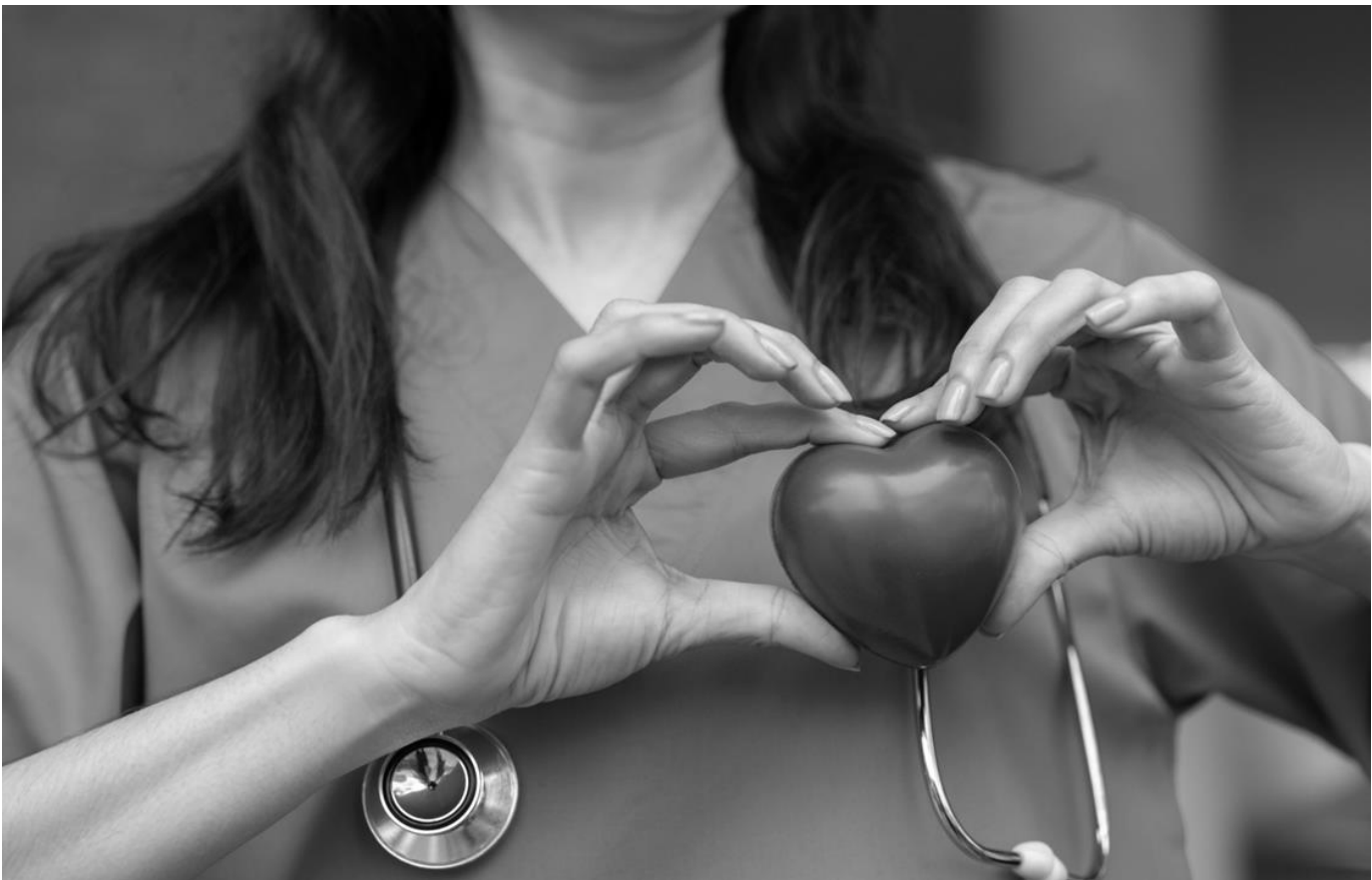




**Aetna Student Health  
Plan Design and Benefits Summary  
Preferred Provider Organization (PPO)**

**Thomas Jefferson University**

Policy Year: 2026 – 2027  
Policy Number: 278757  
<https://www.aetnastudenthealth.com>  
(877) 626 2308



