Aetna Student Health 2021-2022 Rate Proposal
Maryland Institute College of Art

Addendum #3

2021- 2022 Student Health Insurance Program Proposal Addendum Summary of Benefits

Disclaimer: These rates and benefits are pending approval by the Maryland Department of Insurance and can change. If they change, we will update this information.

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	None	$300 per policy year
Spouse	None	$300 per policy year
Each child	None	$300 per policy year
Family	None	$600 per policy year
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • Out-of-network care for Hospital Emergency Room, Ambulance Services, Well newborn nursery care, and Outpatient prescription drugs • Any service identified as "no policy year deductible applies" in the schedule of benefits		
Maximum out-of-pocket limit per **policy year**		
Student	$2,000 per policy year	$4,000 per policy year
Spouse	$2,000 per policy year	$4,000 per policy year
Each child	$2,000 per policy year	$4,000 per policy year
Family	$4,000 per policy year	$8,000 per policy year

Eligible health services	**In-network coverage**	**Out-of-network coverage**
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Maximum age and visit limits per policy year through age 21	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.	
Maximum visits per policy year age 22 and over	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	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	80% (of the recognized charge) per visit

Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Maximums:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Reasonable medical management techniques will be used to determine the frequency, method, treatment, or setting for an item or service.	
Routine cancer screenings Breast cancer screening is not subject to deductible	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Maximums	Subject to any age; 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.	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Lactation support and counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Maximum	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	

Breast pump supplies and accessories	100% (of the negotiated charge) No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Maximum	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Female contraceptive prescription drugs and devices	100% (of the negotiated charge) per item No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Female voluntary sterilization-Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Female voluntary sterilization-Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) includes telemedicine consultations)	$15 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	80% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing & Allergy injections treatment	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Physician and specialist - surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	90% (of the negotiated charge)	70% (of the recognized charge)
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit

anesthetist and surgical assistant expenses)		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$15 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	80% (of the recognized charge) per visit
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	90% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
In-hospital non-surgical physician services	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Home health Care	90% (of the negotiated charge) per visit	90% (of the recognized charge) per visit
Hospice-Inpatient	90% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
Hospice-Outpatient	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Outpatient private duty nursing	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Skilled nursing facility-Inpatient	90% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
Hospital emergency room	$120 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	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.

Urgent Care	$40 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	$40 copayment then the plan pays 100% (of the balance 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	80% (of the recognized charge) per visit
Type B services	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specific Conditions		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Diabetes test strips	100% (of the negotiated charge)	100% (of the recognized charge)
Impacted wisdom teeth	90% (of the negotiated charge)	90% (of the recognized charge)
Accidental injury to sound natural teeth	90% (of the negotiated charge)	90% (of the recognized charge)
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Obesity bariatric Surgery	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maternity care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Postpartum home visits ***See the certificate of coverage for visit limits***	100% (of the negotiated charge) per visit	100% (of the recognized charge) per visit
Well newborn nursery care in a hospital or birthing center	90% (of the negotiated charge) No policy year deductible applies	70% (of the recognized charge) No policy year deductible applies
Family planning services – other		
Voluntary sterilization for males-surgical services	100% (of the negotiated charge)	100% (of the recognized charge)
Abortion Inpatient physician or specialist surgical services	90% (of the negotiated charge)	70% (of the recognized charge)
Abortion Outpatient physician or specialist surgical services	90% (of the negotiated charge)	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.	Covered according to the type of benefit and the place where the service is received.

Autism spectrum disorder			
Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit	
Mental Health & Substance Abuse Treatment			
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	90% (of the negotiated charge) per admission	70% (of the recognized charge) per admission	
Outpatient office visits (includes telemedicine consultations)	$15 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	80% (of the recognized charge) per visit	
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit	
Eligible health services	**In-network coverage Network (IOE facility)**	**In-network coverage Network (Non-IOE facility)**	**Out-of-network coverage Network Non-IOE facility and out-of-network facility**
Transplant services Inpatient and outpatient facility services	Covered according to the type of benefit and the place where the service is received.		
Transplant services Inpatient and outpatient physician and specialist services	Covered according to the type of benefit and the place where the service is received.		
Transplant services-travel and lodging	Covered	Covered	Covered
Eligible health services	**In-network coverage**	**Out-of-network coverage**	
Basic infertility services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	
Comprehensive infertility services and in vitro services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	
Maximum	Outpatient in-vitro services up to 3 attempts	Outpatient in-vitro services up to 3 attempts	
Specific therapies and tests			
Outpatient diagnostic testing			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	90% (of the negotiated charge)	70% (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	90% (of the negotiated charge)	70% (of the recognized charge)	
Outpatient Chemotherapy, Radiation & Respiratory Therapy	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit	
Eligible health services	**In-network coverage**	**Out-of-network coverage**	
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	80% (of the recognized charge) per visit	
Acupuncture therapy	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit	

Chiropractic services	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Other services and supplies		
Emergency ground, air, and water ambulance	90% (of the negotiated charge) per trip No policy year deductible applies	Paid the same as in-network coverage
Non-emergency ambulance	90% (of the negotiated charge) per trip No policy year deductible applies	Paid the same as in-network coverage
Durable medical and surgical equipment	90% (of the negotiated charge) per item	70% (of the recognized charge) per item
Enteral formulas and nutritional supplements	90% (of the negotiated charge) per item	70% (of the recognized charge) per item
Prosthetic Devices & Orthotics Includes Cranial prosthetics *(Medical wigs)*	90% (of the negotiated charge) per item	70% (of the recognized charge) per item
Hearing aid exams	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Hearing aid exam maximum	One hearing exam per policy year	
Hearing aids	90% (of the negotiated charge) per item	70% (of the recognized charge) per item
Hearing aids maximum per ear	One hearing aid per hearing impaired ear every 36 month consecutive period	
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 Includes comprehensive low vision evaluations Includes visit for fitting of contact lenses	100% (of the negotiated charge) per visit	80% (of the recognized charge) per visit
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every 5 years and 4 follow-up visits in any 5 year period 1 visit	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit	80% (of the recognized charge) per visit
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	 One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 12 month supply Extended wear disposable: up to 12 month supply Non-disposable lenses: one set	

*__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.

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Eligible health services	In-network coverage	Out-of-network coverage
Preferred generic prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	$10 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	$10 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
Preferred brand-name prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	$45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	$45 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
Non-preferred generic prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	$65 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	$65 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
Non-preferred brand-name prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	$65 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	$65 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
Specialty prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	50% (of the negotiated charge) per supply	50% (of the recognized charge) per supply No policy year deductible applies
Preventive care drugs and supplements filled at a retail pharmacy For each fill up to a 90 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	100% (of the recognized charge) per prescription or refill No policy year deductible applies
Risk reducing breast cancer prescription drugs filled at a retail pharmacy For each fill up to a 90 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	100% (of the recognized charge) per prescription or refill No policy year deductible applies
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.	
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each fill up to a 90 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	100% (of the recognized charge) per prescription or refill No policy year deductible applies
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.	

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