Student Health Insurance

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

Schedule of benefits

Prepared exclusively for:

Policyholder:	Rider University
Policyholder number:	252650
Student policy effective date:	08/20/2025
Plan effective date:	08/20/2025
Plan issue date:	11/07/2025
Actuarial value and metallic level:	81.37% - Gold

Underwritten by Aetna Life Insurance Company in the State of New Jersey

Schedule of benefits

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

How to read your schedule of benefits

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

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

How to contact us for help

We are here to answer your questions.

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

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

Important note about your cost sharing

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

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

Here's an <u>example</u> of how cost sharing works:

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

Plan features

Policy year deductibles

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

Deductible type	In-network coverage	Out-of-network coverage
Student	$250 per **policy year**	$500 per **policy year**

Policy year deductible waiver

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

In-network care for:

- *Preventive care and wellness*
- *Pediatric Dental Type A services*
- *Pediatric Vision Care Services*
- *Physician & specialist office visits (including Mental Health and Substance Abuse)*
- *Consultant office visits*
- *Walk-in clinic (non-emergency visit)*
- *Male Sterilization*

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

- *Well newborn nursery care*
- *Outpatient prescription drugs*
- *Urgent Care*

Maximum out-of-pocket limits

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

Maximum out-of-pocket type	In-network coverage	Out-of-network coverage
Student	$9,100 per **policy year**	$18,200 per **policy year**

Precertification covered benefit penalty

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

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

- A $500 benefit penalty will be applied separately to each type of **eligible health service.** The reduction will not exceed 50% of the charges which would otherwise be covered under the plan.

The additional percentage or dollar amount of the **recognized charge** which you may pay as a penalty for failure to obtain **precertification** is not a **covered benefit**, and will not be applied to the out-of-network **policy year deductible** amount or the **maximum out-of-pocket limit**, if any.

Eligible health services

Coinsurance listed in the schedule of benefits

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

1. Preventive care and wellness

Routine physical exams

Performed at a **physician's** office

Description	In-network coverage	Out-of-network coverage
Routine physical exam	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit
Routine physical exam limits for **covered persons** through age 21: maximum age and visit limits per **policy year**	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	
Routine physical exam limits for **covered persons** age 22 and over: maximum visits per **policy year**	1 visit	

Preventive care immunizations

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

Description	In-network coverage	Out-of-network coverage
Preventive care immunizations	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (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. For details, contact your **physician** or Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	

Well woman preventive visits

Routine gynecological exams (including Pap smears)

Description	In-network coverage	Out-of-network coverage
Performed at a **physician**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (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	

Preventive screening and counseling services

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

Description	In-network coverage	Out-of-network coverage
Obesity and/or healthy diet counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (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.	
Substance use disorders counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit
Substance use disorders counseling maximum visits per **policy year**	5 visits	
Sexually transmitted infection counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit
Sexually transmitted infection counseling maximum visits per **policy year**	2 visits	

Description	In-network coverage	Out-of-network coverage
Genetic risk counseling for breast and ovarian cancer office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit
Genetic risk counseling for breast and ovarian cancer age limitations	Not subject to any age limitations	

Routine cancer screenings

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

Description	In-network coverage	Out-of-network coverage
Routine cancer screenings	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit
Routine cancer screening maximums	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF Comprehensive guidelines supported by the Health Resources and Services Administration For details, contact your **physician** or Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	
Lung cancer screening maximums	1 screening every 12 months	

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

Prenatal care

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

Description	In-network coverage	Out-of-network coverage
Preventive care services only	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit

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

Comprehensive lactation support and counseling services

Facility or office visits

Description	In-network coverage	Out-of-network coverage
Lactation counseling services	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	100% (of the **actual charge**) per visit No **policy year deductible** applies

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

Breast feeding durable medical equipment

Description	In-network coverage	Out-of-network coverage
Breast pump supplies and accessories	100% (of the **negotiated charge**) per item No **copayment** or **policy year deductible** applies	100% (of the **actual charge**) per item No **policy year deductible** applies

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

Important note:
You are limited to 2 breast pump kits per birth

- The purchase of an electric or manual breast pump, including supplies and accessories
- The purchase or rental of a multi-user breast pump, including supplies and accessories

Family planning services –
Counseling services

Description	In-network coverage	Out-of-network coverage
Contraceptive counseling services office visit	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit
Contraceptive counseling services maximum visits per **policy year** either in a group or individual setting	2 visits	

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

Contraceptives (prescription drugs and devices)

Description	In-network coverage	Out-of-network coverage
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	50% (of the **recognized charge**) per item

Female voluntary sterilization

Description	In-network coverage	Out-of-network coverage
Inpatient **provider** services	100% (of the **negotiated charge**) No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**)
Outpatient **provider** services	100% (of the **negotiated charge**) No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit

2. Physicians and other health professionals

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

Description	In-network coverage	Out-of-network coverage
Office hours visits (non-surgical and non-preventive care by a **physician** or **specialist**, includes **telemedicine** and/or telehealth consultations)	$25 **copayment** per visit No **policy year deductible** applies	50% (of the **recognized charge**) per visit

Allergy testing and treatment

Description	In-network coverage	Out-of-network coverage
Allergy testing performed at a **physician** or **specialist** office	80% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Allergy injections treatment performed at a **physician** or **specialist** office	80% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Allergy sera and extracts administered via injection at a **physician** or **specialist** office	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.

Physician and specialist – inpatient surgical services

Description	In-network coverage	Out-of-network coverage
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**)	50% (of the **recognized charge**)

Physician and specialist – outpatient surgical services

Description	In-network coverage	Out-of-network coverage
Outpatient **surgery** performed at a **physician** or **specialist** 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	50% (of the **recognized charge**) per visit

In-hospital non-surgical physician services

Description	In-network coverage	Out-of-network coverage
In-**hospital** non-surgical **physician** services	80% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Consultant services (non-surgical and non-preventive)

Description	In-network coverage	Out-of-network coverage
Office hours visits (non-surgical and non-preventive care by a consultant, includes **telemedicine** consultations)	$25 **copayment** per visit No **policy year deductible** applies	50% (of the **recognized charge**) per visit

Second surgical opinion

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

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

Description	In-network coverage	Out-of-network coverage
Walk-in clinic (non-emergency visit)	$25 **copayment** per visit No **policy year deductible** applies	50% (of the **recognized charge**) per visit

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

3. Hospital and other facility care

Hospital care (facility charges)

Description	In-network coverage	Out-of-network coverage
Inpatient **hospital** (**room and board** and other miscellaneous services and supplies) Subject to **semi-private room rate** unless **intensive care unit** is required **Room and board** includes intensive care For **physician** charges, refer to the *Physician and specialist – inpatient surgical services* benefit	80% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission

Preadmission testing

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

Anesthesia and related facility charges for a dental procedure

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

Description	In-network coverage	Out-of-network coverage
Anesthesia and related facility charges for a dental procedure	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Alternatives to hospital stays

Outpatient surgery (facility charges)

Description	In-network coverage	Out-of-network coverage
Facility charges for **surgery** performed in the outpatient department of a **hospital** or **surgery center** For **physician** charges, refer to the *Physician and specialist – outpatient surgical services* benefit	80% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Home health care

Description	In-network coverage	Out-of-network coverage
Home health care	80% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Hospice care

Description	In-network coverage	Out-of-network coverage
Inpatient facility (**room and board** and other miscellaneous services and supplies)	80% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission
Outpatient	80% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

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

Skilled nursing facility

Description	In-network coverage	Out-of-network coverage
Inpatient facility (**room and board** and miscellaneous inpatient care services and supplies) Subject to **semi-private room rate** unless **intensive care unit** is required **Room and board** includes intensive care	80% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission

4. Emergency services and urgent care

Emergency services

Description	In-network coverage	Out-of-network coverage
Emergency room	80% (of the **negotiated charge**) per visit	Paid the same as in-network coverage
Non-emergency care in an emergency room	Not covered	Not covered

Emergency services important note:

- **Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, or call Member Services for an address at 1-800-481-8814 and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.
- A separate emergency room **copayment** will apply for each visit to an emergency room. If you are admitted to a **hospital** as an inpatient right after a visit to an emergency room, your emergency room **copayment** will be waived and your inpatient **copayment** will apply.
- **Covered 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**.
- Separate **copayment** amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These **copayment** amounts may be different from the emergency room **copayment**. They are based on the specific service given to you.
- Services given to you in the emergency room that are not part of the emergency room benefit may be subject to **copayment** amounts that are different from the emergency room **copayment** amounts.

Urgent care

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

5. Pediatric dental care

Pediatric dental care

Limited to **covered persons** through the end of the month in which the person turns age 19
Dental benefits are subject to the medical plan's **policy year deductibles** and **maximum out-of-pocket limits** as explained on the schedule of benefits.

Description	In-network coverage	Out-of-network coverage
Type A services	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit
Type B services	80% (of the **negotiated charge**) per visit	50% (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
Adjunctive general services (includes 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.

Important Notes:

(1) Dental services are available from birth with an age one dental visit encouraged.
(2) A second opinion is allowed.
(3) Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
(4) Diagnostic and preventive services are linked to the **dental provider**, thus allowing you and your dependents to transfer to a different **dental provider**/practice and receive these services. The new **dental provider** is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
(5) Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
(6) Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion
(7) Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
(8) Services that are considered experimental in nature will not be considered.
(9) Charges for broken appointments will not be covered.

Pediatric dental care schedule

Diagnostic and preventive care (type A services)

Preventive Services

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

- Dental prophylaxis once every 6 months*****
- Topical fluoride treatment once every 6 months in conjunction with prophylaxis as a separate service*****
- Fluoride varnish once every 3 months for children under the age of 6
- Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.
- Space maintainers to maintain space for eruption of permanent tooth/teeth. Includes placement and removal:
  - Fixed-unilateral and bilateral
  - Removable-bilateral only
  - Recementation of fixed space maintainer
  - Removal of fixed space maintainer. Considered for provider that did not place appliance.

Diagnostic Services

***** Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

- Clinical oral evaluations once every 6 months*****
  - Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
  - Periodic oral evaluation – subsequent thorough evaluation of an established patient*****
  - Oral evaluation for patient under the age of 3 and counseling with primary caregiver*****
  - Limited oral evaluations that are problem focused
  - Detailed oral evaluations that are problem focused
- Diagnostic Imaging with interpretation
  - A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views
  - An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit
  - Additional films/views needed for diagnosing can be provided as needed
  - Bitewings, periapicals, panoramic and cephlometric radiographic images
  - Intraoral and extraoral radiographic images
  - Oral/facial photographic images
  - Maxillofacial MRI, ultrasound
  - Cone beam image capture
- Tests and examinations
- Viral culture
- Collection and preparation of saliva sample for laboratory diagnostic testing
- Diagnostic casts – for diagnostic purposes only and not in conjunction with other services

- Oral pathology laboratory
  - Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
  - Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
- Other oral pathology procedures, by report

Basic restorative care (type B services)

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth
- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered)

Major restorative care (type C services)

Endodontic Services

- Service includes all necessary radiographs or views needed for endodontic treatment
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis
- Emergency services for pain do not require prior authorization
- Service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis

Endodontic service to include:

- Therapeutic pulpotomy for primary and permanent teeth
- Pulpal debridement for primary and permanent teeth
- Partial pulpotomy for apexogensis
- Pulpal therapy for anterior and posterior primary teeth
- Endodontic therapy and retreatment
- Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
- Apexification: initial, interim and final visits
- Pulpal regeneration
- Apicoectomy/Periradicularsurgery
- Retrograde filling
- Root amputation
- Surgical procedure for isolation of tooth with rubber dam
- Hemisection
- Canal preparation and fitting of preformed dowel or post
- Post removal

Periodontal Services
Services require **precertification** with submission of diagnostic materials and documentation of need.

- Surgical services:
  - Gingivectomy and gingivoplasty
  - Gingival flap including root planning
  - Apically positioned flap
  - Clinical crown lengthening
  - Osseous surgery
  - Bone replacement graft – first site and additional sites
  - Biologic materials to aid soft and osseous tissue regeneration
  - Guided tissue regeneration
  - Surgical revision
  - Pedicle and free soft tissue graft
  - Subepithelial connective tissue graft
  - Distal or proximal wedge
  - Soft tissue allograft
  - Combined connective tissue and double pedicle graft
- Non-surgical periodontal service:
  - Provisional splinting – intracoronal and extracoronal. Can be considered for treatment of dental trauma.
  - Periodontal root planing and scaling. With prior authorization, can be considered every 6 months for individuals with special healthcare needs.
  - Full mouth debridement to enable comprehensive evaluation
  - Localized delivery of antimicrobial agents
- Periodontal maintenance

Prosthodontic Services

- All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require **precertification**.
- New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

- Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature
- Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion:
  - Resin base and cast frame dentures including any conventional clasps, rests and teeth
  - Flexible base denture including any clasps, rests and teeth
  - Removable unilateral partial dentures or dentures without clasps are not considered
- Overdenture-complete and partial
- Denture adjustments-6 months after insertion or repair
- Denture repairs-includes adjustments for first 6 months following service
- Denture rebase-following 12 months post denture insertion and subject to **precertification** denture

rebase is covered and includes adjustments for first 6 months following service

- Denture relines-following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service
- Precision attachment, by report
- Maxillofacial prosthetics-includes adjustments for first 6 months following service:
  - Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis-initial, interim and replacement
  - Obturator prosthesis: surgical, definitive and modifications
  - Mandibular resection prosthesis with and without guide flange
  - Feeding aid
  - Surgical stents
  - Radiation carrier
  - Fluoride gel carrier
  - Commissure splint
  - Surgical splint
  - Topical medicament carrier
  - Adjustments, modification and repair to a maxillofacial prosthesis
  - Maintenance and cleaning of maxillofacial prosthesis
- Implant Services are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.

Eligible health services include implant body, abutment and crown.