This is a brief description of the Student Health Plan. The plan is available for Thomas Jefferson University students. The plan is insured by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at <https://www.aetnastudenthealth.com>. If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

**Notice:**

This health insurance policy may not cover all your health care expenses. Read your member certificate carefully to determine which health care services are covered.

## Thomas Jefferson University HEALTH SERVICES

The University Health Services is the University's on-campus health facilities. Center City Health Services can be reached at (215)-395-8087 and East Falls Health Services can be reached at (215)-951-2986. In the event of an emergency, call 911.

Webpage: [Health & Wellness](#)

### Who is eligible?

All matriculated students who are in an on-campus or hybrid program and/or have a clinical/internship are required to have and annually verify health insurance coverage (see exemptions below). Students required to have insurance are charged for the Jefferson Student Health Insurance Plan at registration and must confirm enrollment or submit a waiver to opt out if they have another insurance plan that meets the Jefferson Health Insurance Requirements by the deadline. Students who do not enroll or waive by the deadline will be enrolled in the Jefferson SHIP retroactively to the policy effective date and will be responsible for the Jefferson SHIP premium. Students must actively attend classes for at least 31 days after the date for which coverage is purchased to remain eligible.

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective. You cannot meet this eligibility requirement if you take courses through:

- Home study
- Correspondence
- The internet
- Television (TV).

**Exemptions:** If the academic program is fully online and has no clinical/internship, if the academic program is in Accelerated Online Undergraduate Programs (AOU), or if enrolled in a certificate program without a clinical/internship component then verification is not required and students are not eligible to purchase insurance through the university sponsored plan.

## Coverage Dates and Rates

Coverage for all insured students 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.

### Undergraduates:

	<b>Annual</b> 08/10/2026- 08/09/2027	<b>Spring/Summer</b> 01/01/2027- 08/09/2027	<b>Summer/Pre-Fall</b> 04/25/2027- 08/09/2027	<b>Summer 2/Pre-Fall</b> 07/01/2027- 08/09/2027
<b>Student</b>	\$3,456.00	\$2,093.00	\$1,013.00	\$379.00

Enrollment & waivers must be submitted by:

Annual: 9/1/2026

Spring/Summer: 1/10/2027

Summer/Pre-Fall: 5/5/2027

Summer 2/Pre-Fall: 7/19/2027

### Graduates:

	<b>Annual</b> 08/10/2026- 08/09/2027	<b>Spring/Summer</b> 01/01/2027- 08/09/2027	<b>Summer/Pre-Fall</b> 04/25/2027- 08/09/2027	<b>Summer 2/Pre-Fall</b> 7/01/2027- 08/09/2027
<b>Student</b>	\$5,621.00	\$3,404.00	\$1,648.00	\$616.00

Enrollment & waivers must be submitted by:

Annual: 9/1/2026

Spring/Summer: 1/10/2027

Summer/Pre-Fall: 5/5/2027

Summer 2/Pre-Fall: 7/19/2027

### Medical Students:

	<b>Annual</b> 07/01/2026-06/30/2027
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Student	\$5,621.00
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Enrollment & waivers must be submitted by: 8/15/2026

## Rates

The above rates reflect the total charge for students who enroll in the medical plan, including optional programs purchased by the school.

## Enrollment

To enroll/waive online: The premium for the Plan will be added to your tuition bill. If you have comparable coverage and wish to waive coverage under the Plan, you must submit an Online Waiver Form. To complete the Online Waiver Form, visit [www.universityhealthplans.com/TJU](http://www.universityhealthplans.com/TJU) or call 833-207-7789.

