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

Seton Hall University

Policy Year: 2026 – 2027
Policy Number: 252648
https://www.aetnastudenthealth.com
(800) 481-8814

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

Seton Hall University Health Services

Seton Hall University Health Services is the University's on-campus health facility. Office hours are Monday - Friday from 8:45 a.m. to 4:45 p.m. Hours of operation and closure may vary as University Health Services follows all University closures and summer schedules. Students seeking health care services may call to make an appointment at (973) 761-9175.

For more information, please call University Health Services at (973) 761-9175. University Health Services is located at 303 Centre Street, diagonally across the street from main gate. In the event of an emergency, call 911.

Who is eligible?

You are eligible if you are a:

- Undergraduate students enrolled in twelve (12) or more credits
- Graduate students enrolled in nine (9) or more credits
- Law students enrolled in nine (9) or more credits
- All International students, regardless of credits

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective to remain eligible.

You cannot meet this eligibility requirement if you take courses through:

- Online only programs
- Certificate programs

Coverage Dates and Rates

Coverage for all insured students will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated.

The rates below include premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna).

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
Annual	08/15/2026	08/14/2027	09/05/2026
Fall	08/15/2026	01/13/2027	09/05/2026
Spring (New Students Only)	01/14/2027	08/14/2027	02/03/2027

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), On Call Travel Assistance program, as well as any administrative fees.

	Annual	Fall	Spring (New Students Only)
Undergraduate Student	$2,447.00	$1,019.00	$1,428.00
Graduate Student	$4,782.00	$1,991.00	$2,791.00
Law Student	$4,782.00	$1,991.00	$2,791.00

Medicare Eligibility Notice

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

Termination and Refunds

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

Withdrawal from classes – other than leave of absence

- If you withdraw from classes 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.

In-network Provider Network

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

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

Precertification

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification. Your in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify when required, there is a $500 penalty for each type of eligible health service that was not precertified. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to **https://www.aetnastudenthealth.com.** Precertification is not required for substance use disorders treatments for the first 180 days of treatment.

Precertification Call

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

Non-emergency 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.

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

Coordination of Benefits (COB)

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

CVS Virtual Care®

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

Description of Benefits

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

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

Policy year deductible	**In-network coverage**	**Out-of-network coverage**
Student	$300 per policy year	$1,000 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 Behavioral Health) Consultant office visits Walk-in clinic Services Urgent care Hearing exams Chemotherapy Outpatient Radiation therapy Outpatient Cardiac and Pulmonary Rehabilitation Therapeutic manipulation services Male Sterilization • **In-network care and out-of-network care for:** Well newborn nursery care Outpatient prescription drugs		
Maximum out-of-pocket limits (MOOP)		
Student	$9,200 per policy year	$18,400 per policy year

	In-network coverage	Out-of-network coverage
Preventive care and wellness		
Routine physical exams Performed at a physician's office		
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.	
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		
Preventive care immunizations	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
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		
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	
Well woman preventive visits -Routine gynecological exams (including Pap smears)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	

	In-network coverage	Out-of-network coverage
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Substance use disorders, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	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.	
Sexually transmitted infection counseling Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer limitations Maximum visits per policy year	Not subject to any age or frequency limitations	
Substance use disorder counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Maximum visits per policy year	5 visits	
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Maximums One baseline mammogram for females age 35 but less than age 40 One routine mammogram annually for females age 40 and older.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration.	
Lung cancer screening maximums	1 screenings every 12 months	
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		

	In-network coverage	Out-of-network coverage
Prenatal care--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		
Lactation counseling services - facility or office visits	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
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Important note: Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section.		
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	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		

	In-network coverage	Out-of-network coverage
Family planning services **Counseling services**		
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.		
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		
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) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
The following are not covered under this benefit: • Services provided as a result of complications resulting from a 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		

Physicians and other health professionals	In-network coverage	Out-of-network coverage
Physician & specialist office visits (non-surgical/non-preventive care by a physician and 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 performed at a physician's or specialist's office	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Allergy injections treatment performed at a physician's or specialist's 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's or specialist's 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 surgical services		
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)
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		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
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-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 office visits (includes telemedicine and/or telehealth consultations)	$25 copayment per visit No policy year deductible applies	50% (of the recognized charge) per visit
Second or third 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.
Walk-in clinic (non-emergency visit)	$25 copayment per visit No policy year deductible applies	50% (of the recognized charge) per visit
Hospital care (facility charges)		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
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	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) Facility charges for surgery performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge)	50% (of the recognized charge)
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		