- Fixed prosthodontics (fixed bridges)-are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists:
  - The replacement of an existing defective fixed bridge is also allowed when noted criteria are met
  - A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge
  - Considerations and requirements noted for single crowns apply
  - Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth

- Abutment teeth must be periodontally sound and have a good long term prognosis
- Repair and recementation Pediatric partial denture for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth. Subject to **precertification**.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

- Extraction of teeth:
- Extraction of coronal remnants – deciduous tooth
- Extraction, erupted tooth or exposed root
- Surgical removal of erupted tooth or residual root
- Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
- Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
- Other surgical procedures
- Oroantral fistula
- Primary closure of sinus perforation and sinus repairs
- Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
- Surgical access of an unerupted tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to aid eruption
- Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
- Surgical repositioning of tooth/teeth
- Transseptal fiberotomy/supra crestal fiberotomy
- Surgical placement of anchorage device with or without flap
- Harvesting bone for use in graft(s).
- Alveoloplasty in conjunction or not in conjunction with extractions
- Vestibuloplasty
- Excision of benign and malignant tumors/lesions
- Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
- Destruction of lesions by electrosurgery
- Removal of lateral exostosis, torus palatinus or torus madibularis
- Surgical reduction of osseous tuberosity
- Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
- Surgical Incision
- Incision and drainage of abcess-intraoral and extraoral
- Removal of foreign body
- Partial ostectomy/sequestrectomy
- Maxillary sinusotomy
- Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
- Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider
- Reduction, open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
- Manipulation under anesthesia

- Condylectomy, discectomy, synovectomy
  - Joint reconstruction
  - Services associated with TMJD treatment require prior authorization
- Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
- Arthroscopy
- Occlusal orthotic device – includes placement and removal to same provider
- Surgical and other repairs
  - Repair of traumatic wounds – small and complicated
  - Skin and bone graft and synthetic graft
  - Collection and application of autologous blood concentrate
  - Osteoplasty and osteotomy
  - LeFort I, II, III with or without bone graft
  - Graft of the mandible or maxilla-autogenous or nonautogenous
  - Sinus augmentations
  - Repair of maxillofacial soft and hard tissue defects
  - Frenectomy and frenoplasty
  - Excision of hyperplastic tissue and pericoronal gingiva 11
  - Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
  - Emergency tracheotomy
  - Coronoidectomy
  - Implant-mandibular augmentation purposes
  - Appliance removal-"by report" for provider that did not place appliance, splint or hardware

Adjunctive general services (includes dental emergency treatment)

- Palliative treatment for emergency treatment – per visit
- Anesthesia
  - Local anesthesia NOT in conjunction with operative or surgical procedures
  - Regional block
  - Trigeminal division block
  - Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this policy which requires hospitalization or general anesthesia-2 hour maximum time
  - Intravenous conscious sedation/analgesia-2 hour maximum time
  - Nitrous oxide/analgesia
  - Non-intravenous conscious sedation to include oral medications
- Behavior management for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
  - One unit equals 15 minutes of additional time
  - Utilization thresholds are based on place of service as follows. **Precertification** is required when thresholds are exceeded.
    - Office or clinic maximum-2 units
    - Inpatient or outpatient hospital-4 units
    - Skilled nursing or long term care-2 units
- Consultation by specialist or non-primary care provider
- Professional visits
  - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
  - Hospital or ambulatory surgical center call:
    - For cases that are treated in a facility
    - For cases taken to the operating room. Dental services are provided for patient with a

medical condition covered by this policy which requires this admission as in-patient or out-patient. **Precertification** is required.
    - General anesthesia and outpatient facility charges for dental services are covered
    - Dental services rendered in these settings by a dentist not on staff are considered separately
  - Office visit for observation (during regular hours). No other service performed.
- Drugs:
  - Therapeutic parenteral drug:
    - Single administration
    - Two or more administrations not to be combined with single administration
  - Other drugs and/or medicaments by report
- Application of desensitizing medicament per visit
- Occlusal guard for treatment of bruxism, clenching or grinding
- Athletic mouth guard covered once per year
- Occlusal adjustment
  - Limited - (per visit)
  - Complete (regardless of the number of visits), once in a lifetime
- Odontoplasty
- Internal bleaching

Orthodontic services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment requires **precertification** and is not considered for cosmetic purposes
- Orthodontic consultation can be provided once annually as needed by the same provider
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

- Limited treatment for the primary, transitional and adult dentition
- Minor treatment to control harmful habits
- Continuation of transfer cases or cases started outside of the program
- Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-

Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.

- Orthognathic surgical cases with comprehensive orthodontic treatment
- Repairs to orthodontic appliances
- Replacement of lost or broken retainer
- Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

6. Specific conditions

Abortion

Description	In-network coverage	Out-of-network coverage
Inpatient **physician** or **specialist** surgical services	80% (of the **negotiated charge**)	50% (of the **recognized charge**)
Outpatient **physician** or **specialist** surgical services	80% (of the **negotiated charge**)	50% (of the **recognized charge**)

Birthing center (facility charges)

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

Diabetic services and supplies (including equipment and training)

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

Voluntary sterilization for males

Description	In-network coverage	Out-of-network coverage
Inpatient **physician** or **specialist** surgical services	100% (of the **negotiated charge**) No **policy year deductible** applies	50% (of the **recognized charge**)
Outpatient **physician** or **specialist** surgical services	100% (of the **negotiated charge**) No **policy year deductible** applies	50% (of the **recognized charge**)

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

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

Impacted wisdom teeth

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

Accidental injury to sound natural teeth

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

Dermatological treatment

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

Maternity care

Description	In-network coverage	Out-of-network coverage
Maternity care (includes delivery and postpartum care services in a **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.

Well newborn nursery care

Description	In-network coverage	Out-of-network coverage
Well newborn nursery care in a **hospital** or birthing center	80% (of the **negotiated charge**) No **policy year deductible** applies	50% (of the **recognized charge**) No **policy year deductible** applies

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

Gender affirming treatment

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

Mental health conditions

Mental health conditions treatment – inpatient

Coverage provided under the **same terms and conditions** as for any other condition.

Description	In-network coverage	Out-of-network coverage
Inpatient **hospital mental health disorders** treatment (**room and board** and other miscellaneous **hospital** services and supplies) Inpatient **residential treatment facility mental health disorders** treatment (**room and board** and other miscellaneous **residential treatment facility** services and supplies) Subject to **semi-private room rate** unless **intensive care unit** is required **Mental health disorder room and board** intensive care	80% (of the **negotiated charge**) per admission Coverage is provided under the same terms, conditions as any other **illness**.	50% (of the **recognized charge**) per admission Coverage is provided under the same terms, conditions as any other **illness**.

Mental health conditions treatment – outpatient

Description	In-network coverage	Out-of-network coverage
Outpatient **mental health disorders** office visits to a **physician** or **behavioral health provider** (Includes **telemedicine** consultations)	$25 **copayment** per visit Coverage is provided under the same terms, conditions as any other **illness**. No **policy year deductible** applies	50% (of the **recognized charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**.
Other outpatient **mental health disorders** treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive outpatient program	80% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Autism spectrum disorder or other developmental disabilities

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

Substance use disorders treatment – inpatient

Description	In-network coverage	Out-of-network coverage
Inpatient **hospital substance related disorders detoxification** (**room and board** and other miscellaneous **hospital** services and supplies) Inpatient **hospital substance related disorders** rehabilitation (**room and board** and other miscellaneous **hospital** services and supplies) Inpatient **residential treatment facility substance related disorders** (**room and board** and other miscellaneous **residential treatment facility** services and supplies) Subject to **semi-private room rate** unless **intensive care unit** is required **Substance related disorders room and board** intensive care	80% (of the **negotiated charge**) per admission Coverage is provided under the same terms, conditions as any other **illness**.	50% (of the **recognized charge**) per admission Coverage is provided under the same terms, conditions as any other **illness**.

Substance use disorders treatment – outpatient
Detoxification and rehabilitation

Description	In-network coverage	Out-of-network coverage
Outpatient **substance related disorders** office visits to a **physician** or **behavioral health provider** (Includes **telemedicine** consultations)	$25 **copayment** per visit Coverage is provided under the same terms, conditions as any other **illness**. No **policy year deductible** applies	50% (of the **recognized charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**.
Other outpatient **substance related disorder** services Partial hospitalization treatment Intensive outpatient program	80% (of the **negotiated charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**.	50% (of the **recognized charge**) per visit Coverage is provided under the same terms, conditions as any other **illness**.

Reconstructive surgery and supplies

Description	In-network coverage	Out-of-network coverage
Reconstructive **surgery** and supplies (includes reconstructive breast **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.

Transplant services

Description	In-network coverage (IOE facility)	**Out-of-network coverage** (Includes **providers** who are otherwise part of **Aetna's** network but are non-IOE **providers**)
Inpatient and outpatient transplant facility services Includes transplants for treatment of Wilm's tumor	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 Includes transplants for treatment of Wilm's tumor	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

Comprehensive infertility services (includes basic and advanced reproductive technology (ART) services)

Description	In-network coverage	Out-of-network coverage
Inpatient and outpatient care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of ovulation induction cycles per lifetime while on medications to stimulate the ovaries	4	
Fertility preservation	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 cycles lifetime for ART	4	

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Description	In-network coverage	Out-of-network coverage
Diagnostic complex imaging services performed in the outpatient department of a **hospital** or other facility	80% (of the **negotiated charge**)	50% (of the **recognized charge**)

Diagnostic lab work and radiological services

Description	In-network coverage	Out-of-network coverage
Diagnostic lab work performed in a **physician's** office, the outpatient department of a **hospital** or other facility	80% (of the **negotiated charge**)	50% (of the **recognized charge**)
Diagnostic radiological services performed in a **physician's** office, the outpatient department of a **hospital** or other facility	80% (of the **negotiated charge**)	50% (of the **recognized charge**)

Chemotherapy

Description	In-network coverage	Out-of-network coverage
Chemotherapy	80% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Outpatient infusion therapy

Description	In-network coverage	Out-of-network coverage
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.

Outpatient radiation therapy

Description	In-network coverage	Out-of-network coverage
Outpatient radiation therapy	80% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Specialty prescription drugs

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

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

Outpatient respiratory therapy

Description	In-network coverage	Out-of-network coverage
Respiratory therapy	80% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Transfusion or kidney dialysis of blood

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

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

Description	In-network coverage	Out-of-network coverage
Cardiac rehabilitation	80% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Pulmonary rehabilitation

Description	In-network coverage	Out-of-network coverage
Pulmonary rehabilitation	80% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Short-term rehabilitation and habilitation therapy services

Description	In-network coverage	Out-of-network coverage
Outpatient physical, occupational, speech, and cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services	80% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Maximum visits per **policy year**	Unlimited	

Chiropractic services

Description	In-network coverage	Out-of-network coverage
Chiropractic services	80% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

Diagnostic testing for learning disabilities

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

8. Other services

Ambulance service

Description	In-network coverage	Out-of-network coverage
Emergency ground, air, and water **ambulance** (Includes non-emergency **ambulance**)	80% (of the **negotiated charge**) per trip	Paid the same as in-network coverage

Clinical trials

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

Durable medical equipment (DME)

Description	In-network coverage	Out-of-network coverage
Durable medical equipment	80% (of the **negotiated charge**) per item	50% (of the **recognized charge**) per item

Nutritional support

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

Orthotic and prosthetic devices

Description	In-network coverage	Out-of-network coverage
Cochlear implants limited to covered persons age 18 and older	80% (of the **negotiated charge**) per item	50% (of the **recognized charge**) per item
All other orthotic and prosthetic devices	80% (of the **negotiated charge**) per item	50% (of the **recognized charge**) per item

Hearing aids and cochlear implants

Description	In-network coverage	Out-of-network coverage
Hearing aids and cochlear implant devices	80% (of the **negotiated charge**) per item	50% (of the **recognized charge**) per item
Frequency limit	One per ear every 24 consecutive months	

Hearing exams

Description	In-network coverage	Out-of-network coverage
Hearing exams	80% (of the **negotiated charge**) per visit No **policy year deductible** applies	50% (of the **recognized charge**) per visit
Hearing exam maximum	1 hearing exam every 24 consecutive period	

Podiatric (foot care) treatment

Description	In-network coverage	Out-of-network coverage
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.

Sickle cell anemia treatment

Sickle cell anemia 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.

Home hemophilia treatment

Home hemophilia treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Vision care

Pediatric vision care

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

Pediatric routine vision exams (including refraction)

Description	In-network coverage	Out-of-network coverage
Performed by a legally qualified ophthalmologist or optometrist	$20 **copayment** per visit No **policy year deductible** applies	50% (of the **recognized charge**) per visit
Maximum visits per **policy year**	1 visit	

Pediatric comprehensive low vision evaluations

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

Pediatric vision care services and supplies

Description	In-network coverage	Out-of-network coverage
Office visit for fitting of contact lenses	$20 **copayment** per visit No **policy year deductible** applies	50% (of the **recognized charge**) per visit
Maximum contact lens fitting visits per **policy year**	1 visit	
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	$40 **copayment** per item No **policy year deductible** applies	50% (of the **recognized charge**) per item
Maximum number of eyeglass frames per **policy year**	One set of eyeglass frames	
Maximum number of **prescription** lenses per **policy year**	One pair of **prescription** lenses	

Description	In-network coverage	Out-of-network coverage
Maximum number of **prescription** contact lenses per **policy year** (includes non-conventional **prescription** contact lenses and aphakic lenses prescribed after cataract **surgery**)	Daily disposable: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per **policy year**	One optical device	

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

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

9. Outpatient prescription drugs

Plan features

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

Policy year deductible and copayment waiver for risk reducing breast cancer

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

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

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

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

Policy year deductible and copayment waiver for contraceptives

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

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

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

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

Generic prescription drugs (including specialty drugs)

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	$15 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$15 **copayment** per supply then the plan pays 100% (of the balance of the **recognized charge**) No **policy year deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$37.50 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$37.50 **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 (including specialty drugs)

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	**Copayment** per supply of 50% of the **negotiated charge** No **policy year deductible** applies	**Copayment** per supply of 50% 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 50% of the **negotiated charge** No **policy year deductible** applies	**Copayment** per supply of 50% of the **recognized charge** No **policy year deductible** applies

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

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	**Copayment** per supply of 50% of the **negotiated charge** No **policy year deductible** applies	**Copayment** per supply of 50% 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 50% of the **negotiated charge** No **policy year deductible** applies	**Copayment** per supply of 50% of the **recognized charge** No **policy year deductible** applies

Diabetic drugs, and insulin important note:
Your cost share will not exceed $35 per 30 day supply of a covered preferred **prescription** insulin drug.