## Important note regarding coverage for a newborn infant or newly adopted child:

A newborn child - Your newborn child is covered on your health plan for the first 31-days from the moment of birth.

- If your coverage ends during this 31-day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 31-day period has not ended.

## Medicare Eligibility Notice

You are not eligible to enroll in the student health plan if you have Medicare at the time of enrollment in this student plan. The plan does not provide coverage for people who have Medicare.

## Termination and Refunds

**Withdrawal from Classes – Leave of Absence:** If you withdraw from classes under a school-approved leave of absence, your coverage will remain in force through the end of the period for which payment has been received, and no premiums will be refunded.

**Withdrawal from Classes – Other than Leave of Absence:** If you withdraw from classes other than under a school-approved leave of absence within 31 days\* after the policy effective date, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded.

If the withdrawal is more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which payment has been received, and no premiums will be refunded.

If you withdraw from classes to enter the armed forces of any country, coverage will terminate as of the effective date of such entry and a pro rata refund of premiums will be made if you submit a written request within 90 days of withdrawal from classes.

## In-network Provider Network

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

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

Access our provider directory to find in-network providers for your plan at [<https://www.aetnastudenthealth.com>].

## Precertification

You need pre-approval from us for some covered services. Pre-approval is also called precertification. Your in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify when required, there is a **\$500** penalty for each type of covered service that was not precertified. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to [www.aetna.com](http://www.aetna.com).

## Precertification Call

Precertification should be secured within the timeframes specified below. To obtain precertification, call Member Services at the toll-free number on your ID card. You, your physician or the facility must call us within these timelines:

Non-emergency admissions:	Call at least 14 days before the date you are scheduled to be admitted.
Emergency admission:	Call within 48 hours or as soon as reasonably possible after you have been admitted.
Urgent admission:	Call before you are scheduled to be admitted.
Outpatient non-emergency medical services:	Call at least 14 days before the care is provided, or the treatment is scheduled

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

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

## Coordination of Benefits (COB)

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB). A complete description of the Coordination of Benefits provision is contained in the certificate issued to you.

## CVS Virtual Care®

From everyday illnesses and chronic conditions to mental health support, we've got your back. Once you tell us what you need, we'll connect you with trusted, in-network providers so you can schedule a virtual visit. Most mental health visits are available within two weeks. You can access 24/7 care through our virtual clinic. General Care: 100% coverage. Behavioral Health: See the schedule of benefits for more information. Go to [www.cvs.com/virtual-care](http://www.cvs.com/virtual-care) to register and schedule an appointment.

## Description of Benefits

The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Summary document will tell you about some of the important features of the Plan, other features that may be important to you are defined in the Certificate. To look at the full Plan description, which is contained in the Certificate issued to you, go to <https://www.aetnastudenthealth.com>.

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

	In-network coverage	Out-of-network coverage
<b>Policy year deductibles</b>		
Student	\$300 per policy year	\$600 per policy year
<b>Policy year deductible waiver</b>		
The policy year deductible is waived for all of the following covered services:		
<b>In-network care for:</b>		
<ul style="list-style-type: none"> <li>Preventive care and wellness (includes childhood immunizations)</li> <li>Nutritional supplements</li> <li>Pediatric Dental Type A services</li> <li>Pediatric Vision Care Services</li> <li>Physician, specialist including Consultants Office visits (including Mental Health &amp; Substance related disorders)</li> <li>Walk-in clinic visits (non-emergency visit)</li> <li>Chiropractic services</li> <li>Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)</li> <li>Inpatient hospital (room &amp; board, including intensive care) (including Mental Health &amp; Substance related disorders)</li> </ul>		
<b>In-network care and out-of-network care for:</b>		
<ul style="list-style-type: none"> <li>Well newborn nursery care</li> <li>Outpatient prescription drugs</li> <li>Emergency room</li> <li>Urgent care</li> <li>Ambulance</li> </ul>		
Covered services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Covered services applied to the in-network policy year deductibles will not be applied to satisfy the out-of-network policy year deductibles.		
<b>Maximum out-of-pocket limits</b>		
	In-network coverage	Out-of-network coverage
Student	\$9,200 per policy year	\$18,800 per policy year
Covered services applied to the out-of-network maximum out-of-pocket limit will not be applied to satisfy the in-network maximum out-of-pocket limit and covered services applied to the in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.		

