	70% of the Recognized Charge
Preventive Care Screening and Counseling Services for Misuse of Alcohol and/or Drugs Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.	100% of the Negotiated Charge*	70% of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Screening and Counseling Services for Use of Tobacco Products Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: • Cigarettes; • Cigars; • Smoking tobacco; • Snuff; • Smokeless tobacco; and • Candy-like products that contain tobacco.	100% of the Negotiated Charge*	70% of the Recognized Charge
Preventive Care Screening and Counseling Services for Depression Screening Screening or test to determine if depression is present.	100% of the Negotiated Charge*	70% of the Recognized Charge
Preventive Care Routine Cancer Screenings Covered expenses include but are not limited to: Pap smears; Mammograms; Fecal occult blood tests; Digital rectal exams; Prostate specific antigen (PSA) tests; Sigmoidoscopies; Double contrast barium enemas (DCBE); Colonoscopies (includes: Bowel preparation medications, Anesthesia, Removal of polyps performed during a screening procedure, Pathology exam on any removed polyps) and Lung cancer screenings.	100% of the Negotiated Charge*	70% of the Recognized Charge
Preventive Care Screening and Counseling Services for Genetic Risk for Breast and Ovarian Cancer Covered medical expenses include the counseling and evaluation services to help assess a covered person's risk of breast and ovarian cancer susceptibility.	100% of the Negotiated Charge*	70% of the Recognized Charge
Preventive Care Prenatal Care Coverage for prenatal care under this Preventive Care Expense benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height). Refer to the Maternity Expense benefit for more information on coverage for maternity expenses under the Policy, including other prenatal care, delivery and postnatal care office visits.	100% of the Negotiated Charge*	70% of the Recognized Charge
Preventive Care Lactation Counseling Services Lactation support and lactation counseling services are covered medical expenses when provided in either a group or individual setting.	100% of the Negotiated Charge*	70% of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Breast Pumps and Supplies	100% of the Negotiated Charge*	70% of the Recognized Charge
Preventive Care Female Contraceptive Counseling Services, Preventive Care Female Contraceptive Generic, Brand Name, Biosimilar Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visit, Preventive Care Female Voluntary Sterilization (Inpatient), Preventive Care Female Voluntary Sterilization (Outpatient) Includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered medical expenses when provided in either a group or individual setting. **Voluntary Sterilization** Includes charges billed separately by the provider for female voluntary sterilization procedures & related services & supplies including, but not limited to, tubal ligation and sterilization implants. Covered medical expenses under this benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.	100% of the Negotiated Charge*	70% of the Recognized Charge
Contraceptives can be paid either under this benefit or the prescribed medicines expense depending on the type of expense and how and where the expense is incurred. Benefits are paid under this benefit for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.	100% of the Negotiated Charge*	70% of the Recognized Charge
OTHER FAMILY PLANNING SERVICES EXPENSE	**Preferred Care**	**Non-Preferred Care**
Voluntary Sterilization for Males (Outpatient) Covered medical expenses include charges for certain family planning services, even though not provided to treat a sickness or injury as follows.	100% of the Negotiated Charge*	70% of the Recognized Charge
AMBULANCE EXPENSE	**Preferred Care**	**Non-Preferred Care**
Ground, Air, Water and Non-Emergency Ambulance Includes charges incurred by a covered person for the use of a professional ambulance in an emergency. Covered medical expenses for the service are limited to charges for ground transportation to the nearest hospital equipped to render treatment for the condition. Air transportation is covered only when medically necessary.	80% of the Negotiated Charge	80% of the Recognized Charge
ADDITIONAL BENEFITS	**Preferred Care**	**Non-Preferred Care**
Allergy Testing and Treatment Expense Includes charges incurred by a covered person for diagnostic testing and treatment of allergies and immunology services.	Covered according to the type of benefit incurred and the place where the service is received.	
Diagnostic Testing For Learning Disabilities Expense Covered medical expenses include charges incurred by a covered person for diagnostic testing for: • Attention deficit disorder; or • Attention deficit hyperactive disorder.	Covered according to the type of benefit incurred and the place where the service is received.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
High Cost Procedures Expense Includes charges incurred by a covered person as a result of certain high cost procedures provided on an outpatient basis. Covered medical expenses for high cost procedures include; but are not limited to; charges for the following procedures and services: • Computerized Axial Tomography (C.A.T.) scans; • Magnetic Resonance Imaging (MRI); and • Positron Emission Tomography (PET) Scans.	80% of the Negotiated Charge	50% of the Recognized Charge