Asthma inhaler important note:
Your cost share will not exceed $50 per 30 day supply of a covered **prescription** asthma inhalers filled at a network pharmacy.

Epinephrine autoinjector device important note:
Your cost share will not exceed $25 per 30 day supply of a covered **prescription** epinephrine autoinjector device filled at a network pharmacy.

Infertility drugs

Description	In-network coverage	Out-of-network coverage
For each fill up to a 30 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits. For example, if you have a **generic prescription drug**, refer to the **generic prescription drug** section of the schedule of benefits.	Paid according to the type of drug per the schedule of benefits. For example, if you have a **generic prescription drug**, refer to the **generic prescription drug** section of the schedule of benefits.
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits, above. For example, if you have a **generic prescription drug**, refer to the **generic prescription drug** section of the schedule of benefits.	Paid according to the type of drug per the schedule of benefits, above. For example, if you have a **generic prescription drug**, refer to the **generic prescription drug** section of the schedule of benefits.

Anti-cancer drugs taken by mouth

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

Contraceptives (birth control)

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

Description	In-network coverage	Out-of-network coverage
For each fill up to a 12 month supply of generic and OTC drugs and devices filled at a **retail 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

Preventive care drugs and supplements

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

Risk reducing breast cancer prescription drugs

Description	In-network coverage	Out-of-network coverage
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
Risk reducing breast cancer **prescription drugs** maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered risk reducing breast cancer **prescription drugs**, contact Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	

Tobacco cessation prescription and over-the-counter drugs

<table>
<tr><th>Description</th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td>Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy

For each 30 day supply</td><td>100% (of the negotiated charge) per prescription or refill

No copayment or policy year deductible applies</td><td>Paid according to the type of drug per the schedule of benefits, above. For example, if you have a generic prescription drug, refer to the generic prescription drug section of the schedule of benefits.</td></tr>
<tr><td>Tobacco cessation prescription drugs and OTC drugs maximums</td><td colspan="2">Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits.
Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number in the How to contact us for help section.</td></tr>
</table>

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

General coverage provisions

This section provides detailed explanations about these features:

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

Policy year deductible provisions

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

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

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

Individual

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

Copayments

In-network coverage

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

Out-of-network coverage

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

Coinsurance

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

Maximum out-of-pocket limits provisions

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

Eligible health 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**. **Eligible health services** applied to thein-network **maximum out-of-pocket limit** will not be applied to satisfy the out-of-network **maximum out-of-pocket limit**.

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

Individual

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

Medical and outpatient prescription drugs

In-network care

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

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

- All costs for non-covered services

Out-of-network care

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

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

- Any out-of-pocket costs for outpatient **prescription drugs**

Calculations; determination of recognized charge; determination of benefits provisions

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

Student Health Insurance

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

Certificate of Coverage

Prepared exclusively for:

Policyholder:	Rider University
Policyholder number:	252650
Student policy effective date:	08/20/25
Plan effective date:	08/20/25
Plan issue date:	11/07/25

Underwritten by Aetna Life Insurance Company

Notice of Non-Discrimination:

Aetna Life Insurance Company does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.

Welcome

Thank you for choosing **Aetna®**.

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

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

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

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

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

Welcome to your **Aetna** plan.

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Schedule of benefits	Issued with your certificate of coverage

Let’s get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire certificate of coverage and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words in the certificate of coverage and schedule of benefits

- When we say “you” and “your”, we mean the **covered student**
- When we say “us”, “we”, and “our”, we mean **Aetna**
- Some words appear in **bold** type and we define them in the *Glossary* section

Sometimes we use technical medical language that is familiar to medical **providers**. If you need help with any of the terms, call Member Services at the toll-free number on your ID card.

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible health services** for which your plan has the obligation to pay.

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

How your plan works – starting and stopping coverage

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

Your coverage typically ends when you are no longer a student. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn’t necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

Eligible health services

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

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

- They are listed in the *Eligible health services and exclusions* section.
- They are not carved out in the *What your plan doesn’t cover – general exclusions* section.
- They are not beyond any limits in the schedule of benefits.

Paying for eligible health services– the general requirements

There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:

- The **eligible health service** is **medically necessary**
- You get the **eligible health service** from an **in-network provider** or **out-of-network provider**
- You or your **provider precertifies** the **eligible health service** when required

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

Paying for eligible health services– sharing the expense

Generally your plan and you will share the expense of your **eligible health services** when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense and sometimes you will. For more information see the *What the plan pays and what you pay* section, and see the schedule of benefits.

Disagreements

We know that people sometimes see things differently.

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

For more information see the *When you disagree - claim decisions and appeals procedures* section.

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

Your in-network coverage helps you:

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

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

School health services

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

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

You don’t have to access care through **school health services**. You may go directly to **in-network providers** for **eligible health services**. Your plan often will pay a bigger share for **eligible health services** that you get through **school health services**.

For more information about **in-network providers**, see the *Who provides the care* section.

Aetna's network of providers

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

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

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

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

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

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

Your out-of-network coverage:

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

You will find details on:

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

Surprise bill

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

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

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

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

Ancillary services mean any professional services including:

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

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

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

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

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

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

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

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

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

How to contact us for help

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

- Calling our Member Services at the toll-free number 1-800-481-8814
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156
- Visiting https://www.aetnastudenthealth.com to register and access your **Aetna** website

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

Your ID card

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

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

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

Who the plan covers

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

You will find information in this section about:
- Who is eligible?
- When you can join the plan
- Special times you can join the plan

Who is eligible?
Undergraduate Students taking 12 or more credits, Graduate Students taking 9 or more credits and all International Students are required to have health insurance. Students required to have health insurance will be enrolled in and charged for the Student Health Insurance Plan (SHIP). Students may opt-out of the SHIP by submitting a waiver form documenting proof of comparable coverage.

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

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

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

When you can join the plan
As a student you can enroll yourself:
- During the enrollment period
- At other special times during the year (see the *Special times you can join the plan* section below)

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

Notification of change in status
It is important that you notify us and the **policyholder** of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us and the **policyholder** as soon as possible of status changes such as:
- Change of address or phone number
- Change in marital status
- Enrollment in **Medicare**
- You enroll in any other health plan

Special times you can join the plan
You can enroll in these situations:
- When you did not enroll in this plan before because:
  - You were covered by another health plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
- You become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.
- You lose your eligibility for enrollment in Medicaid, NJ Family Care or an S-CHIP plan. We must receive the completed enrollment information within 120 days of the date coverage ends.
- When you are a victim of domestic abuse or spousal abandonment and you don't want to be enrolled in the perpetrator's health plan.

We must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above. We must receive your completed enrollment information from you within 60 days of the date you become eligible for State premium assistance under Medicaid or and S-CHIP plan.

Effective date of coverage
Enrollment
Student coverage
If you enrolled on or before the effective date of the **student policy** and you were eligible for health benefits at the time, your coverage will take effect as of the effective date of the **student policy**. Your coverage will take effect on this date if we received your completed enrollment application or you did not submit a waiver form to waive automatic enrollment in the student plan and you paid any required **premium** contribution.

If you enroll after the effective date of the **student policy** and you are eligible for health benefits at the time, your coverage will take effect as of that date as long as:
- We agree
- We receive your completed request for enrollment
- You pay any **premium** contribution.

Late enrollment
If we receive your enrollment application and **premium** contribution more than 31 days after the date you become eligible, coverage will only become effective if, and when:
- We agree to enroll you
- You enroll during the **policyholder's** late enrollment period, or
- You enroll because you lost coverage for any reason under another health plan with similar health coverage

Medical necessity and precertification requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible health services.** See the *Eligible health services and exclusions* and *General exclusions* sections plus the schedule of benefits.

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

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

This section addresses the **medical necessity** and **precertification** requirements.

Medically necessary; medical necessity

As we said in the *Let's get started!* section, **medical necessity** is a requirement for you to receive a **covered benefit** under this plan.

The **medical necessity** requirements are stated in the *Glossary* section, where we define "**medically necessary, medical necessity**”. That is where we also explain what our medical directors or their **physician** designees consider when determining if an **eligible health service** is **medically necessary**.

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

Precertification

READ THIS PROVISION CAREFULLY TO LEARN HOW TO AVOID POSSIBLE BENEFIT REDUCTIONS.

You need **precertification** from us for some **eligible health services**.

Precertification for medical services and supplies

In-network care

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

Out-of-network care

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

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

Type of care	Timeframe
Non-emergency admission	Call at least 14 days before the date you are scheduled to be admitted
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**.

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

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

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

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

What if you don't obtain the required precertification?
If you don't obtain the required **precertification**:
- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits *Precertification covered benefit penalty* section.
- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your out-of-network **policy year deductibles** or **maximum out-of-pocket limits**.

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

Inpatient –
- Gender affirming treatment
- Obesity (bariatric) **surgery**
- **Stays** in a **hospice facility**
- **Stays** in a **hospital**
- **Stays** in a rehabilitation facility
- **Stays** in a **residential treatment facility** for treatment of **mental health conditions** and **substance use disorders** beginning on the 181st day of the plan year whether the days are consecutive or intermittent partial days or full days
- **Stays** in a **skilled nursing facility**

Outpatient –
- ART services
- Certain **prescription drugs** and devices
- Gender affirming treatment
- Home health care
- **Hospice care**
- Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
- Obesity (bariatric) **surgery**
- Partial hospitalization treatment – **mental health conditions** and **substance use disorders** treatment beginning on the 181st day of the plan year whether the days are consecutive or intermittent partial days or full days

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

Sometimes you or your **provider** may want us to review a service that doesn't require **precertification** before you get care. This is called a predetermination, and it is different from **precertification**. Predetermination means that you or your **provider** requests the pre-service clinical review of a service that does not require **precertification**. If you need help with these terms, contact Member Services by calling the toll-free number on your ID card.

For certain drugs covered under your medical plan or **prescription drug** plan, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**.

Requesting a medical exception

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

- Contact Member Services at the toll-free number 1-800-481-8814
- Log in to your **Aetna** website at https://www.aetnastudenthealth.com
- Submit the request in writing to CVS Health, ATTN: **Aetna** PA, 1300 E Campbell Road, Richardson, TX 75081

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

Eligible health services and exclusions

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

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

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

For example:

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

We explain **eligible health services** and exclusions in this section. You can find out about general exclusions in the *General exclusions* section and about limitations in the schedule of benefits.

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

Important note:
Sex-specific **eligible health services** are covered when medically appropriate, regardless of identified gender.

1. Preventive care and wellness

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

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

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

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

- Diagnostic testing for the treatment or diagnosis of a medical condition will not be covered under the preventive care and wellness benefit. For those types of tests and treatment, you will pay the cost sharing specific to **eligible health services** for diagnostic testing and treatment.

- Gender-specific preventive care and wellness benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

- To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging in to your **Aetna** website at https://www.aetnastudenthealth.com or by calling the toll-free number in the *How to contact us for help* section. This information can also be found at the https://www.healthcare.gov website.

Routine physical exams

Eligible health services include office visits to your **physician** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
    - Screening and counseling services on topics such as:
        - Interpersonal and domestic violence
        - Sexually transmitted diseases
        - Human Immune Deficiency Virus (HIV) infections
    - Screening for gestational diabetes for women
    - High-risk Human Papillomavirus (HPV) DNA testing for women age 30 and older
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns:
    - An initial **hospital** checkup
    - Hearing loss screenings by appropriate electrophysiologic screening measures
    - Periodic monitoring for delayed onset hearing loss

Preventive care immunizations

Eligible health services include immunizations provided by your **physician** or other **health professional** for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the New Jersey Department of Health and Senior Services.

The following is not covered under this benefit:

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

Well woman preventive visits

Eligible health services include your routine:

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

Preventive screening and counseling services

Eligible health services include screening and counseling by your **health professional** for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting.

Here is more detail about those benefits:

- **Obesity and/or healthy diet counseling**
  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Substance use disorders**
  Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment
  - Tobacco cessation
    - Preventive counseling visits
    - Treatment visits
    - Class visits

  Tobacco product means a substance containing tobacco or nicotine such as:
  - Cigarettes
  - Cigars
  - Smoking tobacco
  - Snuff
  - Smokeless tobacco
  - Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**
  Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**
  Eligible health services include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms
- A digital tomosynthesis if you are age 40 or older
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Computed tomography colonography
- Colonoscopies (includes:
  - Bowel preparation medications
  - Anesthesia
  - Removal of polyps performed during a screening procedure
  - Pathology exam on any removed polyps)
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

Prenatal care

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

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

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

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

Comprehensive lactation support and counseling services

Eligible health services include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast-feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support **provider**.

Breast feeding durable medical equipment

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

Breast pump

Eligible health services include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**
- Purchase of breast pump equipment is limited to two breast pump kits per birth. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility

Family planning services –contraceptives

Eligible health services include family planning services such as:

Counseling services

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

Contraceptives

Eligible health services include contraceptive **prescription drugs** (except for over-the-counter contraceptives approved by the FDA) and devices (including any related services or supplies) when they are provided by, administered, or removed by a **provider**.

Voluntary sterilization

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

Important note:

See the following sections for more information:

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

The following are not covered under this benefit:

- Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a **provider**

2. Physicians and other health professionals

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

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

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

Important note:
Your **student policy** covers **telemedicine** and/or **telehealth**. All in-person **physician** or **specialist** office visits that are **covered benefits** are also covered if you use **telemedicine** and/or **telehealth** instead.