	In-network coverage	Out-of-network coverage
<b>Preventative care and wellness</b>		
Routine physical exams	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Covered persons through age 21: Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents.	
Covered persons age 22 and over: Maximum visits per policy year	1 visit	
<b>Preventive care immunizations</b>		
Preventive care immunizations	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Preventive care immunization maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention	
The following is not covered under this benefit: <ul style="list-style-type: none"> <li>Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment</li> </ul>		
<b>Routine gynecological exams (including Pap smears and cytology tests)</b>		
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	60% (of the recognized charge) per visit
Well woman routine gynecological exam maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Maximum visits per policy year	1 visit	

	In-network coverage	Out-of-network coverage
<b>Preventive screening and counseling services</b>		
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	60% (of the recognized charge) per visit
Obesity and/or healthy diet counseling Maximum visits	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	
Misuse of alcohol and/or drugs counseling Maximum visits per policy year	5 visits	
Use of tobacco products counseling Maximum visits per policy year	8 visits	
Sexually transmitted infection counseling Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations	
Routine cancer screenings	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum:	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF</li> <li>Comprehensive guidelines supported by the Health Resources and Services Administration</li> </ul>	
Lung cancer screening maximums	1 screening every 12 months	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit

	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Lactation counseling services	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting]	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per item  No copayment or policy year deductible applies	60% (of the recognized charge) per item
<b>Family planning services – female contraceptives</b>		
<b>Counseling services</b>		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per item  No copayment or policy year deductible applies	60% (of the recognized charge) per item
<b>Female Voluntary sterilization</b>		
Inpatient provider services	100% (of the negotiated charge)  No copayment or policy year deductible applies	60% (of the recognized charge)
Outpatient provider services	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care</li> <li>• Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA</li> <li>• Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a provider</li> </ul>		

	In-network coverage	Out-of-network coverage
<b>Physicians and other health professionals</b>		
Physician, specialist including Consultants Office visits (non-surgical/ non-preventive care by a physician and specialist, includes telemedicine consultations)	\$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit  No policy year deductible applies	60% (of the recognized charge) per visit]
<b>Allergy testing and treatment</b>		
Allergy testing performed at a physician's or specialist's office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Allergy injections treatment performed at a physician's, or specialist office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Allergy sera and extracts administered via injection at a physician's or specialist's office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
<b>Physician and specialist surgical services</b>		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) after the per admission copayment	60% (of the recognized charge)
The following are not covered under this benefit: <ul style="list-style-type: none"> <li>• A stay in a hospital (Hospital stays are covered in the <i>Covered services and exclusions – Hospital and other facility care</i> section)</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: <ul style="list-style-type: none"> <li>• A stay in a hospital (Hospital stays are covered in the <i>Covered services and exclusions – Hospital and other facility care</i> section)</li> <li>• A separate facility charge for surgery performed in a physician's office</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>		
<b>Alternatives to physician office visits</b>		
Walk-in clinic visits (non-emergency visit)	\$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit  No policy year deductible applies	60% (of the recognized charge) per visit