Urgent Care Expense from an Urgent Care Facility Covered medical expenses include charges incurred by a covered person for an urgent care provider to evaluate and treat an urgent condition.	80% of the Negotiated Charge	50% of the Recognized Charge
Dental Expense for Impacted Wisdom Teeth Includes charges incurred by a covered person for services of a dentist or dental surgeon for removal of one or more impacted wisdom teeth. Not more than the Maximum Benefit will be paid. Includes expenses for the treatment of: the mouth; teeth; and jaws; but only those for services rendered and supplies needed for the following treatment of; or related to conditions; of the: • mouth; jaws; jaw joints; or • supporting tissues; (this includes: bones; muscles; and nerves).	80% of the Negotiated Charge	80% of the Recognized Charge
Accidental Injury to Sound Natural Teeth Expense Covered medical expenses include charges incurred by a covered person for services of a dentist or dental surgeon as a result of an injury to sound natural teeth.	80% of the Negotiated Charge	80% of the Recognized Charge
Non-Elective Second Surgical Opinion Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Consultant Expense Includes the charges incurred by covered person in connection with the services of a consultant. The services must be requested by the attending physician to confirm or determine a diagnosis. Coverage may be extended to include treatment by the consultant.	After a $20 Copay per visit, 80% of the Negotiated Charge	50% of the Recognized Charge
Skilled Nursing Facility Expense	After a $200 Copay per admission, 80% of the Negotiated Charge	50% of the Recognized Charge
Rehabilitation Facility Expense Includes charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility.	After a $200 Copay per admission, 80% of the Negotiated Charge	50% of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Home Health Care Expense Covered medical expenses **will not** include: • Services by a person who resides in the covered person's home, or is a member of the covered person's immediate family • Homemaker or housekeeper services; • Maintenance therapy; • Dialysis treatment; • Purchase or rental of dialysis equipment; • Food or home delivered services; or • Custodial care.	80% of the Negotiated Charge	50% of the Recognized Charge
Temporomandibular Joint Dysfunction Expense Covered medical expenses include physician's charges incurred by a covered person for Temporomandibular Joint (TMJ) Dysfunction.	Covered according to the type of benefit incurred and the place where the service is received.	
Dermatological Expense Includes physician's charges incurred by a covered person for the diagnosis and treatment of skin disorders. Unless specified above, not covered under this benefit are charges incurred for: • Treatment for acne; or • Cosmetic treatment and procedures.	After a $20 Copay per visit , 80% of the Negotiated Charge	50% of the Recognized Charge
Prosthetic Devices Expense. All Other Prosthetic Devices Includes charges made for internal and external prosthetic devices and special appliances, as prescribed by a physician for a device or appliance that improves or restores body part function that has been lost or damaged by sickness, injury or congenital defect. Covered medical expenses also include instruction and incidental supplies needed to use a covered prosthetic device. The plan covers prosthesis a covered person needs that temporarily or permanently replaces all or part of an body part lost or impaired as a result of sickness or injury or congenital defects as described in the list of covered devices below for an: • Internal body part or organ; or • External body part. Covered medical expenses also include replacement of a prosthetic device as prescribed by a physician, if: • The replacement is needed because of a change in the covered person's physical condition; or normal growth or wear and tear; or • It is likely to cost less to buy a new one than to repair the existing one; or • The existing one cannot be made serviceable. The list of covered devices includes, but is not limited to: • An artificial arm, leg, hip, knee or eye; • Eye lens; • An external breast prosthesis and the first bra made solely for use with it after a mastectomy;	80% of the Negotiated Charge	50% of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Prosthetic Devices Expense. All Other Prosthetic Devices (continued) A breast implant after a mastectomy; No time limit will be imposed for the receipt of related prosthetic devices following a mastectomy; • Ostomy supplies, urinary catheters and external urinary collection devices; • Speech generating device; • Orthopedic shoes; foot orthotics; or other devices to support the feet [but only when required for the treatment of, or to prevent complications of, diabetes]; • A cardiac pacemaker and pacemaker defibrillators; • A durable brace that is custom made for and fitted for the covered person; • Wigs (the first one following cancer treatment, not to exceed one per calendar year)	80% of the Negotiated Charge	50% of the Recognized Charge
Podiatric Expense Includes charges incurred by a covered person for podiatric services; provided on an outpatient basis following an injury. Unless specified above, not covered under this benefit are charges incurred for routine foot care, such as trimming of corns, calluses, and nails.	Covered according to the type of benefit incurred and the place where the service is received.	