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

Allergy testing and treatment

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

- Allergy testing
- Allergy injections treatment
- Allergy sera and extracts administered via injection

Physician and specialist – inpatient surgical services

Eligible health services include the services of:

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

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

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

we will pay for the one that costs the most.

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

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

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

The following are not covered under this benefit:

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

Physician and specialist – outpatient surgical services

Eligible health services include the services of:

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

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

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

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

The following are not covered under this benefit:

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

In-hospital non-surgical physician services

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

Consultant services (non-surgical and non-preventive)

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

Covered benefits include treatment by the consultant.

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

Coverage includes treatment for child lead poisoning.

Important note:
Your **student policy** covers **telemedicine** and/or **telehealth**. All in-person consultant office visits provided by a **physician** or **specialist** that are **covered benefits** are also covered if you use **telemedicine** instead.

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

Second surgical opinion

Eligible health services include a second surgical opinion by a s**pecialist** to confirm your need for a **surgery**. The **specialist** must be board-certified in the medical field for the **surgery** that is being proposed by your **physician**.

Covered benefits include diagnostic lab work and radiological services ordered by the **specialist**.

We must receive a written report from a **specialist** on the second surgical opinion.

Alternatives to physician and specialist office visits

Walk-in clinic (non-emergency visit)

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

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

3. Hospital and other facility care

Hospital care (facility charges)

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

- Semi-private **room and board**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition or when only private rooms are available.
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge.
- Services of **physicians** employed by the **hospital**.
- **Intensive care units** of a **hospital**

The following are not **eligible health services**:

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

Preadmission testing

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

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

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

Anesthesia and related facility charges for dental care

Eligible health services include:

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

for your dental care.

The following conditions must be met:

- Your **dental provider** cannot safely perform the oral **surgery** in a dental office setting, and
- You are a child age 6 or under, or
- You are developmentally disabled

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

Alternatives to hospital stays

Outpatient surgery (facility charges)

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

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

The following are not covered under this benefit:
- A **stay** in a **hospital** (See the *Hospital care – facility charges* benefit in this section)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Home health care

Eligible health services include home health care services provided by a **home health care agency** in the home, but only when all of the following criteria are met:
- Your **physician** orders them
- The services take the place of your needing to **stay** in a **hospital** or a **skilled nursing facility**, or needing to receive the same services outside your home
- The services are part of a **home health care plan**
- The services are **skilled nursing services**, **home health aide** services or medical social services, or are short-term speech, physical or occupational therapy
- **Home health aide** services are provided under the supervision of a home health care provider

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

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

The following are not covered under this benefit:
- Nursing and **home health aide** services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Homemaker or housekeeper services
- Maintenance therapy

Hospice care

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

The types of **hospice care** services that are eligible for coverage include:
- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a **hospice care agency** or **hospice care** provided in a **hospital**
- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day
- Part-time or intermittent **home health aide** services to care for you up to eight hours a day

- Medical social services under the direction of a **physician** such as:
  - Assessment of your social, emotional and medical needs, and your home and family situation
  - Identification of available community resources
  - Assistance provided to you to obtain resources to meet your assessed needs

Hospice care services provided by the **providers** below may be covered, even if the **providers** are not an employee of the **hospice care agency** responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient **prescription drugs**
  - Psychological counseling
  - Dietary counseling

The following are not covered under this benefit:

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

Skilled nursing facility

Eligible health services include inpatient **skilled nursing facility** care.

The types of **skilled nursing facility** care services that are eligible for coverage include:

- **Room and board**, up to the **semi-private room rate**
- Services and supplies that are provided during your **stay** in a **skilled nursing facility**

4. Emergency services and urgent care

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

Emergency services

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

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

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

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

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

For follow-up care, you are covered when:

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

In case of a medical emergency

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

Non-emergency condition

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

The following are not covered under this benefit:

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

Urgent care

In case of an urgent condition

Urgent condition

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

Non-urgent care

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

Examples of non-urgent care are:

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

The following is not covered under this benefit:

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

5. Pediatric dental care

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

Dental emergencies

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

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

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

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

Orthodontic treatment

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

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

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

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

Replacements

The plan's "replacement rule" applies to:

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

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

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

Missing teeth that are not replaced

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

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

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

Getting an advance claim review

This only applies to out-of-network coverage. The purpose of the advance claim review is to determine, in advance, what we will pay for proposed services. Knowing ahead of time which services are covered and the benefit amount payable, helps you and your **dental provider** make informed decisions about the care you are considering.

Important note:
The advance claim review is not a guarantee of coverage and payment, but rather an estimate of the amount or scope of benefits to be paid.

When to get an advance claim review
An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $350. Here are the steps to get an advance claim review:

1. Ask your **dental provider** to write down a full description of the treatment you need, using either an **Aetna** claim form or an American Dental Association (ADA) approved claim form
2. Before treating you, your **dental provider** should send the form to us
3. We may request supporting images and other diagnostic record.
4. Once all of the information has been gathered, we will review the proposed treatment plan and provide you and your **dental provider** with a statement outlining the benefits payable
5. You and your **dental provider** can then decide how to proceed

The advance claim review is voluntary. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, we will take into account alternate procedures, services, or courses of dental treatment for the dental condition in question in order to accomplish the anticipated result. See the *When does your plan cover other treatment?* section below.

What is a course of dental treatment?
A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more **dentists** to treat a dental condition that was diagnosed by the attending **dentist** during an oral examination. A course of treatment starts on the date your **dentist** first renders a service to correct or treat the diagnosed dental condition.

Pediatric dental care exclusions

Any dental services and supplies that are not covered under the New Jersey Child Health Insurance Plan. See the Pediatric dental care section in the Schedule of benefits for a description of eligible dental services and supplies.

6. Specific conditions

Abortion

Eligible health services include services provided and supplies used in connection with an abortion.

Birthing center (facility charges)

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

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

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

Dental care anesthesia

Eligible health services include anesthesia for dental care, that your physician has certified, cannot be performed in the dentist's office due to age or condition of the covered person.

The related dental service unless specifically listed as a covered service in this certificate are not **eligible health services.**

Diabetic services and supplies (including equipment and training)

Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Insulin preparations
  - Hypodermic needles and syringes used for the treatment of diabetes
  - Injection aids for the blind
  - Diabetic test agents
  - Lancets/lancing devices
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Injectable glucagons
  - Glucagon emergency kits
- Equipment
  - External insulin pumps
  - Blood glucose meters without special features, unless required due to blindness
- Training
  - Self-management training provided by a health care **provider** certified in diabetes self-management training
  - An in-network dietician registered by a nationally recognized Professional Association of Dietitians
  - A health professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators

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

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

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

Eligible health services include:

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

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

The following are not covered under this benefit:

- Dental implants

Impacted wisdom teeth

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

Accidental injury to sound natural teeth

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

The following are not covered under this benefit:

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

Dermatological treatment

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

The following are not covered under this benefit:

- **Cosmetic** treatment and procedures

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

After your child is born, **eligible health services** include:
- 48 hours of inpatient care in a **hospital** or birthing center after a vaginal delivery
- 96 hours of inpatient care in a **hospital** or birthing center after a cesarean delivery
- A shorter **stay** if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier
- The mother could be discharged earlier. If so, the plan will pay for 2 post-delivery home visits by a health care **provider**

We provide such coverage subject to the following:
- The attending **physician** prescribes inpatient care
- The mother must request the inpatient care

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

Well newborn nursery care
Eligible health services include routine care of your well newborn child in a **hospital** or birthing center such as:
- Well newborn nursery care during the mother's **stay** but for not more than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery
- **Hospital** or birthing center visits and consultations for the well newborn by a **physician** but for not more than 1 visit per day

Gender affirming treatment
Eligible health services include certain services and supplies for gender affirming treatment.

Important note:
Visit https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html for detailed information about this benefit, including eligibility and **medical necessity** requirements. You can also call *Member Services* at the toll-free number in the *How to contact us for help* section.

Mental health Conditions
Mental health Conditions treatment
Eligible health services include the treatment of **mental health conditions** provided by a general medical **hospital**, **psychiatric hospital**, **residential treatment facility**, **physician**, or **behavioral health provider** as follows:
- **Inpatient room and board** at the **semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition or when only private rooms are available).
- Other services and supplies related to your condition that are provided during your **stay** in a general medical **hospital**, **psychiatric hospital**, or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a general medical **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
    - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** and/or **telehealth** consultations)
    - Individual, group and family therapies for the treatment of mental health

- Other outpatient mental health treatment such as:
  - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
  - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
  - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
    - Your **physician** orders them
    - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
    - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease
  - Electro-convulsive therapy (ECT)
  - Transcranial magnetic stimulation (TMS)
  - Psychological testing
  - Neuropsychological testing
  - Observation
  - Peer counseling support by a peer support specialist (including **telemedicine** and/or **telehealth** consultation)

Autism spectrum disorder or other developmental disabilities

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

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

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

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

Substance use disorders treatment

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

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

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

Telemedicine and/or **telehealth important note:**
Your **student policy** covers **telemedicine** for **mental health conditions** and **substance use disorders**. All in-person **physician** or **behavioral health provider** office visits that are **covered benefits** are also covered if you use **telemedicine** and/or **telehealth** provided by a **physician** or **behavioral health provider** instead.

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

Reconstructive surgery and supplies

Eligible health services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed. Services and supplies include:
  - An implant
  - Areolar and nipple reconstruction
  - Areolar and nipple re-pigmentation
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema and prosthetic devices
- The following coverage is provided following a mastectomy:
  - A minimum of 72 hours of inpatient care following a modified radical mastectomy
  - A minimum of 48 hours of inpatient care following a simple mastectomy
  - A shorter length of **stay** if you and your **physician** determines that a shorter length of **stay** is **medically necessary**
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Transplant services
Eligible health services include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types:

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

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

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

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

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

Infertility services
You are eligible for infertility services if:

- You are covered under this plan. For the purposes of this provision, when we refer to your partner, we mean spouse, domestic partner or civil union partner.
- There exists a condition that:
  - Is demonstrated to cause the disease of infertility.
  - Has been recognized by your or your partner's **physician** or infertility **specialist** and documented in your or your partner's medical records.
  - You or your partner are unable to carry a pregnancy to live birth.

- Or any procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or as defined by the New Jersey Department of Health.
- You or your partner do not have infertility that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.

Eligible health services include:

- Seeing an in-network **provider** to diagnose and evaluate the underlying medical cause of infertility including up to 12 intrauterine insemination (IUI) for members without a partner as limited under the definition of infertility. Covered services are dependent on age and prior care received.
- Seeing an in-network **provider** to do **surgery** to treat the cause of infertility. Examples are endometriosis **surgery** or, for men, varicocele **surgery.**
- Artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination.
- **Prescription** drugs injected by your **provider** to stimulate the ovaries
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.

Infertility **covered services** may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your plan. For plans with cycle limits, a "cycle" is defined as:

- An attempt at ovulation induction while on medication to stimulate the ovaries with or without artificial insemination

Aetna's National Infertility Unit

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with determining eligibility for benefits and **precertification**. They can also give you information about our infertility **Institutes of Excellence™ (IOE) facilities**. You can call the NIU at 1-800-575-5999.

Your in-network **provider** will request approval from us in advance for your infertility services.

Eligible **services** include the following services provided by an ART **specialist**:

- Ovulation induction cycle(s) using medication to stimulate the ovaries. This may include the use of ultrasound and lab tests.
- In vitro fertilization (IVF).
- Zygote intrafallopian transfer (ZIFT).
- Gamete intrafallopian transfer (GIFT).
- Cryopreserved (frozen) embryo transfers (FET).
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery
- Assisted hatching (AH)
- Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)
- **Prescription** drugs injected by your **network provider** to stimulate the ovaries.

ART **covered services** may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your plan.
For plans with ovulation induction cycle limits, an ovulation induction cycle is defined as an attempt at ovulation induction while on medication to stimulate the ovaries with or without artificial insemination.

For plans with ART cycle limits, an ART "cycle" is defined as:

ART service	Procedure	Cycle count
IVF	One complete fresh cycle with transfer (egg retrieval, fertilization, and transfer of embryo)	One full cycle
IVF	One fresh cycle with attempted egg aspiration (with or without egg retrieval) but without transfer of embryo	One half cycle
IVF	Fertilization of egg and transfer of embryo	One half cycle
IVF	One cryopreserved (frozen) embryo transfer	One half cycle
GIFT	One complete cycle	One full cycle
ZIFT	One complete cycle	One full cycle

Fertility preservation
Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use.

Eligible health services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned medical services may cause infertility such as:
  - Chemotherapy or radiation therapy that is established in medical literature to result in infertility
  - Other gonadotoxic therapies
  - Removing the uterus
  - Removing both ovaries or testicles
- You have a diagnosis of iatrogenic infertility caused by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.
- You require a procedure consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or as defined by the New Jersey Department of Health.
- You have a diagnosis of cancer and you are planning cancer treatment that is demonstrated to result in **infertility.** Planned cancer treatments include:
  - Bilateral orchiectomy (removal of both testicles).
  - Bilateral oophorectomy (removal of both ovaries).
  - Hysterectomy (removal of the uterus).
  - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**.
- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the criteria below:
  - You are a member under 35 years of age that has had an unmedicated day 3 FSH test done within the past 12 months. The results of your unmedicated day 3 FSH test must be less than 19mlU/mL in your most recent lab test to use your own eggs.
  - You are a member 35 years of age or older that has had an unmedicated day 3 FSH test done within the past 6 months. The results of your unmedicated day 3 FSH test must be less than 19mlU/mL in your most recent lab test to use your own eggs if you are less than age 40. If you are age 40 and older, the results of your unmedicated day 3 FSH test must be less than 19mlU/mL in all prior tests to use your own eggs.