	In-network coverage	Out-of-network coverage
<b>Hospital and other facility care</b>		
Inpatient hospital (room & board, including intensive care) and other miscellaneous services and supplies)  Includes birthing center facility charges	\$500 copayment then the plan pays 100% (of the balance of the negotiated charge) per admission  No policy year deductible applies	60% (of the recognized charge) per admission
The following are not covered services: <ul style="list-style-type: none"> <li>• All services and supplies provided in: <ul style="list-style-type: none"> <li>- Rest homes</li> <li>- Any place considered a person's main residence or providing mainly custodial or rest care</li> <li>- Health resorts</li> <li>- Spas</li> <li>- Schools or camps</li> </ul> </li> </ul>		
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Preadmission testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Alternatives to hospital stays</b>		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: <ul style="list-style-type: none"> <li>• The services of any other physician who helps the operating physician</li> <li>• A stay in a hospital (See the <i>Hospital care – facility charges</i> benefit in this section)</li> <li>• A separate facility charge for surgery performed in a physician's office</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>		
Home health Care	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Home health care maximum visits per policy year	120	
The following are not covered under this benefit: <ul style="list-style-type: none"> <li>• 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)</li> <li>• Transportation</li> <li>• Homemaker or housekeeper services</li> <li>• Food or home delivered services</li> <li>• Maintenance therapy</li> </ul>		

	In-network coverage	Out-of-network coverage
Hospice-Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospice-Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Respite care-maximum number of days per 30 day period	7	
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Funeral arrangements</li> <li>• Pastoral counseling</li> <li>• Bereavement counseling</li> <li>• Financial or legal counseling which includes estate planning and the drafting of a will</li> <li>• Homemaker or caretaker services that are services which are not solely related to your care and may include: <ul style="list-style-type: none"> <li>- Sitter or companion services for either you or other family members</li> <li>- Transportation</li> <li>- Maintenance of the house</li> </ul> </li> </ul>		
Skilled nursing facility-Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Emergency room	\$100 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 an emergency room	Not covered	Not covered
<p>Emergency services important note:</p> <ul style="list-style-type: none"> <li>• Out-of-network providers do not have a contract with us. The provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by the plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card and we will resolve any payment issue with the provider. Make sure the member ID is on the bill.</li> <li>• A separate emergency room copayment will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment will be waived and your inpatient copayment will apply.</li> <li>• Covered benefits that are applied to the emergency room copayment cannot be applied to any other copayment under the plan. Likewise, a copayment that applies to other covered benefits under the plan cannot be applied to the emergency room copayment.</li> <li>• Separate copayment amounts may apply for certain services given to you in the emergency room that are not part of the hospital emergency room benefit. These copayment amounts may be different from the emergency room copayment. They are based on the specific service given to you.</li> <li>• Services given to you in the emergency room that are not part of the emergency room benefit may be subject to copayment amounts.</li> </ul>		
<p>The following are not covered under this benefit:            Non-emergency services in a hospital emergency room or an independent freestanding emergency department</p>		

	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Urgent care	\$50 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit  No policy year deductible applies	\$50 copayment then the plan pays 80% (of the balance of the recognized charge) per visit  No policy year deductible applies
Non-urgent use of an urgent care provider	Not covered	Not covered
The following is not covered under this benefit: Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)		
	<b>Contracting dental provider coverage</b>	<b>Non-contracting dental provider coverage</b>
<b>Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)</b>		
Type A services	100% (of the negotiated charge) per visit  No copayment or deductible applies	70% (of the recognized charge) per visit
Type B services	80% (of the negotiated charge) per visit	60% (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 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.

## Pediatric dental care exclusions

These dental exclusions are in addition to the exclusions that apply to health coverage.

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- Cosmetic services and supplies including:
  - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Covered services and exclusions* section
  - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Mouth guards, and other devices to protect, replace or reposition teeth
- Dental implants except when part of an approved treatment plan for a covered service described in Covered services and exclusion-Reconstructive surgery and supplies
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) treatment, and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Covered services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another covered service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered above and in the [*Pediatric*] *dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider

	In-network coverage	Out-of-network coverage
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Podiatric (foot care) treatment Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Services and supplies for: <ul style="list-style-type: none"> <li>- The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches</li> <li>- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes</li> <li>- Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies</li> <li>- Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet</li> </ul> </li> </ul>		
Impacted wisdom teeth	80% (of the negotiated charge)	60% (of the recognized charge)
Accidental injury to sound natural teeth	80% (of the negotiated charge)	60% (of the recognized charge)
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• The care, filling, removal or replacement of teeth and treatment of diseases of the teeth</li> <li>• Dental services related to the gums</li> <li>• Apicoectomy (dental root resection)</li> <li>• Orthodontics</li> <li>• Root canal treatment</li> <li>• Soft tissue impactions</li> <li>• Bony impacted teeth</li> <li>• Alveolectomy</li> <li>• Augmentation and vestibuloplasty treatment of periodontal disease</li> <li>• False teeth</li> <li>• Prosthetic restoration of dental implants</li> <li>• Dental implants</li> </ul>		
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not covered under this benefit:</p> <p>Dental implants</p>		

	In-network coverage	Out-of-network coverage
<b>Clinical trials</b>		
Routine patient costs	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not covered services:</p> <ul style="list-style-type: none"> <li>• Services and supplies related to data collection and record-keeping needed only for the clinical trial</li> <li>• Services and supplies provided by the trial sponsor for free</li> <li>• The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)</li> </ul>		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Cosmetic treatment and procedures</li> </ul>		
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.
<p>The following are not covered under this benefit: Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries</p>		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Voluntary sterilization for males-Inpatient physician or specialist surgical services	80% (of the negotiated charge) after the per admission copay	60% (of the recognized charge)
Voluntary sterilization for males-outpatient physician or specialist surgical services	80% (of the negotiated charge)	60% (of the recognized charge)
Abortion-Inpatient physician or specialist surgical services	80% (of the negotiated charge) after the per admission copay	60% (of the recognized charge)
Abortion-Outpatient physician or specialist surgical services	80% (of the negotiated charge)	60% (of the recognized charge)
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Reversal of voluntary sterilization procedures, including related follow-up care</li> <li>• Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care</li> </ul>		

	In-network coverage	Out-of-network coverage
<b>Gender affirming treatment</b>		
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.
<b>Autism spectrum disorder</b>		
Autism spectrum disorder treatment, diagnosis and testing. Includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Mental Health &amp; Substance related disorders</b>		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	\$500 copayment then the plan pays 100% (of the balance of the [negotiated charge]) per admission  No policy year deductible applies	60% (of the recognized charge) per admission
Outpatient office visits (includes telemedicine consultations)	\$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit  No policy year deductible applies	60% (of the recognized charge) per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

	<b>In-network coverage (IOE facility)</b>	<b>Out-of-network coverage</b> (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
<b>Transplant services</b>		
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Transplant services-travel and lodging	Covered	
Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	\$10,000	
Maximum payable for Lodging Expenses per IOE patient	\$50 per night	
Maximum payable for Lodging Expenses per companion	\$50 per night	
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Services and supplies furnished to a donor when the recipient is not a covered person</li> <li>• Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness</li> <li>• Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness</li> </ul>		
	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Infertility Services</b>		
Treatment of Basic infertility	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.

## Infertility services exclusions

The following are not covered under the infertility services benefit:

- All infertility services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Infertility medication. See the *Covered services and exclusions-Outpatient prescription drugs* section for information on coverage of infertility prescription drugs.
- All infertility services associated with or in support of an Advanced Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, and professional services
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers
  - Gestational carrier cycles
  - Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery).
- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- Infertility medication not injected by your provider, including but not limited to menotropins, hCG, and GnRH agonists. See the *Covered services and exclusions-Outpatient prescription drugs* section for information on coverage of infertility prescription drugs.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's infertility clinical policy.