Hypodermic Needles Expense Includes expenses incurred by a covered person for hypodermic needles and syringes.	Covered according to the type of benefit incurred and the place where the service is received.	
Maternity Expense Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person, and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother and done in accordance with the rules and regulations promulgated by State Mandate. Covered medical expenses may include home visits, parent education, and assistance and training in breast or bottle-feeding.	Covered according to the type of benefit incurred and the place where the service is received.	
Non-Prescription Enteral Formula Expense Includes charges incurred by a covered person, for non-prescription enteral formulas for which a physician has issued a written order, and are for the treatment of malabsorption caused by: • Crohn's Disease; • Ulcerative colitis; • Gastroesophageal reflux; • Gastrointestinal motility; • Chronic intestinal pseudo obstruction; and • Inherited diseases of amino acids and organic acids. Covered medical expenses for inherited diseases of amino acids; and organic acids; will also include food products modified to be low protein.	80% of the Negotiated Charge	50% of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Acupuncture in Lieu of Anesthesia Expense Includes charges incurred by a covered person for acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician; practicing within the scope of their license.	80% of the Negotiated Charge	50% of the Recognized Charge
Transfusion or Kidney Dialysis of Blood Expense Includes charges incurred by a covered person for the transfusion or kidney dialysis of blood, including the cost of: Whole blood; blood components; and the administration of whole blood and blood components.	80% of the Negotiated Charge	50% of the Recognized Charge
Hospice Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Private Duty Nursing Includes private duty nursing services provided by an R.N. or L.P.N. if the covered person's condition requires skilled nursing care and visiting nursing care is not adequate.	80% of the Negotiated Charge	50% of the Recognized Charge
Nutritional Supplements Covered medical expenses include charges incurred for nutritional supplements (formulas and low protein modified food products) as needed for the treatment of phenylketonuria or an inherited disease of amino and organic acids, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a physician. For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.	Covered according to the type of benefit incurred and the place where the service is received; not to exceed 50% of the cost of the formula or food products.	
Osteoporosis (bone mass measurement) Covered medical expenses include the diagnosis, treatment and management of osteoporosis by a physician for individuals with a condition or medical history that requires bone mass measurement. The services include Food and Drug Administration approved technologies, including bone mass measurement.	Covered according to the type of benefit incurred and the place where the service is received.	
Diabetes Benefit Expense Includes charges for services, supplies, equipment, & training for the treatment of insulin and non-insulin dependent diabetes & elevated blood glucose levels during pregnancy. Self-management training provided by a licensed health care provider certified in diabetes self-management training.	Covered according to the type of benefit incurred and the place where the service is received.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Reconstructive Breast Surgery Expense Covered medical expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema; and breast prosthesis. No time limit will be imposed for reconstructive surgery for breast reconstruction and the receipt of related prosthetic devices following a mastectomy.	Covered according to the type of benefit incurred and the place where the service is received.	
Autism Spectrum Disorder Expense Includes charges incurred for services and supplies required for the diagnosis & treatment of autism spectrum disorder when ordered by a physician or behavioral health provider as part of a treatment plan.	Covered according to the type of benefit incurred and the place where the service is received.	
Applied Behavior Analysis (ABA) for the treatment of Autism Spectrum Disorders	Covered according to the type of benefit incurred and the place where the service is received.	
Basic Infertility Expense Covered medical expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.	Covered according to the type of benefit incurred and the place where the service is received.	
Clinical Trials Expense (Experimental or Investigational Treatment) Includes charges made by a provider for experimental or investigational drugs, devices, treatments or procedures “under an approved clinical trial” only when a covered person has cancer or a terminal illness.	Covered according to the type of benefit incurred and the place where the service is received.	
Clinical Trials Expense Routine Patient Costs Covered Percentage Includes charges made by a provider for "routine patient costs" furnished in connection with a covered person’s participation in an "approved clinical trial” for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.	Covered according to the type of benefit incurred and the place where the service is received.	