A cycle is an attempt at ovulation induction or intrauterine insemination. The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered complete at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

Premature ovarian insufficiency

If your infertility has been diagnosed as premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services using donor eggs/embryos through age 45 regardless of FSH level.

Infertility services exclusions

The following are not **eligible health services**:

- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- 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.
- Reversal of voluntary sterilizations, including follow-up care.
- More than four completed egg retrievals while you are covered under this plan or any other plan with this contract holder. Any egg retrievals cycles that were not covered by insurance do not count against the four completed egg retrieval limit.
- Egg retrievals if you are over 45 years of age.
- 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.

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Eligible health services include complex imaging services by a **provider**, including:

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans

Diagnostic lab work and radiological services

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

Chemotherapy

Eligible health services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**. **Covered benefits** for chemotherapy include anti-nausea **prescription drugs**.

Outpatient infusion therapy

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

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

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

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

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

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

The following are not covered under this benefit:

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

Outpatient radiation therapy

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

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

Specialty prescription drugs

Eligible health services include **specialty prescription drugs** when they are:

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

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

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

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

Outpatient respiratory therapy

Eligible health services include outpatient respiratory therapy services you receive at a **hospital, skilled nursing facility** or **physician's** office but only if those services are part of a treatment plan determined by your risk level and ordered by your **physician**.

Transfusion or kidney dialysis of blood

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

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

Short-term cardiac and pulmonary rehabilitation services

Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation

Eligible health services include cardiac rehabilitation services you receive at a **hospital, skilled nursing facility** or **physician's** office, but only if those services are part of a treatment plan determined by your risk level and ordered by your **physician**.

Pulmonary rehabilitation

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

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

Short-term rehabilitation and habilitation therapy services

Short-term rehabilitation therapy services

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

Eligible health services include short-term rehabilitation therapy services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital**, **skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician**

Short-term rehabilitation therapy services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, but only if it is expected to improve or restore physical functions lost as a result of an acute **illness**, **injury** or **surgical procedure**
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - improve, develop or restore physical functions you lost as a result of an acute **illness**, **injury** or **surgical procedure** or
  - Relearn skills so you can improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to:
  - improve or restore the speech function or correct a speech impairment as a result of an acute **illness, injury** or **surgical procedure** or
  - Improve delays in speech function development caused by a gross anatomical defect present at birth

  Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

- Cognitive rehabilitation therapy associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Short-term habilitation therapy services

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

Eligible health services include short-term habilitation therapy services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital**, **skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician**

Short-term habilitation therapy services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient physical, occupational, and speech habilitation therapy

Eligible health services include:

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

Chiropractic services

Eligible health services include chiropractic services to correct a muscular or skeletal problem.

Your **provider** must establish or approve a treatment plan that details the treatment, and specifies frequency and duration.

Diagnostic testing for learning disabilities

Eligible health services include diagnostic testing for:

- Attention deficit disorder
- Attention deficit hyperactive disorder
- Dyslexia

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

8. Other services

Ambulance services

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

Emergency

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

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

Non-emergency

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

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

The following are not **eligible health services**:

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

Clinical trials

Routine patient costs

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

The following are not **eligible health services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free

  The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

Experimental or investigational therapies

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

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

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

- The Food and Drug (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar organization and:
  - It conforms to standards of the NCI or other applicable federal organization
  - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the protocols of that study

Durable medical equipment (DME)

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

Coverage includes:

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

We:

- Assume no responsibility
- Make no express or implied warranties

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

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

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

Your plan only covers the same type of **DME** that **Medicare** covers. But there are some **DME** items **Medicare** covers that your plan does not. You or your **provider** can contact us to find out if a DME item is a **covered service** under your plan.

The following are not covered under this benefit:

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

Nutritional support

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

For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein. Also for the purposes of this benefit, “medical food” means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under direction of a **physician**.

Orthotic devices

Eligible health services include mechanical supportive devices ordered by your **physician** for the treatment of weak or muscle deficient feet.

Prosthetic devices

Eligible health services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.
Prosthetic device means:

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

Coverage includes:

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

The following are not covered under this benefit:

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

Hearing aids and cochlear implants

Eligible health services include prescribed hearing aids and hearing aid services, cochlear implants and cochlear implant services as described below.

Hearing aid means:

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

Cochlear implant means:

- Bone anchored hearing aid(s)

Hearing aid services are:

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

Hearing aids alternate treatment rule

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

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

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

The following are not covered under this benefit:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 24 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist

Hearing exams

Eligible health services include hearing exams for evaluation and treatment of **illness**, **injury** or hearing loss when performed by a hearing **specialist**.

The following are not covered under this benefit:

- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**

Home hemophilia treatment

Eligible health services include treatment of bleeding disorders associated with hemophilia in a home-setting. **Covered benefits** include blood products and blood infusion equipment for treatment of routine bleeding episodes associated with hemophilia.

The home treatment must be provided by a “designated” health care **provider.** This means a **provider** approved by the New Jersey Department of Banking and Insurance to contract with carriers for the purpose of rendering services for the home treatment of bleeding episodes associated with hemophilia.

Loss of designated status
When a designated health care **provider** loses their designation, we shall not continue to refer you to that health care **provider**. If you have been using such a **provider**, we will continue to provide services at an in-network level until:

- A new designated health care **provider** arrangement is made or
- Four months following the date of the loss of designation

whichever occurs first.

We shall not be required to continue to provide services at an in-network level when the **provider's** loss of designation is the result of:

- Revocation or surrender of a license, permit or registration or
- Suspension of a license, permit or registration that cannot be corrected by reinstatement within 45 days following the date of the suspension, except as may be necessary for **Aetna** and the **provider** to transition care to another designated health care provider

Termination of the agreement
In the event that we or a designated health care provider terminates their agreement, we shall continue to provide services at an in-network level until:

- A new designated health care provider arrangement is made or
- Four months following the date of the loss of designation

whichever occurs first

The requirements above shall not apply when the agreement terminates on the basis of:

- Breach
- Fraud
- Determination by our medical director that the **provider** is an imminent danger to you and others

whether such breach, fraud or imminent harm is related to the provision of services or supplies for home hemophilia treatment, or other services and supplies for which **Aetna** and the **provider** have an agreement.

Podiatric (foot care) treatment

Eligible health services include non-routine foot care for the treatment of **illness** or **injury** of the feet by **physicians** and **health professionals**.

Non-routine treatment means:

- It would be hazardous for you if someone other than a **physician** or **health professional** provided the care
- You have an **illness** that makes the non-routine treatment essential
- The treatment is routine foot care but it's part of an **eligible health service** (e.g., debriding of a nail to expose a subungual ulcer, or treatment of warts)
- The treatment you need might cause you to have a change in your ability to walk.

The following are not covered under this benefit:

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

Sickle cell anemia treatment

Eligible health services include the diagnosis and treatment of sickle cell anemia. **Prescription drug** coverage for this **illness** is provided under the *Outpatient prescription drug benefit* section of this certificate of coverage.

Telemedicine

Eligible health services include **telemedicine** and/or **telehealth** consultations when provided by a **physician**, **specialist**, **behavioral health provider telemedicine** and/or **telehealth provider** acting within the scope of their license.

Vision care

Pediatric vision care

Routine vision exams

Eligible health services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.

Vision care services and supplies

Eligible health services include:

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

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

The following are not covered under this benefit:

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

9. Outpatient prescription drugs

Prescription drugs

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

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

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

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

Eligible health services are based on the drugs in the **drug guide**. We exclude **prescription drugs** listed on the formulary exclusions list unless we approve a medical exception. The formulary exclusions list is a list of **prescription drugs** not covered under the plan. This list is subject to change. If it is **medically necessary** for you to use a **prescription drug** that is not on this **drug guide**, you or your **provider** must request a medical exception. See the *Requesting a medical exception* section or just contact us.

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

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

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

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

Prescription drug synchronization

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

How to access in-network pharmacies

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

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 90 day supply of a **prescription drug**.

Mail order pharmacy

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

Prescriptions can be filled at an in-network **mail order pharmacy**.

Specialty pharmacy

A **specialty pharmacy** may be used for up to a 90 day supply of a **specialty prescription drug**. You can view the list of **specialty prescription drugs**. See the *How to contact us for help* section.

Specialty starter fill program

This program provides **covered persons**, who are prescribed certain **prescription drugs**, with a partial fill to make sure that you tolerate the drug without harmful impacts. The drugs in this program are ones with a higher instance of intolerance and this program helps reduce potential waste by having you try the drug first. Your cost share will be prorated based on the day supply in your starter fill. If you are taking a **specialty prescription drug** included in the program, we'll contact you to confirm if you are tolerating the **specialty prescription drug**. You can access the list of these **prescription drugs** by calling the toll-free number in the *How to contact us for help* section or logging in to your **Aetna** website at https://www.aetnastudenthealth.com.

How to access out-of-network pharmacies

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

- Paying your in-network outpatient **prescription drug** cost share
- Paying any applicable out-of-network outpatient **prescription drug deductible**
- Your out-of-network **copayment**
- Your out-of-network **coinsurance**
- Any charges over the **recognized charge**
- Submitting your own claims if you receive services from a **provider** outside of New Jersey

Other covered services

Abortion drugs

Eligible health services include **prescription drugs** used for elective termination of pregnancy.

Anti-cancer drugs taken by mouth

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

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

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

Preventive contraceptives important note:
You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **eligible health services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review.

Diabetic supplies
Eligible health services include but are not limited to the following:
- Alcohol swabs
- Blood glucose calibration liquid
- Diabetic syringes, needles and pens
- Continuous glucose monitors
- Insulin infusion disposable pumps
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine

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

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

Infertility drugs
Eligible health services include oral and injectable ovulation induction **prescription drugs**.
Preventive care drugs and supplements
Eligible health services include preventive care drugs and supplements, including OTC ones, as required by the ACA.

Risk reducing breast cancer prescription drugs
Eligible health services include **prescription drugs** used to treat people who are at:
- Increased risk for breast cancer
- Low risk for medication side effects

Tobacco cessation prescription and OTC drugs
Eligible health services include FDA approved **prescription** and OTC drugs to help stop the use of tobacco products. You must receive a **prescription** from your **provider** and submit the **prescription** to the **pharmacy** for processing.

Outpatient prescription drug exclusions

The following are not **eligible health 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
- **Cosmetic** drugs including medication and preparations used for **cosmetic** purposes
- Devices, products and appliances unless listed as an **eligible health service**
- Dietary supplements including medical foods except those defined under *Nutritional support*
- Drugs or medications:
  - Which do not require a **prescription** by law, even if a **prescription** is written, unless listed as a covered service (such as contraceptives) or we approved 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
- 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, due to relationship distress or other stressors, the effects of substance or medication, or the effects of another medication condition, 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 an **eligible health 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 except as described in the certificate unless such change in weight is due to the effects of substance or medication, or the effects of another medication condition
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the **covered person** meets one or more clinical criteria detailed in our **precertification** and clinical policies
- Duplicative drug therapy; 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 an **eligible health service**
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
- 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
- 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

Where your schedule of benefits fits in

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

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

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

How your copayment works

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

What your plan doesn't cover – general exclusions

General exclusions

The following are not **eligible health services** under your plan:

Acupuncture

- Acupuncture
- Acupressure

Blood and blood products

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

This exception does not apply to services described in the *Home hemophilia treatment* section.

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, except where described in the *Eligible health services and exclusions* section

Court-ordered testing

- Court-ordered testing or care unless **medically necessary**

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 /changing containers and clamping tubing)
- Watching or protecting you
- **Respite care**, adult or child day care, or convalescent care
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health **conditions** and **substance use disorders** treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function
    - Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults

- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of **injuries** to or diseases of the teeth
  - Dental services related to the gums

- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants except when part of an approved treatment plan for an **eligible health service** described in the *Eligible health 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
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school 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 or, 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 trial therapies

Gene-based, cellular and other innovative therapies

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

Jaw joint disorder

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

This exclusion does not apply to **covered benefits** for treatment of **TMJ** and **CMJ** as described in the *Eligible health 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 are:
  - 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

Mental health conditions and substance use disorders conditions treatment

- Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:
  - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities

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 *Eligible health 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 charge that **Medicare** or another party is responsible for as the primary payer

Outpatient prescription or non-prescription drugs and medicines

- **Specialty prescription drugs** except as stated in the *Eligible health services and exclusions* section

Personal care, comfort or convenience items

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

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 *Eligible health 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
  - 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

- 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

Telemedicine and/or telehealth

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

Therapies and tests

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

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, except to the extent 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 worker's compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment

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

Who provides the care

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

School health services

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

In-network providers

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

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

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

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

Out-of-network providers

You also have access to **out-of-network providers.** This means you can receive **eligible health services** from an **out-of-network provider.** If you use an **out-of-network provider** to receive **eligible health services**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network **policy year deductible**
- Your out-of-network **coinsurance**
- Any charges over our **recognized charge**
- Submitting your own claims and getting **precertification**

Keeping a provider you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the network
- You are already covered under another **Aetna** plan and your **provider** stops being in our network

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

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

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

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

What the plan pays and what you pay

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

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

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

The general rule

When you get **eligible health services**:

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

And then

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

And then

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

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

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

Important exception – when your plan pays all

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

Important exceptions – when you pay all

You pay the entire expense for an **eligible health service**:

- When you get a health care service or supply that is not **medically necessary.** See the *Medical necessity and precertification requirements* section.

- When your plan requires **precertification**, your **physician** requested it, we refused it, and you get an **eligible health service** without **precertification**. You may be subject to a penalty or you may be required to pay a higher cost share. See the *Medical necessity and precertification requirements* section.

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

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

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

Instead:

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

And then

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

And then

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

And then

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

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

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the **negotiated charge** for in-network **covered benefits**
- Standby charges made by a **physician**

Where your schedule of benefits fits in

How your policy year deductible works

Your **policy year deductible** is the amount you need to pay for **eligible health services** per **policy year** before your plan begins to pay for **eligible health services**. Your schedule of benefits shows the **policy year deductible** amounts for your plan.