	In-network coverage	Out-of-network coverage
<b>Specific therapies and tests</b>		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge)	60% (of the recognized charge)
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge)	60% (of the recognized charge)
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge)	60% (of the recognized charge)
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan</li> <li>• Enteral nutrition</li> <li>• Blood transfusions and blood products</li> <li>• Dialysis</li> </ul>		
	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  No policy year deductible applies	60% (of the recognized charge) per visit
Chiropractic services	\$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit  No policy year deductible applies	60% (of the recognized charge) per visit

	In-network coverage	Out-of-network coverage
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	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.
<b>Other services</b>		
<b>Ambulance service</b>		
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	\$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per trip  No policy year deductible applies	Paid the same as in-network coverage
The following are not covered services: <ul style="list-style-type: none"> <li>Ambulance services for routine transportation to receive outpatient or inpatient services</li> </ul>		
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: <ul style="list-style-type: none"> <li>Whirlpools</li> <li>Portable whirlpool pumps</li> <li>Sauna baths</li> <li>Massage devices</li> <li>Over bed tables</li> <li>Elevators</li> <li>Communication aids</li> <li>Vision aids</li> <li>Telephone alert systems</li> <li>Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician</li> </ul>		
Nutritional support	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: <ul style="list-style-type: none"> <li>Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition</li> </ul>		
Prosthetic Devices & Orthotics	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Cranial prosthetics ( <i>Medical wigs</i> )	80% (of the negotiated charge) per item	80% (of the actual charge) per item
The following are not covered under this benefit: <ul style="list-style-type: none"> <li>Services covered under any other benefit</li> <li>Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace</li> <li>Trusses, corsets, and other support items</li> <li>Repair and replacement due to loss, misuse, abuse or theft</li> <li>Communication aids</li> <li>Cochlear implants</li> </ul>		

**Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)**

	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations)	100% (of the negotiated charge) per visit  No policy year deductible applies	60% (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 policy year 1 visit	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item  No policy year deductible applies	60% (of the recognized charge) per item
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 3-month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per policy year	One optical device	
<p><b>Important note:</b> Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.</p> <p>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.</p>		
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes</li> </ul>		

	In-network coverage	Out-of-network coverage
<b>Outpatient prescription drugs</b>		
<b>Coinsurance waiver for risk reducing breast cancer</b>		
The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
<b>Copayment waiver for tobacco cessation prescription and over-the-counter drugs</b>		
The prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail or mail order in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.		
Any prescription drug copayment will apply after those two regimens per policy year have been exhausted.		
<b>Copayment waiver for contraceptives</b>		
The prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network and out-of-network pharmacy.		
This means that such contraceptive methods are paid at 100% for:		
<ul style="list-style-type: none"> <li>• Certain over-the-counter (OTC) and [generic] contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%.</li> <li>• If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%.</li> </ul>		
The prescription drug copayment continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
<b>Preferred and Non-Preferred generic prescription drugs</b>		
For each fill up to a 30-day supply filled at a retail pharmacy	\$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	70% (of the recognized charge)  No policy year deductible applies
More than a 30-day supply but less than a 91-day supply filled at a retail pharmacy	\$45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	70% (of the recognized charge)  No policy year deductible applies
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	\$45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	Not Covered

	In-network coverage	Out-of-network coverage
<b>Preferred brand-name prescription drugs</b>		
For each fill up to a 30-day supply filled at a retail pharmacy	Copayment per supply of 20% of the negotiated charge then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	70% (of the recognized charge)  No policy year deductible applies
More than a 30-day supply but less than a 91-day supply filled at a retail pharmacy	Copayment per supply of 20% of the negotiated charge then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	70% (of the recognized charge)  No policy year deductible applies
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	Copayment per supply of 20% of the negotiated charge then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	Not covered
<b>Non-preferred brand-name prescription drugs</b>		
For each fill up to a 30-day supply filled at a retail pharmacy	Copayment per supply of 20% of the negotiated charge then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	70% (of the recognized charge)  No policy year deductible applies
More than a 30-day supply but less than a 91-day supply filled at a retail pharmacy	Copayment per supply of 20% of the negotiated charge then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	70% (of the recognized charge)  No policy year deductible applies
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	Copayment per supply of 20% of the negotiated charge then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	Not Covered