Gender Reassignment (Sex Change) Treatment Expense
Includes charges made in connection with a medically necessary gender reassignment surgery (sometimes called sex change surgery) as long the covered student or their covered dependent has obtained pre-certification from Aetna.
 	
Covered medical expenses include:
• Charges made by a physician for:
  ○ Performing the surgical procedure; and
  ○ Pre-operative and post-operative hospital and office visits.
• Charges made by a hospital for inpatient and outpatient services (including outpatient surgery).
• Charges made by a Skilled Nursing Facility for inpatient services and supplies.
	Covered according to the type of benefit incurred and the place where the service is received.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Gender Reassignment (Sex Change) Treatment Expense (continued) • Charges made for the administration of anesthetics. • Charges for outpatient diagnostic laboratory and x-rays. • Charges for blood transfusion and the cost of unreplaced blood and blood products. • Charges made by a behavioral health provider for gender reassignment counseling. • Charges incurred for injectable and non-injectable hormone replacement therapy. No benefits will be paid for covered medical expenses under this benefit unless they have been pre-certified by Aetna. Refer to the Pre-certification section for more information.	Covered according to the type of benefit incurred and the place where the service is received.	
Lead Poisoning Covered expenses include charge for testing pregnant women for lead poisoning and for all testing for lead poisoning.	Covered according to the type of benefit incurred and the place where the service is received.	
Cancer Coverage-Second Opinion Covered medical expenses include charges for a second opinion rendered by a specialist in that specific cancer diagnosis area when newly diagnosed.	Covered according to the type of benefit incurred and the place where the service is received.	
Early Intervention Services Early Intervention Services are covered even though they may not be in connection with treatment of an injury or disease. They are covered only for: a dependent child from birth to 3 years of age, who is identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, as amended. A covered person must submit proof of such identification. These are services, provided as part of an active individualized family service plan that enhances functional ability without effecting care. They include, but are not limited to, speech and language therapy, occupational therapy, physical therapy and assistive technology devices.	Covered according to the type of benefit incurred and the place where the service is received.	
Chiropractic Treatment Expense Includes charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.	80% of the Negotiated Charge	50% of the Recognized Charge

SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE

Inpatient rehabilitation benefits for the services listed will be paid as part of the Hospital Expense and Skilled Nursing Facility Expense benefits.

Cardiac Rehabilitation Benefits.

Cardiac rehabilitation benefits received at a hospital, skilled nursing facility, or physician's office. This Plan will cover charges in accordance with a treatment plan as determined by a covered person's risk level when recommended by a physician.

Pulmonary Rehabilitation Benefits

Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Cardiac Rehabilitation	80% of the Negotiated Charge	50% of the Recognized Charge
Pulmonary Rehabilitation	80% of the Negotiated Charge	50% of the Recognized Charge
SHORT-TERM REHABILITATION EXPENSE Includes charges for short-term rehabilitation services, as described below, when prescribed by a physician. Short-term rehabilitation services must follow a specific treatment plan that: • Details the treatment, and specifies frequency and duration; • Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and • Allows therapy services, provided in a covered person's home, if the covered person is homebound. • Inpatient rehabilitation benefits for the services listed will be paid as part of the inpatient hospital and skilled nursing facility benefits.		
Short-Term Rehabilitation Expense Outpatient Physical and Occupational Rehabilitation and Habilitation Therapy Services (combined)	80% of the Negotiated Charge	50% of the Recognized Charge
Speech and Hearing Disorders Includes medically necessary care and treatment to identify, assess, diagnose and consult about the need for treatment and to evaluate and monitor the effectiveness of treatment whether by instrumental, perceptional, or standard procedures as well as the provision of treatment of communicative disorders as included in the definition of Loss or Impairment of Speech or Hearing.	Covered according to the type of benefit incurred and the place where the service is received.	
Biofeedback Covered medical expenses include biofeedback when provided by an eligible practitioner.	Covered according to the type of benefit incurred and the place where the service is received.	
HEARING AIDS	**Preferred Care**	**Non-Preferred Care**
Hearing Aid Expenses Covered medical expenses for hearing care includes charges for prescribed hearing aids and hearing aid expenses. Covered medical expenses for hearing aids will not include per 12 consecutive month period: • Charges for more than one hearing aid per ear	80% of the Negotiated Charge	50% of the Recognized Charge
Cochlear Implants	80% of the Negotiated Charge	50% of the Recognized Charge
TREATMENT OF MENTAL DISORDER EXPENSE	**Preferred Care**	**Non-Preferred Care**
Inpatient Mental Health Expense Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	After a $200 Copay per admission, 80% of the Negotiated Charge	50% of the Recognized Charge
Outpatient Mental Health Expense	After a $20 Copay per visit, 80% of the Negotiated Charge	50% of the Recognized Charge

TREATMENT OF MENTAL DISORDER EXPENSE (continued)	Preferred Care	Non-Preferred Care
Outpatient Mental Health Partial Hospitalization Expense	After a $200 Copay per admission, 80% of the Negotiated Charge	50% of the Recognized Charge
ALCOHOLISM AND DRUG ADDICTION TREATMENT	**Preferred Care**	**Non-Preferred Care**
Inpatient Substance Abuse Treatment Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	After a $200 Copay per admission, 80% of the Negotiated Charge	50% of the Recognized Charge
Outpatient Substance Abuse Treatment	After a $20 Copay per visit, 80% of the Negotiated Charge	50% of the Recognized Charge
TRANSPLANT SERVICES EXPENSE	**Preferred Care**	**Non-Preferred Care**
Transplant Services Expense Benefits may vary if an Institute of Excellence™ (IOE) facility or non-IOE or non-preferred care provider is used. Through the IOE network, the covered person will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure the covered person requires. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.	Covered according to the type of benefit incurred and the place where the service is received.	
Transplant Travel and Lodging Expense The plan will reimburse a covered person for some of the cost of their travel and lodging expenses.	$50 per night Maximum Benefit for Lodging Expenses per IOE patient & $50 per night Maximum Benefit for Lodging Expenses per companion up to $10,000 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.	
PEDIATRIC DENTAL SERVICES EXPENSE **(Coverage is limited to covered persons until the end of the month in which the covered person turns 19)**	**Preferred Care**	**Non-Preferred Care**
Type A Expense (Pediatric Routine Dental Exam Expense) 1 visit every 6 months	100% of the Negotiated Charge*	70% of the Recognized Charge
Type B Expense (Pediatric Basic Dental Care Expense)	70% of the Negotiated Charge*	50% of the Recognized Charge
Type C Expense (Pediatric Major Dental Care Expense)	50% of the Negotiated Charge*	50% of the Recognized Charge
Pediatric Orthodontia Expense Orthodontics Medically necessary comprehensive treatment • Replacement of retainer (limit one per lifetime).	50% of the Negotiated Charge*	50% of the Recognized Charge