	In-network coverage	Out-of-network coverage
Home health care No additional expense, such as coinsurance, copayments, or deductible amounts, will be imposed for newborn home visit services	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
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 -Inpatient	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Hospice care -Outpatient	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
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 – Inpatient facility)	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission

	In-network coverage	Out-of-network coverage
Emergency services and urgent care		
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
Important note: • As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment and coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • A separate 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.		
The following are not covered under this benefit: • Non-emergency services in an emergency room facility		
Urgent medical care provided by an urgent care provider	$25 copayment per visit No policy year deductible applies	50% (of the recognized charge) per visit
Non-urgent use of urgent care provider	Not covered	Not covered
The following is not covered under this benefit: • Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)		

	In-network coverage	Out-of-network coverage
Pediatric dental care (**Limited to covered persons through the end of the month in which the person turns age 19)** Refer to the certificate of coverage for detailed description of covered services		
Type A services: Preventive and diagnostic services	100% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit
Type B services: Restorative services	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Type C services: Endodontic, periodontal, prosthodontic and oral and maxillofacial surgical 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.
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.		
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 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.		

	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 Inpatient physician or specialist surgical services	100% (of the negotiated charge) No policy year deductible applies	50% (of the recognized charge)
Voluntary sterilization for Males Outpatient physician or specialist surgical services	100% (of the negotiated charge) No policy year deductible applies	50% (of the recognized charge)
Abortion		
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)
Temporomandibular joint dysfunction (TMJ) and Craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Dental implants		
Impacted wisdom teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Accidental injury to sound natural teeth	80% (of the negotiated charge)	80% (of the recognized charge)
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		

	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.
The following are not covered under this benefit: • Cosmetic treatment and procedures		
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.
Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries, are not covered under this benefit.		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	50% (of the recognized charge) No policy year deductible applies
Note: 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 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 Coverage provided under the same terms and conditions as for any other condition.		
Mental health -Inpatient hospital (room and board and other miscellaneous hospital services & supplies)	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Outpatient mental health conditions office visits (includes telemedicine and/or telehealth cognitive behavioral therapy consultations)	$25 copayment per visit No policy year deductible applies	50% (of the recognized charge) per visit
Other outpatient services including: • 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

	In-network coverage	Out-of-network coverage
Autism spectrum disorder or other developmental disabilities		
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 hospital substance use disorders detoxification (room and board and other miscellaneous hospital services & supplies)	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Outpatient substance use disorders office visits to a physician or behavioral health provider (includes telemedicine and/or telehealth cognitive behavioral therapy consultations)	$25 copayment per visit No policy year deductible applies	50% (of the recognized charge) per visit
Other outpatient services including: • Partial hospitalization treatment • Intensive outpatient program	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit

	In-network coverage	Out-of-network coverage
Obesity surgery inpatient and outpatient facility and physician 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.
The following are not eligible health services: • Weight management treatment. • Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate. • Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes: - 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.		
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.
	In-network coverage (IOE facility)	**Out-of-network coverage** (Includes **providers** who are otherwise part of **Aetna's** network but are non-IOE **providers**)
Transplant services		
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.
The following are not covered under this benefit: • Services and supplies furnished to a donor when the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness • Travel and lodging expenses		

	In-network coverage	Out-of-network coverage
Infertility services **Comprehensive infertility services (includes basic and advanced reproductive technology (ART) services**		
Inpatient and outpatient care – (Includes basic and advanced reproductive technology (ART) 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.
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 ovulation induction cycles per lifetime while on medications to stimulate the ovaries	4	
Maximum number of cycles lifetime for ART	4	

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.

	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 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	$25 copayment per visit No policy year deductible applies	50% (of the recognized charge) per visit
Outpatient infusion 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.
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	$25 copayment per visit No policy year deductible applies	50% (of the recognized charge) per visit
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient Respiratory therapy	$25 copayment per visit No policy year deductible applies	50% (of the recognized charge) per visit
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.

	In-network coverage	Out-of-network coverage
Cardiac rehabilitation	$25 copayment per visit No policy year deductible applies	50% (of the recognized charge) per visit
Pulmonary rehabilitation	$25 copayment per visit No policy year deductible applies	50% (of the recognized charge) per visit
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
Chiropractic services	$25 copayment per visit No policy year deductible applies	50% (of the recognized charge) per visit
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.
Other services		
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient care		
Clinical trials		
Clinical trial therapies	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.
Clinical trial (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.
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)		

	In-network coverage	Out-of-network coverage
Durable medical equipment	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
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	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.
Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, other nutritional items except as described above, are not covered under this benefit.		
Orthotic and prosthetic devices		
Cochlear implants	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item	80% (of the actual charge) per item
All other Orthotic and prosthetic devices	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
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	80% (of the negotiated charge) per item	50% (of the recognized charge) per item

Hearing aids maximum per ear	One hearing aid per ear every 24 month consecutive period	
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		
	In-network coverage	**Out-of-network coverage**
Hearing exams	$25 copayment per visit No policy year deductible applies	50% (of the recognized charge) per visit
Hearing exam maximum	1 hearing exams every 24 month consecutive period	
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		
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.
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	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	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.