How your copayment works

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

How your maximum out-of-pocket limit works

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

Important note:
See the schedule of benefits for any **policy year deductibles**, **copayments**, **coinsurance**, **maximum out-of-pocket limit** and maximum age, visits, days, hours, admissions that may apply.

When you disagree - claim decisions and appeals procedures

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

When a claim comes in, we decide and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

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

Submit a claim

- You should notify and request a claim form from the **policyholder**
- The claim form will provide instructions on how to complete and where to send the form
- If you are unable to complete a claim form, you may send us:
  - A description of services
  - A bill of charges
  - Any medical documentation you received from your **provider**

Proof of loss (claim)

- Proof of loss is a completed claim form and any additional information required by us
- You or your **provider** must send us notice and proof within 12 months of the date you received services, unless you are legally unable to notify us. If you are legally unable to notify us within this time frame, it will not reduce or invalidate any claim when it is shown to have not been reasonably possible to furnish such proof and such proof is furnished a soon as it is reasonably possible.

Benefit payment

- Written proof must be provided for all benefits
- If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss
- Benefits will be paid within 60 days of receipt of the necessary proof to support the claim is received

Types of claims and communicating our claim decisions

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

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim

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

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim
A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them.

Post-service claim
A post service claim is a claim that involves health care services you have already received.

Concurrent care claim extension
A concurrent care claim extension occurs when you ask us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**.

Concurrent care claim reduction or termination
A concurrent care claim reduction or termination occurs when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as **copayments**, **coinsurance** and **deductibles** that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

We may need to tell your **physician** about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the **hospital.**

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination	72 hours	15 days	30 days	Urgent request: 24 hours Non-urgent request: 15 calendar days
Extension	None	15 days	15 days	Not applicable
Our additional information request to you	72 hours	15 days	30 days	Not applicable
Your response to our additional information request	48 hours	45 days	45 days	Not applicable

Important note for concurrent care urgent requests:
We have to receive the request at least 24 hours before the previously approved health care services end.

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** with **in-network provider** and the **recognized charge** with an **out-of-network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an "adverse benefit determination" or "adverse decision". It is also an "adverse benefit determination" if we rescind your coverage entirely.

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal

A Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call Member Services at the toll-free number in the *How to contact us for help* section or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint**.** We will let you know if we need more information to make a decision.

An Appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us by calling Member Services at the toll-free number in the *How to contact us for help* section.

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination or by calling Member Services at the toll-free number in the *How to contact us for help* section. For a written appeal, you need to include:

- Your name
- The **policyholder's** name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by calling Member Services at the toll-free number in the *How to contact us for help* section. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 180 calendar days from the date you receive the notice of the first appeal decision.

Urgent care or pre-service claim appeals
If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out a form.

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

Timeframes for deciding appeals
The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim.

We will answer urgent utilization review claim appeals within 36 hours for level one and two appeals and within 72 hours for an initial determination. We will answer utilization review pre-service claims within 15 calendar days. We will answer utilization review pre-service claim appeals within 10 calendar days for level one appeals and within 15 calendar days for level two appeals. There are no extensions for urgent care utilization review claims. Extensions for pre-service claim utilization are 15 days. The additional information request timeframe for urgent care utilization review claims is 72 hours. The additional information request timeframe for pre-service claim utilization review is 15 days. Responses to additional information requests are required within 48 hours for urgent care utilization claims and within 45 days for pre-service utilization claims.

A concurrent claim appeal will be addressed according to what type of service and claim it involves. We will answer urgent concurrent care claims within 24 hours if received at least 24 hours before the previously approved health care services end. Non-urgent concurrent care utilization claim review timeframes are 15 calendar days.

Appeals of inpatient substance use disorders claims
We will notify you, an authorized representative and your **physician** of an inpatient **substance use disorder** claim decision within 24 hours. This notice will include your rights with regard to filing an expedited internal **appeal** of an **adverse determination**. We will communicate the determination regarding your **appeal** of the **adverse determination** within 24 hours to you, an authorized representative and your **physician**.

If the determination is to uphold the denial, you, an authorized representative or your **physician** have the right to file an expedited external appeal with the Independent Health Care Appeals Program through the Department of Banking and Insurance. An independent utilization review organization shall make a determination within 24 hours.

If the independent utilization review organization upholds the determination and it is determined continued inpatient care is not **medically necessary**, we shall remain responsible to provide benefits for the inpatient care through the day following the date the determination is made. You shall only be responsible for any applicable **copayment, deductible** and **coinsurance** for the **stay** through that date, as applicable under this policy. For any costs incurred after the day following the date of determination until the day of discharge, you shall only be responsible for any applicable cost sharing. Any additional charges will be paid by the **facility** or **provider**.

Exhaustion of appeals process

In most situations you must complete the appeal process with us before you can take these other actions:

- Contact the New Jersey Department of Banking and Insurance to request an investigation of a complaint or appeal
  Department of Banking and Insurance
  Consumer Protection Services
  Office of Managed Care
  PO Box 329
  Trenton, New Jersey 08625-0329
  (888) 393-1062

- File a complaint or appeal with the New Jersey Department of Banking and Insurance
- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding

But sometimes you do not have to complete the appeals process before you may take other actions. These situations are:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.
- We did not follow all of the claim determination and appeal requirements of the New Jersey Department of Banking and Insurance. But you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you.
  - The violation was for a good cause or beyond our control.
  - The violation was part of an ongoing, good faith exchange between you and us.

External review

External review is a review done by people in an organization outside of **Aetna**. This is called an Independent Utilization Review Organization (IURO). An IURO is assigned by the State Insurance Commissioner and is made up of physicians or other appropriate providers. The IURO must have expertise in the problem or question involved.

You have a right to external review only if:

- Our claim decision involved medical judgment
- We decided the service or supply is not **medically necessary** or not appropriate
- We decided the service or supply is **experimental, investigational, or unproven**
- You have received an adverse determination

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

There are times when you do not have to complete the level one and level two appeals processes. You may pursue an appeal directly through the Independent Health Care Appeals program if:

- A determination on any appeal regarding urgent or emergency care is not given to you within 72 hours of receipt by us
- A determination on an initial appeal, is not given to you within 10 calendar days of the date we received the notice
- A determination of a subsequent level of appeals is not given to you within 20 business days of the date we received notice

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To Independent Health Care Program
  Maximus Federal – NJ IHCAP
  3750 Monroe Avenue, Suite 705
  Pittsford, NY 14534
  Phone: (888) 866-6205
  Fax: (585) 425-5296
  Stateappealseast@maximus.com
- Within 4 months of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

You will pay for any information that you send and want reviewed by the IURO. the filing fee is $25.00 and will not exceed $75.00 annually per covered person. We will pay for information we send to the IURO plus the cost of the review.

- The New Jersey Department of Banking and Insurance will contact the IURO that will conduct the review of your claim
- The IURO will:
  - Perform a preliminary review and immediately notify the covered person and/or **provider** in writing as to whether the appeal is accepted for processing
  - Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
  - Consider appropriate credible information that you sent
  - Follow our contractual documents and your plan of benefits
  - Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the IURO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an IURO decision?

We will tell you of the IURO decision not more than 45 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

But sometimes you can get a faster external review decision. Your **provider** must call us or send us a Request for External Review Form.

There are two scenarios when you may be able to get a faster external review:

For initial adverse determinations

Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function or
- Be much less effective if not started right away (in the case of experimental or investigational treatment)

For final adverse determinations

Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of experimental or investigational treatment) or
- The final adverse determination concerns an admission, availability of care, continued **stay** or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 48 hours of us getting your request.

We will stand by the decision of the IURO unless we can show conflict, bias or fraud. We will provide claim payments immediately, even if we want to seek legal review of the IURO's decision. Within 10 days of receipt of the decision, we will send a copy of our plan to implement the IURO's decision to you, the IURO and the New Jersey Department of Banking and Insurance. If we request a legal review of the IURO's decision, we will pay the cost.

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal except those described in the *External review* provision.

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).

Key terms

Here are some key terms we use in this section. These terms will help you understand this COB section.

Allowable expense means:

- The charge for any health care service, supply or other expense for which you are responsible when the health care service, supply or other expense is covered at least in part by any of the plans involved, except where a law requires another definition, or as stated below.

  When this plan is coordinating benefits with a plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, allowable expense is limited to items covered under the other plan.

  We will not consider the difference between the cost of a private **hospital** room and that of a semi-private **hospital** room as an allowable expense unless the stay in a private room is **medically necessary** and appropriate.

  When this plan is coordinating benefits with a plan that limits coordination of benefits to a specific coverage, we will only consider corresponding services, supplies or other expense which the other plan considers an allowable expense.

Claim determination period means:

- A **calendar yea**r, or any part of **a calendar year**, during which you are covered by this plan and at least one other plan and incurs allowable expense(s) under these plans

Plan means:

- Coverage with which coordination of benefits is allowed. Plan includes:
  - Group insurance and group subscriber contracts, including insurance continued according to a federal or state continuation law
  - Self-funded arrangements of group or group-type coverage, including insurance continued according to a federal or state continuation law
  - Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued according to a federal or state continuation law
  - Group hospital indemnity benefit amounts that exceed $150.00 per day
  - Medicare or other governmental benefits, except when, according to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan

- Plan does not include:
  - Individual or family insurance contracts or subscriber contracts
  - Individual or family coverage through a health maintenance organization (HMO) or under any other prepayment, group practice and individual practice plans
  - Group or group-type coverage where the cost of coverage is paid solely by the covered person coverage being continued according to a federal or state continuation law will be considered a plan
  - Group hospital indemnity benefit amounts of $150.00 per day or less
  - School accident-type coverage
  - A state plan under Medicaid

Primary plan means:

- A plan whose benefits for your health care coverage must be determined without taking into consideration the existence of any other plan. There may be more than one primary plan. A plan will be the primary plan if either of the below exist:
  - The plan has no order of benefit determination rules, or it has rules that differ from those contained in this coordination of benefits section, or
  - All plans which cover you use order of benefit determination rules consistent with those contained in the coordination of benefits section and under those rules, the plan determines its benefits first.

Reasonable and Customary means:

- An amount that is not more than the usual or customary charge for the service or supply as determined by us, based on a standard which is most often charged for a given service by a **provider** within the same geographic area.

Secondary plan means:

- A plan which is not a primary plan. If you are covered by more than one secondary plan, the order of benefit determination rules of this coordination of benefits section will be used to determine the order in which the benefits payable under the multiple secondary plans are paid. The benefits of each secondary plan may consider:
  - The benefits of the primary plan(s) and
  - The benefits of any other plan which, under this coordination of benefits section, has its benefits determined before those of that secondary plan.

Here's how COB works

We consider each plan separately when coordinating payments. The primary plan pays or provides services or supplies first, as though the secondary plan doesn't exist. If a plan has no COB provision or if the order of benefit determination rules differ from those in this section it is the primary plan. A secondary plan takes into consideration the benefits provided by a primary plan when, according to the rules below, the plan is the secondary plan. If there is more than one secondary plan the order of benefit determination rules determine the order among the secondary plans. During each claim determination period the secondary plan(s) will pay up to the remaining unpaid allowable expenses, but no secondary plan will pay more than it would have paid if it had been the primary plan. The method the secondary plan uses to determine the amount to pay is outlined below in the *Determining who pays* provision.

The secondary plan will not reduce allowable expenses for **medically necessary** and appropriate services or supplies on the basis that **precertification**, preapproval, notification or second surgical opinion procedures were not followed.

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. A plan that does not contain a COB provision is always the primary plan.

COB rule	Primary plan	Secondary plan
Covered under this plan as a student	Plan covering you as a student	Plan covering you as a dependent

How are benefits paid?

In order to determine which procedure to follow, it is necessary to consider:

- How the primary plan and the secondary plan pay benefits
- Whether the **provider** who provides or arranges the services and supplies is in the network of either the primary plan or the secondary plan.

Benefits may be based on the reasonable and customary charge (R & C), or some similar term. This means that the **provider** bills a charge and you may be responsible for the full amount of the billed charge. In this section, a plan that bases benefits on a reasonable and customary charge is called an R & C plan.

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a **provider**, called a **network provider**, bills a charge, you may be responsible only for an amount up to the negotiated fee. In this section, a plan that bases benefits on a negotiated fee schedule is called a fee schedule plan. If you use the services of a non-network **provider**, the plan will be treated as an R & C plan even though the plan under which you are covered calls for a fee schedule.

Payment to the **provider** may be based on a capitation. This means that the HMO or other plan pays the **provider** a fixed amount per covered person. You are responsible only for the applicable **deductible, coinsurance** or **copayment**. If you use the services of a non-network **provider**, the HMO or other plan will only pay benefits in the event of **emergency services** or urgent care. In this section, a plan that pays **providers** based upon capitation is called a capitation plan. In the rules below, **provider** refers to the **provider** who provides or arranges the services or supplies and HMO refers to a health maintenance organization plan.

A plan determined to be a secondary plan may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. Where a benefit is payable by both the primary and secondary plans on the basis of usual, customary and reasonable fees (UCR), the secondary plan will pay the difference between billed charges for allowable expenses and the amount paid by the primary plan as long as the amount is no greater than the amount the secondary plan would have paid if primary. The amount by which the secondary plan’s benefits have been reduced will be used by the secondary plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by you. As each claims is submitted the secondary plan will determine its obligation to pay for allowable expenses based on all claims which were submitted up to that time during the claim determination period.

The benefits of the secondary plan will be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of this COB provision, and the benefits that would be payable for the allowable expenses under other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds those allowable expenses in a claim determination period. In this case, the benefits of the secondary plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of this plan are reduced as described above, each benefit will be reduced in proportion, and the amount paid will then be charged against any applicable benefit limit of this plan.

Primary plan is R & C plan and secondary plan is R & C plan
The secondary plan will pay the lessor of:
- The difference between the amount of the billed charges and the amount paid by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

When the benefits of the secondary plan are reduces as a result of this calculation, each benefit will be reduced in proportion, and the amount paid will be charged against any applicable benefit limit of the plan.