PEDIATRIC ROUTINE VISION (Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	Preferred Care	Non-Preferred Care
Pediatric Routine Vision Exams (including refractions) Includes charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction & glaucoma testing.	100% of the Negotiated Charge*	70% of the Recognized Charge
Pediatric Visit for the fitting of prescription contact lenses, Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses Includes charges for the following vision care services and supplies: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a preferred care provider. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a non-preferred care provider. Coverage includes charges incurred for: • Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses. Aphakic prescription lenses prescribed after cataract surgery has been performed. 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.	100% of the Negotiated Charge *	70% of the Recognized Charge
E-VISITS AND TELEMEDICINE CONSULTATIONS Important Note: The cost-share for E-Visit or telemedicine services will be no greater than a face-to-face visit with a provider in the same setting.	Preferred Care	Non-Preferred Care
Specialist E-Visit or Telemedicine Consultation and Non-Specialist E-Visit or Telemedicine Consultation Covered expenses include charges made by a covered person's physician or PCP for a routine, non-emergency, medical consultation. A covered person may have to register with a web-based internet service vendor in order to make an E-visit appointment or participate in a telemedicine consultation with his or her provider. Information about E-Visit or telemedicine providers may be found online in DocFind or on **www.aetna.com** or by calling the number on his or her identification card. **Limitations:** Not covered under this plan are charges made for: • Facsimile transmissions, unsecured electronic mail, or a combination thereof; • Site origination fees.	After a $20 Copay per visit, 80% of the Negotiated Charge	50% of the Recognized Charge

PRESCRIBED MEDICINES EXPENSE

COVERED PERCENTAGE*	Preferred Care	Non-Preferred Care
Preventive Care Drugs and Supplements **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.**		
Risk Reducing Breast Cancer Prescription Drugs For each 30-day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	100% of the Recognized Charge
Other preventive care drugs and supplements For each 30-day supply filled at a retail pharmacy.	100% per supply	100% of the Recognized Charge
Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs. (for two 90-day treatment regimens only)	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	100% of the Recognized Charge
CONTRACEPTIVES	**Preferred Care**	**Non-Preferred Care**
For each 30-day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	100% of the Recognized Charge
All OTHER PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each 30-day supply filled at a retail pharmacy.	100% of the Negotiated Charge	100% of the Recognized Charge

*The prescription drug plan covered percentage is the percentage of prescription drug covered medical expenses that the plan pays after any applicable deductibles and copays have been met.

Per Prescription Copay/Deductible		
GENERIC PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each 30-day supply filled at a retail pharmacy.	$15 Copay per supply	$15 Deductible per supply
PREFERRED BRAND-NAME PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each 30-day supply filled at a retail pharmacy.	$35 Copay per supply	$35 Deductible per supply
NON-PREFERRED BRAND-NAME PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each 30-day supply filled at a retail pharmacy.	$50 Copay per supply	$50 Deductible per supply
Orally Administered Anti-Cancer Prescription Drugs (including Chemotherapy Drugs)	Payable on the same basis as covered cancer chemotherapy medications that are administered intravenously or by injection.	

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

Aetna will make a coverage determination within 24 hours after receipt of the request and will notify the covered person, the covered person's designee or the covered person's prescriber of Aetna's decision.

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

The per prescription copay/deductible and policy year deductible will not apply to risk-reducing breast cancer generic, prescription drugs when obtained at a preferred care pharmacy. This means that such risk-reducing breast cancer generic prescription drugs will be paid at 100%.

Waiver for Prescription Drug Contraceptives

The per prescription copay/deductible and policy year deductible will not apply to:

- Female contraceptives that are:
  - Oral prescription drugs that are generic prescription drugs.
  - Injectable prescription drugs that are generic prescription drugs.
  - Vaginal ring prescription drugs that are generic prescription drugs, brand-name prescription drugs and biosimilar prescription drugs.
  - Transdermal contraceptive patch prescription drugs that are generic prescription drugs, brand-name prescription drugs, and biosimilar prescription drugs.
- Female contraceptive devices.
- FDA-approved female:
  - generic emergency contraceptives; and
  - generic over-the-counter (OTC) emergency contraceptives.

when obtained at a preferred care pharmacy. This means that such contraceptive methods will be paid at 100%.
The per prescription copay/deductible and policy year deductible continue to apply:

- When the contraceptive methods listed above are obtained at a non-preferred pharmacy.
- To female contraceptives that are:
  - Oral prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.

- Injectable prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.