	In-network coverage	Out-of-network coverage
<b>Contraceptives (birth control)</b>		
Brand-name prescription drugs and devices are covered at 100% at an in-network pharmacy when a generic is not available		
For each fill up to a 12-month supply of generic and OTC drugs and devices filled at a retail pharmacy or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
For each fill up to a 12-month supply of brand-name prescription drugs and devices filled at a retail pharmacy or mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
Anti-cancer drugs taken by mouth For each fill up to a 30-day supply	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Preventive care drugs and supplements filled at a retail or mail order pharmacy For each 30-day supply	100% (of the negotiated charge per prescription or refill) No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30-day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30-day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	

### **Outpatient prescription drug exclusions**

The following are not covered services:

- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones, unless we have approved a medical exception
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a covered service
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a covered service
  - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications unless listed as a covered service
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as a covered service
- Immunizations related to travel or work
- Immunization or immunological agents unless listed as a covered service
- Implantable drugs and associated devices unless listed as a covered service
- Infertility:
  - Prescription drugs used primarily for the treatment of infertility
- Injectables including:
  - Any charges for the administration or injection of prescription drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception, unless listed in the drug guide or we have approved a medical exception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide

- That are used for the purpose of improving visual acuity or field of vision
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Prescription drugs indicated for the purpose of weight loss.
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

## General Exclusions

### Acupuncture

- Acupuncture
- Acupressure

### Blood and blood products

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

### Cosmetic services and plastic surgery

- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, including cosmetic drugs, medications and preparations used for cosmetic purposes, except where described in the *Covered services and exclusions* section

### Court-ordered services and supplies

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

### Custodial care

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

Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- Respite care except in connection with hospice care, adult or child day care, or convalescent care
- Institutional care, including room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and substance related disorder treatment):

- Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - o Maintain, not improve, a level of function
- Provide a place free from conditions that could make your physical or mental state worse

### **Dental care for adults**

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

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

### **Educational services**

Examples of these are:

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

### **Examinations**

Any health or dental examinations needed:

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

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

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

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

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

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

### **Growth/Height care**

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

### **Hearing aids**

Any tests, appliances and devices to:

- Improve your hearing
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech

### **Hearing exams**

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

### **Jaw joint disorder**

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

This exclusion does not apply to covered benefits for treatment of TMJ and CMJ as described in the *Covered services and exclusions – Temporomandibular joint dysfunction (TMJ) and Craniomandibular joint dysfunction (CMJ) treatment* section.

### **Maintenance care**

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

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

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

### **Non-U.S. citizen**

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

### **Obesity surgery and services**

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

### **Other primary payer**

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

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

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

### **Private duty nursing**

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

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

### **School health services**

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

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

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

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

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

### **Sexual dysfunction and enhancement**

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

### **Sports**

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

### **Strength and performance**

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

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

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

### **Therapies and tests**

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

### **Tobacco cessation**

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

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

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

### **Vision care for adults**

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

### **Voluntary sterilization**

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

### **Wilderness treatment programs**

See *Educational services* in this section

### **Work related illness or injuries**

Coverage available to you under workers' compensation or a similar program under local, state or federal law for any illness or injury related to employment or self-employment

Thomas Jefferson University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company Aetna Student Health<sup>SM</sup> is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

## **Sanctioned Countries**

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

## Discrimination is Against the Law

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Aetna Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). Aetna Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aetna Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 1-877-480-4161 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

### Civil Rights Coordinator

Attn: 1557 Coordinator  
CVS Pharmacy, Inc.  
1 CVS Drive, MC 2332,  
Woonsocket, RI 02895

Phone: 1-800-648-7817, TTY: 711  
Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

### U.S. Department of Health and Human Services

200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at Aetna Inc.'s website: <https://www.aetnastudenthealth.com>