Primary plan is fee schedule plan and secondary plan is fee schedule plan
If the **provider** is a **network provider** in both the primary plan and the secondary plan, the allowable expense will be the fee schedule of the primary plan. The secondary plan will pay the lessor or
- The amount of any **deductible, coinsurance** or **copayment** required by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

The total amount the **provider r**eceives from the primary plan, the secondary plan and you will not exceed the fee schedule of the primary plan. In no event will you be responsible for any payment in excess of the **copayment, coinsurance** or **deductible** of the secondary plan.

Primary plan is R & C plan and secondary plan is fee schedule plan
If the **provider** is a **network provider** in the secondary plan, the secondary plan will pay the lesser of:
- The difference between the amount of the billed charges for the allowable expenses and the amount paid by the primary plan' or
- The amount the secondary plan would have paid if it had been the primary plan.

You will only be responsible for the **copayment, deductible** or **coinsurance** under the secondary plan if you have no responsibility for **copayment, deductible** or **coinsurance** under the primary plan and the total payments by both the primary and secondary plans are less than the **provider's** billed charges. In no event will you be responsible for any payment in excess of the **copayment, coinsurance** or **deductible** of the secondary plan.

Primary plan is fee schedule plan and secondary plan is R & C plan
If the **provider** is a **network provider** in the primary plan, the allowable expense considered by the secondary plan will be the fee schedule of the primary plan. The secondary plan will pay the lesser of:
- The amount of any **deductible, coinsurance** or **copayment** required by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

Primary plan is fee schedule plan and secondary plan is R & C plan or fee schedule plan
If the primary plan is an HMO plan that does not allow for the use of non-network **providers** except in the event of urgent care or **emergency services** and the service or supply you receive from a non-network **provider** is not considered as urgent care or **emergency services**, the secondary plan will pay benefits as if it were the primary plan.

Primary plan is capitation plan or fee schedule plan or R & C plan and secondary plan is capitation plan
If you receive services or supplies from a **provider** who is in the network of the secondary plan, the secondary plan will be responsible to pay the capitation to the **provider** and will not be responsible to pay the **deductible, coinsurance** or **copayment** imposed by the primary plan. You will not be responsible to pay any **deductible, coinsurance** or **copayments** of either the primary plan or the secondary plan.

Primary plan is an HMO and secondary plan is an HMO
If the primary plan is an HMO plan that does not allow for the use of non-network **providers** except in the event of urgent care or **emergency services** and the service or supply you receive from a non-network **provider** is not considered as urgent care or **emergency services**, but the **provider** is in the network of the secondary plan, the secondary plan will pay benefits as if it were the secondary plan, except that the primary plan will pay out-of-network services, if any, authorized by the primary plan.

How COB works with Medicare

This section explains how the benefits under this plan interact with benefits available under **Medicare**. Keep in mind, if you have **Medicare** you are not eligible to enroll in this plan. But you might get **Medicare** after you are already enrolled in this plan, so these rules will apply.

You have **Medicare** when you are entitled to premium-free **Medicare** Part A or enrolled in **Medicare** Part B or Premium Part A, or both, by reason of:

- Age
- Disability
- ALS / Lou Gehrig's disease or
- End stage renal disease (ESRD)

When you have **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before **Medicare** pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after **Medicare**.

Who pays first?

- **Medicare** pays first when you have **Medicare** because of:
  - Age
  - Disability
  - ALS / Lou Gehrig's disease
- When you have **Medicare** because of ESRD:
  - We pay first for the first 3 months unless you take a self-dialysis course.
  - If you take a self-dialysis course, there is no **Medicare** waiting period and **Medicare** becomes primary payer on the first of the month of dialysis.
  - If a transplant takes place within the 3-month waiting period, **Medicare** becomes primary payer on the first of the month in which the transplant takes place.

ESRD important note:
If you have **Medicare** due to age and then later have it due to ESRD, **Medicare** will remain your primary plan and this plan will be secondary.

This plan is secondary to **Medicare** in all other circumstances.

How are benefits paid?

Plan status	How we pay
We are primary	We pay your claims as if there is no **Medicare** coverage.
Medicare is primary	We calculate our benefit as if there were no **Medicare** coverage. We reduce our benefit so that when combined with the **Medicare** payment, the total payment is no more than 100% of the allowable expense.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly:

- **Online:** Log in to your **Aetna** member website at https://www.aetnastudenthealth.com. Select Find a Form, then select Your Other Health Plans.
- **By phone:** Call Member Services at the toll-free number in the *How to contact us for help* section.

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid or
- Any other plan that is responsible under these COB rules

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends and when you may still be able to continue coverage.

When will your coverage end?

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

- This plan is discontinued
- The **student policy** ends
- You are no longer eligible for coverage
- The last day for which any required **premium** contribution has been paid
- The date you are no longer in an eligible class
- We end your coverage
- You become covered under another medical plan offered by the **policyholder**
- The date you withdraw from the school because of entering the armed forces of any country

Withdrawal from classes – leave of absence

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

Withdrawal from classes – other than leave of absence

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

Why would we suspend paying claims or end your coverage?

We will give you 30 days advance written notice if we suspend paying your claims because:

- You do not cooperate or give facts that we need to administer the COB provisions.

We may immediately end your coverage if:

- You commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know- Honest mistakes and intentional deception* section for more information on rescissions.

On the date your coverage ends, we will refund to the **policyholder** any prepayments for periods after the date your coverage ended.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Continuation of coverage for other reasons

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

How can you extend coverage if you are totally disabled when coverage ends?

Your coverage may be extended if you are totally disabled when coverage ends.

You are "totally disabled" if you cannot engage in most normal activities of a healthy person of the same age and gender.

You may extend coverage until the earliest of:

- When you are no longer totally disabled
- When you become covered by another health benefits plan or
- 12 months of coverage

General provisions – other things you should know

Entire student policy
The **student policy** consists of several documents taken together. These documents are:
- The **policyholder's** application
- Your enrollment form**,** if the **policyholder** requires one
- The **student policy**
- The certificate(s) of coverage
- The schedule of benefits
- Any riders, endorsement, inserts, attachments, and amendments to the **student policy**, the certificate of coverage, and the schedule of benefits

Administrative provisions
How you and we will interpret this certificate
We prepared this certificate according to federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this certificate when we administer your coverage. Our interpretation can be reversed by an internal utilization review organization, a court of law, arbitrator or administrative agency having jurisdiction. See the *When you disagree-claim decisions and appeal procedures* section.

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

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

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

Coverage and services
Your coverage can change
Your coverage is defined by the **student policy**. This document may have amendments and riders too. Under certain circumstances, we, the **policyholder** or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive **precertification**, **prescription** quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the **policyholder** or **provider**, can do this.

If your student status changes the amount of your coverage or benefit levels, the change will take effect on the date of the status change and the amount of coverage or benefit level will be changed to the new amount.

A retroactive change in your student status will not cause a retroactive change in your coverage.

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

Records of expenses

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

Things that would be important to keep are:

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

Honest mistakes and intentional deception

Honest mistakes

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

Intentional deception

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

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

If we have a reason to believe that a claim has been submitted fraudulently, we shall:

- Investigate the claim in accordance with our fraud prevention plan
- Refer the claim and supporting documentation to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to New Jersey law

We also may report fraud to criminal authorities.

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

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

- We will give you 30 days advanced written notice of any rescission of coverage
- You have the right to an **Aetna** appeal
- You have the right to a third-party review conducted by an independent external review organization

Some other money issues

Legal action

You must complete the appeal process before you take any legal action against us for any expense or bill. See the *When you disagree - claim decisions and appeals procedures* section. You cannot take any action until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Assignment of benefits

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

When you submit a claim for an **emergency medical condition** or treatment for an **urgent condition** situation and you assign your rights to receive reimbursement for **eligible health services** to an **out-of-network provider,** we are required to pay benefits in line with the assignment of benefits. We will directly pay the health care **provider** in the form of a check payable:

- To the health care **provider** or
- To the health care **provider** and you as a joint payee

with signature lines for each.

Any payment made solely to you rather than the health care **provider** under these circumstances shall be considered unpaid, and unless remitted to the health care **provider** within the time frames established by New Jersey Law, shall be considered overdue and subject to an interest charge as provided in that act.

Financial sanctions exclusions

If coverage provided under this **student policy** violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible health services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). Visit https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx to find out more.

Grace period

You have a grace period of 30 days after the due date for the payment of each contribution due after the first contribution payment. If contributions are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period.

Payment of premium

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

Recovery of overpayments

We sometimes pay too much for **eligible health services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid. However, we have to request reimbursement no more than 18 months following the date the first payment on the particular claim was made. We can only request one reimbursement per particular claim. We have the right to reduce any future benefit payments by the amount we paid by mistake.

We will work directly with your **provider** throughout the reimbursement process.

Your health information

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

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

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

Effect of benefits under other plans

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

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

Effect of prior coverage - transferred business

Prior coverage means:

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

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

Glossary A-M

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

Actual charge
The standard office charge established by a **provider** for services and supplies that are **covered benefits** under the plan and that the **provider** gives to you.

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

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

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

Calendar year
A period of 12 months beginning January 1st and ending on December 31st.

Clinical related injury
As used within the *Blood and body fluid exposure* **covered benefit**, this is any **incident** which exposes you, acting as a student in a clinical capacity, to an **illness** that requires testing and treatment. Incident means unintended:
- Needlestick pricks
- Exposure to blood and body fluid
- Exposure to highly contagious pathogens

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

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

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

Covered benefits
Eligible health services that meet the requirements for coverage under the terms of this plan, including:
- They are **medically necessary**
- You received **precertification** if required

Covered person

A **covered student** for whom all of the following applies:

- The person is eligible for coverage as defined in the certificate of coverage
- The person has enrolled for coverage and paid any required **premium** contribution
- The person's coverage has not ended

Covered student

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

Craniomandibular joint dysfunction (CMJ)

This is a disorder of the jaw joint.

Custodial care

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

Dental emergency

Any dental condition that:

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

Dental emergency services

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

Dental provider

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

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

Dentist

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

Detoxification

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

Directory

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

Drug guide

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

Durable medical equipment (DME)

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

- Made to withstand prolonged use
- Mainly used in the treatment of an **illness** or **injury**
- Suited for use in the home
- Not normally used by people who do not have an **illness** or **injury**
- Not for altering air quality or temperature
- Not for exercise or training

Effective date of coverage

The date your coverage begins under this certificate of coverage as noted in **Aetna's** records.

Eligible health services

The health care services and supplies and outpatient **prescription drugs** listed in the *Eligible health services and exclusions* section and not carved out or limited in the *General exclusions* section of this certificate of coverage or in the schedule of benefits.

Emergency admission

An admission to a **hospital** or treatment facility ordered by a **physician** within 24 hours after you receive **emergency services**.

Emergency medical condition

An acute, severe medical condition that would lead a prudent layperson to reasonably believe that the condition, **illness**, or **injury** is of a severe nature. And that if you don't get immediate medical care it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus
- In the case of a pregnant woman:
  - Serious jeopardy to the health of the fetus
  - One who is having contractions and there is inadequate time to effect a safe transfer to another **hospital** before delivery or
  - A transfer may pose a threat to the health or safety of the woman or unborn child

Emergency services

Treatment given in an ambulance and a **hospital**'s emergency room or an independent freestanding emergency department. This includes evaluation of and treatment to stabilize the **emergency medical condition**. An "independent freestanding emergency department" means a health care facility that is geographically separate, distinct and licensed separately from a **hospital** and provides **emergency services**.

Experimental, investigational, or unproven

A drug, device, procedure, supply, treatment, test, or technology is considered by us to be **experimental, investigational, or unproven** if any of the following apply:

- It hasn't been shown through well-conducted clinical trials or cohort studies published in peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which it's meant.
  - A well-conducted clinical trial means a randomized, controlled trial where the experimental intervention is compared to a control group receiving care according to best practice and study participants are randomly assigned to the experimental or control group.
  - A well-conducted cohort study means a prospective cohort study from more than one institution where the experimental intervention is compared to a group of subjects receiving care according to best practice and where the comparison group is well matched to the experimental intervention group.
- There isn't FDA approval or clearance to market it for the proposed use.
- A national medical society, dental society, or regulatory agency has written that it's **experimental, investigational, or unproven**, or mainly for research purposes.
- It's the subject of a Phase I, Phase II, or the experimental or research arm of a Phase III clinical trial. The FDA and Department of Health and Human Services define these.
- Written procedures or consent form used by a facility **provider** says it's **experimental, investigational, or unproven**.

Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product. It is considered to be as effective as the brand-name product and offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, **physicians**, nurses, **dental providers**, vision care **providers**, and physical therapists.

Home health aide

A **health professional** that provides services through a **home health care agency.** The services that they provide are not required to be performed by an **R.N.**, **L.P.N.**, or **L.V.N**. A **home health aide** primarily aids you in performing the normal activities of daily living while you recover from an **injury** or **illness**.

Home health care agency

An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

Home health care plan

A plan of services prescribed by a **physician** (or other **health professional**) to be provided in the home setting. These services are usually provided after your discharge from a **hospital.** All plans shall be in place within 14 days following the start of home health care.

Hospice benefit period
A period that begins on the date your **physician** certifies that you have a **terminal illness**. It ends after 6 months (or later for which your treatment is certified) or on your death; if sooner.

Hospice care
Care designed to give supportive care to people in the final phase of a **terminal illness** and focus on comfort and quality of life, rather than cure.

Hospice care agency
An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**. These services may be available in your home or inpatient setting.

Hospice care program
A program prescribed by a **physician** or other **health professional** to provide **hospice care** and supportive care to their families.

Hospice facility
An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**.

Hospital
An institution licensed as a **hospital** by applicable law and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can stay overnight for care. Or they can be treated and leave the same day. All **hospitals** must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

Hospital stay
This is your **stay** of 18 or more hours in a row as a resident bed patient in a **hospital**.