- To female contraceptive devices that are brand-name devices.
- To FDA-approved female:
  - brand-name and biosimilar emergency contraceptives; and
  - brand-name over-the-counter (OTC) emergency contraceptives.
- To FDA-approved female brand-name over-the-counter (OTC) contraceptives.
- To FDA-approved male brand-name over-the-counter (OTC) contraceptives.

However, the per prescription copay/deductible and policy year deductible will not apply to such contraceptive methods if:

- A generic equivalent, biosimilar or generic alternative, within the same therapeutic drug class is not available; or
- A covered person is granted a medical exception; or
- A physician specifies “Dispense as Written” (DAW).

A covered person's prescriber may seek a medical exception by submitting a request to Aetna's Pre-certification Department. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case medically necessary determination and coverage will not apply or extend to other covered persons.

Exclusions

This Plan does not cover nor provide benefits for:

1. Expense incurred for dental treatment, services and supplies except for those resulting from injury to sound natural teeth or for extraction of impacted wisdom teeth and those as specially covered under the Policy.

2. Expense incurred for services normally provided without charge by the Policyholder's school health services; infirmary or hospital; or by health care providers employed by the Policyholder.

3. Expense incurred as a result of injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way; including inciting the riot or conspiring to incite it. It does not include actions taken in self - defense; so long as they are not taken against persons who are trying to restore law and order.

4. Expense incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation; except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.

5. Expense incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.

6. Expense incurred as a result of an injury sustained or sickness contracted while in the service of the Armed Forces of any country. Upon the covered person entering the Armed Forces of any country; the unearned pro rata premium will be refunded to the Policyholder.

7. Expense incurred for treatment provided in a governmental hospital unless there is a legal or regulatory obligation to pay such charges in the absence of insurance.

8. Expense incurred for elective treatment or elective surgery except as specifically covered under the Policy and provided while the Policy is in effect.

9. Expense incurred for cosmetic surgery; reconstructive surgery; or other services and supplies which improve; alter; or enhance appearance; whether or not for psychological or emotional reasons; except to the extent needed to: Improve the function of a part of the body that: is not a tooth or structure that supports the teeth; and is malformed: as a result of a severe birth defect; including harelip; webbed fingers; or toes; or as direct result of: disease; or surgery performed to treat a disease or injury. Repair an injury (including reconstructive surgery for prosthetic device for a covered person who has undergone a mastectomy;) which occurs while the covered person is covered under the Policy. Surgery must be performed:
   - in the policy year of the accident which causes the injury; or
   - in the next policy year.

10. Expense incurred for voluntary or elective abortions unless to save the life of the mother.

11. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits provision.

12. Expense incurred for injury resulting from the plan or practice of collegiate or intercollegiate sports including collegiate or intercollegiate club sports.

13. Expense incurred for the male or female reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.

14. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.

15. Expense incurred for custodial care.

16. Expense incurred for the removal of an organ from a covered person for the purpose of donating or selling the organ to any person or organization except as specifically covered in the Policy. This limitation does not apply to a donation by a covered person to a spouse; child; brother; sister; or parent.

17. Expense incurred for, or in connection with, drugs, devices, procedures, or treatments that are, as determined by Aetna to be, experimental or investigational except as specifically covered under the Policy.

18. Expenses incurred for gastric bypass; and any restrictive procedures; for weight loss except screening and counseling services specifically covered under the Policy.

19. Expenses incurred for breast reduction/mammoplasty.

20. Expenses incurred for gynecomastia (male breasts).

21. Expenses incurred for any sinus surgery; except for acute purulent sinusitis.

22. Expense incurred by a covered person; not a United States citizen; for services performed within the covered person’s home country; if the covered person’s home country has a socialized medicine program.

23. Expense incurred for acupuncture except as specifically covered under the Policy.

24. Expense incurred for alternative; holistic medicine; and/or therapy; including but not limited to; yoga and hypnotherapy unless specifically covered under the Policy.

25. Expense for injuries sustained as the result of a motor vehicle accident; to the extent that benefits are payable under other valid and collectible insurance; whether or not claim is made for such benefits. The Policy will only pay for those losses; which are not payable under the automobile medical payment insurance Policy.

26. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.

27. Expense incurred for hearing exams, hearing aids; the fitting; or prescription of hearing aids except as specifically covered under the Policy. Not covered are:
    - Any hearing service or supply that does not meet professionally accepted standards;
    - Hearing exams given during a stay in a hospital or other facility;
    - Any tests, appliances, and devices for the improvement of hearing, including aids, hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech; and
    - Routine hearing exams, except for routine hearing screenings as specifically described under Preventive Care Benefits.

28. Expense for charges for failure to keep a scheduled visit; or charges for completion of a claim form.

29. Expense for personal hygiene and convenience items; such as air conditioners; humidifiers; hot tubs; whirlpools; or physical exercise equipment; even if such items are prescribed by a physician.

30. Expense for incidental surgeries; and standby charges of a physician.

31. Expense for services and supplies for or related to gamete intrafallopian transfer; artificial insemination; in-vitro fertilization (except as required by the state law); or embryo transfer procedures; male elective sterilization; male or female elective sterilization reversal; unless specifically covered in the Policy. Elective abortion is specifically excluded from this policy.

32. Expense incurred for non-preferred care charges that are not recognized charges.

33. Expense for treatment of covered students who specialize in the mental health care field; and who receive treatment as a part of their training in that field.

34. Expense incurred for routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically covered in the Policy.

35. Expense incurred for a treatment; service; prescription drug, or supply; which is not medically necessary; as determined by Aetna; for the diagnosis, care, or treatment of the sickness or injury involved, the restoration of physiological functions, or covered preventive services. This includes behavioral health services that are not primarily aimed at treatment of sickness, 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 the person's attending physician, dentist, or vision provider.

36. Expenses incurred for vision-related services and supplies, except as specifically covered in the Policy. In addition, the plan does not cover:
    - Special supplies such as non-prescription sunglasses;
    - Vision service or supply which does not meet professionally accepted standards;
    - Special vision procedures, such as orthoptics or vision training;
    - Eye exams during a stay in a hospital or other facility for health care;
    - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
    - Replacement of lenses or frames that are lost or stolen or broken;
    - Acuity tests; and
    - Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
    - Services to treat errors of refraction.

37. 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).

38. Expense incurred in relation to genetics: Except as specifically covered in the Policy, the plan does not cover 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.

39. Expense incurred for therapies and tests: Any of the following treatments or procedures including but not limited to:
    - Aromatherapy;
    - Bioenergetic therapy;
    - Carbon dioxide therapy;
    - Chelation therapy (except for heavy metal poisoning);
    - Computer-aided tomography (CAT) scanning of the entire body;
    - Educational therapy, except for treatment of Autism Spectrum Disorders;
    - Gastric irrigation;
    - Hair analysis;
    - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
    - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
    - Massage therapy;
    - Megavitamin therapy;
    - Primal therapy;
    - Psychodrama;
    - Purging;
    - Recreational therapy;
    - Rolfing;
    - Sensory or auditory integration therapy;
    - Sleep therapy;
    - Thermograms and thermography except for computer-aided tomography (CAT) scanning of the entire body and full body CT scans that are covered under the Diagnostic Complex Imaging benefit.

40. Expense incurred for any non-emergency charges incurred outside of the United States except for those services that are covered under this plan. Additionally, expenses incurred outside of the United States: 1) If a covered person traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under the Policy, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal.

The Pediatric Dental Services benefit is subject to the following additional exclusions and limitations:

41. Expenses incurred for dental services and supplies that are covered in whole or in part under any other part of this plan.

42. Expenses incurred for orthodontic treatment except as specifically covered in the Policy.

43. Expenses incurred for routine dental exams and other preventive services and supplies, except as specifically covered in the Policy.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

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

IMPORTANT NOTICES:

Sanctioned Countries:

If payment for any claim under this Certificate violates or will violate any economic or trade sanctions, the claim will not be paid. Your coverage will continue under this Certificate; however you will be responsible for the entire claim. 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 **1-877-375-7905**.

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).

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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)