	In-network coverage	Out-of-network coverage
Pediatric vision care **Limited to covered persons through the end of the month in which the person turns age 19**		
Pediatric routine vision exams (including refraction) Performed by a legally qualified ophthalmologist or optometrist includes contact fitting exam	100% (of the negotiated charge) 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 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	
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) 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	
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3-month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per policy year	One optical device	
*__Important note__: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.		
The following are not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		

	In-network coverage	Out-of-network coverage
Outpatient prescription drug copayment waiver for risk reducing breast cancer		
The outpatient prescription drug copayment will not apply to risk reducing breast cancer prescription drugs when obtained at a retail or mail order in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs		
The outpatient prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail or mail order in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your outpatient prescription drug copayment will apply after those two regimens per policy year have been exhausted.		
Outpatient prescription drug copayment waiver for contraceptives		
The outpatient prescription drug prescription drug copayment will not apply to contraceptive methods when obtained at an in-network and out-of-network pharmacy. This means that such contraceptive methods are paid at 100% for: • Certain over-the-counter (OTC) and [generic] contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. • If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%. The 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 a in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		

	In-network coverage	Out-of-network coverage
Outpatient prescription drugs		
Generic prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	$15 copayment per supply No policy year deductible applies	50% (of the recognized charge amount) 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	50% (of the recognized charge amount) No policy year deductible applies
Preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30day supply filled at a retail pharmacy	Copayment per supply of 30% of the negotiated charge No policy year deductible applies	50% (of the recognized charge amount) 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 30% of the negotiated charge No policy year deductible applies	50% (of the recognized charge amount) No policy year deductible applies
Non-preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30day supply filled at a retail pharmacy	Copayment per supply of 30% of the negotiated charge No policy year deductible applies	50% (of the recognized charge amount) 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 30% of the negotiated charge No policy year deductible applies	50% (of the recognized charge amount) No policy year deductible applies

	In-network coverage	Out-of-network coverage
Infertility drugs		
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 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.
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		
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
Diabetic drugs, and insulin important note: Your cost share will not exceed $35 per 30 day supply of a covered 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.		
Contraceptives (birth control)]		
For each fill up to a 12 month supply of generic and OTC drugs and devices filled at a retail or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
For each fill up to a 12 month supply of brand name prescription drugs and devices filled at a retail or mail order 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.
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a retail or mail order pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above. For example, if you have a generic prescription drug, refer to the generic prescription drug section of the schedule of benefits.
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 United States Preventive Services Task Force. For details on the guidelines and the current list of covered	

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

Outpatient prescription drugs exclusions

The following are not eligible health services:

- Abortion drugs used for elective termination of pregnancy except when the pregnancy [is the result of rape or incest or if it places the woman's life in serious danger
- 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 we have 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

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.

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

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

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

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

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

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

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

General 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 [except in connection with hospice care], adult or child day care, or convalescent care
- Institutional care including room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health 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 (GCIT)

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 therapeutics services related to jaw joint disorders including associated myofascial pain

This exclusion does not apply to covered benefits for treatment of TMJ and CMJ as described in the *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

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

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

Services, supplies and drugs received outside of the United States

- Non-emergency medical services, outpatient prescription drugs or supplies received outside of the United States. They are not covered even if they are covered in the United States under this certificate.

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.

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

NJ Transplant Donation Disclosure

For information on how to make an anatomical gift, including information on the registration of a gift in the Donate Life New Jersey registry, please use the following contact information, depending on where you live:

If you live in northern or central New Jersey, contact:
691 Central Avenue, New Providence, NJ 07974
Phone: (800) 742-7365
Email: info@NJSharingNetwork.org
www.NJSharingNetwork.org

If you live in southern New Jersey, contact:
401 N. 3rd Street, Philadelphia, PA 19123
Phone: (800) DONORS-1
(800) 366-6771
Email: info@donors1.org
www.donors1.org

If you have any questions, please contact our customer service department at the number on the back of your ID card.

Sanctioned Countries

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.