Illness or illnesses
Poor health resulting from disease of the body or mind.

In-network dental provider
A **dental provider** listed in the **directory** for your plan.

In-network pharmacy
A **retail pharmacy**, **mail order pharmacy** or **specialty pharmacy** that has contracted with **Aetna**, an affiliate, or a third-party vendor, to provide outpatient **prescription drugs** to you.

In-network provider
A **provider** listed in the **directory** for your plan. However, a NAP **provider** listed in the NAP directory is not an **in-network provider**.

Injectable drug(s)
These are **prescription drugs** when an oral alternative drug is not available.

Injury or injuries
Physical damage done to a person or part of their body.

Institutes of Excellence™ (IOE) facility
A facility designated by **Aetna** in the **provider directory** as Institutes of Excellence **in-network provider** for specific services or procedures.

Intensive care unit
A ward, unit, or area in a **hospital** which is set aside to provide continuous specialized or intensive care services to your because your **illness** or **injury** is severe enough to require such care.

Jaw joint disorder
This is:

- A disorder of the jaw joint
- A Myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

L.P.N.
A licensed practical nurse or a licensed vocational nurse.

Mail order pharmacy
A **pharmacy** where **prescription drugs** are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit
The maximum out-of-pocket amount for payment of **copayments** and **coinsurance** including any **policy year deductible**, to be paid by you per **policy year** for **eligible health services**.

Medically necessary/Medical necessity
Health care services or supplies that prevent, evaluate, diagnose or treat an **illness**, **injury**, disease or its symptoms, and that are all of the following, as determined by us within our discretion:

- In accordance with "generally accepted standards of medical practice"
- Clinically appropriate, in terms of type, frequency, extent, site, place of service, duration, and considered effective for your **illness**, **injury** or disease
- Not primarily for your convenience, the convenience of your **physician**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your **illness**, **injury** or disease

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and
- Following the standards set forth in our clinical policies and applying clinical judgment

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

With respect to **substance use disorder** your provider will determine **medical necessity** for the first 180 days of treatment.

Medicare

As used in this plan, **Medicare** means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of **Medicare.**

Mental health condition

A **mental health condition** as defined to be consistent with the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and any subsequent editions published by the American Psychiatric Association.

Glossary N-Z

Negotiated charge

Health coverage

This is either:

- The amount an **in-network provider** has agreed to accept
- The amount we agree to pay directly to an **in-network provider** or third-party vendor (including any administrative fee in the amount paid)

for providing services, **prescription drugs** or supplies to **covered persons** in the plan. This does not include **prescription drug** services from an **in-network pharmacy**.

For surprise billing, calculations will be made based on the median contracted rate.

We may enter into arrangements with **in-network providers** or others related to:

- The coordination of care for **covered persons**
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing

These arrangements will not change the **negotiated charge** under this plan.

In-network pharmacy

The amount we established for each **prescription drug** obtained from an **in-network pharmacy** under this plan. This **negotiated charge** may reflect amounts we agreed to pay directly to the **in-network pharmacy** or to a third-party vendor for the **prescription drug**, and may include a rebate, an additional service or risk charge set by us.

We may receive or pay additional amounts from or to third parties underprice guarantees. These amounts may change the **negotiated charge** under this plan.

Non-preferred drug

A **prescription drug** or device that may have a higher out-of-pocket cost than a **preferred drug**.

Out-of-network dental provider

A **dental provider** who is not an **in-network dental provider** and does not appear in the **directory** for your plan**.**

Out-of-network pharmacy

A **pharmacy** that is not an **in-network pharmacy** or National Advantage Program (NAP) **provider** and does not appear in the **directory** for your plan.

Out-of-network provider

A **provider** who is not an **in-network provider** or National Advantage Program (NAP) **provider** and does not appear in the **directory** for your plan.

Pharmacy
An establishment where **prescription drugs** are legally dispensed. This includes an in-network **retail pharmacy**, **mail order pharmacy** and **specialty pharmacy**. It also includes an out-of-network **retail pharmacy** and **mail order pharmacy**.

Physician
A skilled **health professional** trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Policy year
This is the period of time from anniversary date to anniversary date of the **student policy** except in the first year when it is the period of time from the effective date to the first anniversary date.

Policy year deductible
The amount you pay for **eligible health services** per **policy year** before your plan starts to pay as listed in the schedule of benefits.

Policyholder
The school named on the front page of the **student policy** and your certificate of coverage and schedule of benefits for the purpose of coverage under the **student policy**.

Precertification, precertify
A requirement that you or your **physician** contact **Aetna** before you receive coverage for certain services. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage.

Preferred drug
A **prescription drug** or device that may have a lower out-of-pocket cost than a **non-preferred drug**.

Preferred in-network pharmacy
A network **retail pharmacy** that **Aetna** has identified as a **preferred in-network pharmacy.**

Premium
The amount you or the **policyholder** are required to pay to **Aetna**.

Prescription
As to hearing care:
A written order for the dispensing of **prescription** electronic hearing aids by otolaryngologist, otologist or audiologist.

*As to **prescription drugs**:*
A written order for the dispensing of a **prescription drug** or device by a **provider**. If it is a verbal order, it must promptly be put in writing by the **in-network pharmacy**.

As to vision care:
A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

Prescription drug

An FDA approved drug or biological which can only be dispensed by **prescription.**

Provider(s)

A **physician**, other **health professional**, **hospital**, **skilled nursing facility**, **home health care agency, pharmacy,** or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all **Medicare** accreditation standards (even if it does not participate in **Medicare**). With respect to the treatment of autism, the treatment must be administered directly by or under the direct supervision of an individual who is credentialed by the national Behavior Analyst Certification Board as either:

- a Board Certified Behavior Analyst – Doctoral (BCBA-D)
- a Board Certified Behavior Analyst – (BCBA)

Psychiatric hospital

An institution licensed or certified as a **psychiatric hospital** by applicable laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse or **mental health disorders** (including **substance related disorders**).

Recognized charge

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The **recognized charge** depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Professional services and other services or supplies not mentioned below	105% of the **Medicare** allowed rate
Services of **hospitals** and other facilities	140% of the **Medicare** allowed rate
Prescription drugs	100% of the average wholesale price (AWP)
Dental expenses	80% of the prevailing charge rate

Important note:
If the **provider** bills less than the amount calculated using the method above, the **recognized charge** is what the **provider** bills.

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP **provider**. NAP **providers** are **out-of-network providers** and third-party vendors that have contracts with us but are not **in-network providers**. Claims for services received from a NAP **provider** and paid at the NAP contracted rate are not subject to the federal surprise bill law.

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

- **Medicare** allowed rates are the rates CMS establishes for services and supplies provided to **Medicare** enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If **Medicare** does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set **Medicare** rates
  - What other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply

  When the **recognized charge** is based on a percentage of the **Medicare** allowed rate, it is not affected by adjustments or incentives given to **providers** under **Medicare** programs.
- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.

Our reimbursement policies

We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the **recognized charge**. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the **provider**

Our reimbursement policies are based on our review of:

- The Centers for **Medicare** and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and **dentists** practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits
We have online tools to help you decide whether to get care and if so, where. Log in to your **Aetna** website at https://www.aetnastudenthealth.com. The website contains additional information that can help you determine the cost of a service or supply.

R.N.

A registered nurse.

Residential treatment facility
A facility that provides **mental health disorder** services or **substance related disorder** services and meets the following requirements:
- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed **physician** for the level of care provided
- Maintains a written treatment plan prepared by a licensed **behavioral health provider** (**R.N.** or master's level) requiring full-time residence and participation
- Has a licensed **behavioral health provider** (**R.N.** or master's level) on-site 24 hours per day 7 days per week
- And is:
  - Credentialed by us, or
  - Certified by **Medicare**, or
  - Accredited by The Joint Commission (TJC); The Committee on Accreditation of Rehabilitation Facilities (CARF); The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP); or The Council on Accreditation (COA)

Respite care
This is care provided to you when you have a **terminal illness** for the sole purpose of providing temporary relief to your family (or other care givers) from the daily demands of caring for you**.**

Retail pharmacy
A community **pharmacy** that dispenses outpatient **prescription drugs**.

Room and board
A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

Same terms and conditions
With respect to the treatment of **mental health conditions** and **substance use disorders**, we will not apply more restrictive non-quantitative limitations or more restrictive quantitative limitations to **mental health conditions** and **substance use disorders,** than we apply to substantially all other medical or surgical benefits.

School health services
The **policyholder's** school's student health center or a **provider** or organization that is identified as a **school health services provider**. This includes any organization, facility or clinic operated, maintained or supported by the school or other entity under contract to the school.

Semi-private room rate
An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, **Aetna** will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility
A facility that provides skilled nursing care and meets the following requirements:
- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed **physician** for the level of care provided

- Maintains a written treatment plan prepared by a licensed **provider** (**R.N.** or master's level) requiring full-time residence and participation
- Has a licensed **provider** (**R.N.** or master's level) on-site 24 hours per day 7 days per week
- And is:
  - Credentialed by us, or
  - Certified by **Medicare**, or
  - Accredited by The Joint Commission (TJC) or The Committee on Accreditation of Rehabilitation Facilities (CARF)

Skilled nursing facilities also include rehabilitation **hospitals**, and portions of a rehabilitation **hospital** and a **hospital** designated for skilled or rehabilitation therapy services.

Skilled nursing facility does not include institutions that provide only:
- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of **mental health disorders** or **substance related disorders**.

Skilled nursing services
Services provided by an **R**.**N**. or **L.P.N.** within the scope of his or her license.

Sound natural teeth
These are natural teeth. If there is a filling in a tooth, the major portion of the tooth must be present. A tooth cannot be decayed, abscessed, or defective. **Sound natural teeth** are not capped teeth, implants, crowns, bridges, or dentures.

Specialist
A **physician** who practices in any generally accepted medical or surgical sub-specialty and is board-certified.

Specialty pharmacy
A **pharmacy** that fills **prescriptions** for specialty drugs.

Specialty prescription drug
An FDA-approved **prescription drug** that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:
- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

Stay
A full-time inpatient confinement for which a **room and board** charge is made.

Student policy
The **student policy** consists of several documents taken together. The list of documents can be found in the *Entire student policy* section of this certificate of coverage.

Substance use disorder
A substance related disorder, addictive disorder, or both in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and any subsequent editions published by the American Psychiatric Association,

Surgery center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all **Medicare** accreditation standards (even if it does not participate in **Medicare**).

Surgery, surgeries or surgical procedures
The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as:
- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution or
- Otherwise physically changing body tissues and organs

Telehealth
The use of information and communication technologies such as:
- Telephones
- Remote patient monitoring devices
- Other electronic means

to support:
- Clinical health care
- **Provider** consultation
- Patient and professional health-related education
- Public health
- Health administration
- Other services

in accordance with New Jersey state law.

Telemedicine
The delivery of health services using:
- Electronic communications
- Information technology
- Other electronic or technological means

to bridge the gap between a **provider** and you, either with or without the assistance of another **provider** in accordance with New Jersey state law.

Telemedicine does not include the use, in isolation, of:

- Audio-only telephone conversation
- Electronic mail
- Instant messaging
- Phone text
- Facsimile transmission

Temporomandibular joint dysfunction (TMJ)
This is a disorder of the jaw joint.

Terminal illness
A medical prognosis that you are not likely to live more than 12 months.

Urgent admission
This is an admission to the **hospital** due to an **illness** or **injury** that is severe enough to require a **stay** in a **hospital** within 2 weeks from the date the need for the **stay** becomes apparent.

Urgent care facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition.**

Urgent condition
An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

Walk-in clinic
A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near, or within a:

- Drug store
- **Pharmacy**
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- **Hospital**
- Outpatient department of a **hospital**
- **Physician's** office
- **Urgent care facility**

TTY: **711**

English	**To access language services at no cost to you, call the number on your ID card.**
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով անվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	**無料の言語サービスは、IDカードにある番号にお電話ください。**
Karen	လၢတၢကမၤန့ၢ်ကျိာ်တၢမၤစၢၤအတၢဖံးတၢမၤတဖၣ် လၢတအိၣ်ဒီးအပ့ၢ်လၢနကဘၣ်ဟ့ၣ်အီၤအဂီၢ်ကီးဘၣ်လီၤတံၤစီနီၣ်ကၢ်လၢအအိၣ်လၢနခိၣ်ကီၤ ဗ (ၡိ) အလိၤ်ဘၣ်တက့ၢ်ၡ်
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó naaltsoos bee atah nílį́igo nanitinígíí bee nééhó'dólzinígíí béésh bee hane'í biká'ígíí áaji' hólne'.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	[illegible]
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน

Ukrainian	Щоб безкоштовнј отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý

Aetna Life Insurance Company

**New Jersey Life And Health Insurance
Guaranty Association Act**

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer
The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The New Jersey Life and Health Insurance Guaranty Association
521 Newman Springs Road, Suite 22
Lincroft, NJ 07738

State of New Jersey
Department of Banking and Insurance
20 West State Street
P.O. Box 325
Trenton, NJ 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Insurance Guaranty Association Act, N.J.S.A. 17B:32A-1, et seq, (the "Act").

Coverage
The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

Generally, the beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage
However, persons owning such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy was issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

Limitations of Coverage
The Act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy of contract.

With respect to any one insured individual, regardless of the number of policies or contracts, and subject to other limitations imposed by the Act, for life insurance policies, the Association will not pay more than $100,000 in cash surrender values or $500,000 in life insurance death benefits; for annuity contracts, the Association will not pay more than $250,000 in cash surrender value or, for annuity contracts with no cash surrender value, benefits payments of up to $500,000 in present value. These limits apply no matter how many policies and contracts were with the same company, and no matter how many different types of coverages.

The Association will not pay more than $2,000,000 in benefits to any one contract holder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.

Discrimination is Against the Law

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