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

Stevens Institute of Technology

Policy Year: 2023 - 2024
Policy Number: 175454
https://www.aetnastudenthealth.com
(800) 481-8814

This is a brief description of the Student Health Plan. The Plan is available for Stevens Institute of Technology students and their eligible dependents. The Plan is underwritten by Aetna Health and Life Insurance Company (Aetna). 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.

HEALTH SERVICES

Stevens Institute of Technology Health Services is open Monday through Friday from 9:00 a.m. to 4:00 p.m.

For more information, call the Health Services at (201) 216-5678. In the event of an emergency, call 911 or the Campus Police at (201) 216-3911.

Coverage Dates and Rates

Coverage for all insured students and eligible dependents will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

The rates below include premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna). They also include a Travel Assistance Fee and the School Administrative Fee.

	Annual 08/18/23-08/17/24	Spring 01/01/24-08/17/24	Summer 1 05/15/24-08/17/24	Summer 2 07/14/24 - 08/17/24
Student	$2,204	$1,383	$574	$211
Spouse	$2,204	$1,383	$574	$211
Each Child	$2,204	$1,383	$574	$211
Children	$4,408	$2,766	$1,148	$422
Spouse + Children	$6,612	$4,149	$1,722	$633
Enrollment and Waiver deadlines: Fall: 09/15/23 Spring: 02/02/24				

STUDENT COVERAGE

Who is eligible?

All full-time undergraduate students and all full-time graduate students are automatically enrolled in this insurance plan at registration and premium for coverage is added to their tuition billing unless proof of comparable coverage is furnished. Students enrolled in Steven's Cooperative Education program have full-time status.

International students are automatically enrolled in this insurance plan.

All part-time students taking 1 or more credit hours are eligible to enroll on a voluntary basis.

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

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

Enrollment

To enroll online visit www.universityhealthplans.com/stevens.

Dependent Coverage

Eligibility

Covered students may also enroll their lawful spouse, domestic partner (same-sex, opposite sex), and dependent children up to the age of 26.

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting www.universityhealthplans.com/stevens and selecting the Dependent Enrollment form. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. The deadline to enroll a dependent is 31 days after the significant life changing event. (An example of a significant life change would be loss of health coverage under another health plan.) In that case contact University Health Plans at 1-833-250-9006.

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

- A newborn child - Your newborn child is covered on your health plan for the first 60 days from the moment of birth.
  - To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 60-day period.
  - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
  - If you miss this deadline, your newborn will not have health benefits after the first 60 days.
  - If your coverage ends during this 60-day period, then your newborn coverage will end on the same date as your coverage. This applies even if the 60-day period has not ended.
- An adopted child or a child legally placed with you for adoption - A child that you, or that you and your spouse or domestic partner adopts or is placed with you for adoption is covered on your plan for the first 31 days after the adoption or the placement is complete.
  - To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption or placement for adoption.
  - You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
  - If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
  - If your coverage ends during this 31-day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31-day period has not ended.
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage, civil union or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
  - To keep your stepchild covered, we must receive your completed enrollment information within 31 days after the date of your marriage or your Declaration of Domestic Partnership.
  - You must still enroll the stepchild within 31 days after the date of your marriage or your Declaration of

Domestic Partnership even when coverage does not require payment of an additional premium contribution for the stepchild.
  - If you miss this deadline, your stepchild will not have health benefits after the first 31 days.
  - If your coverage ends during this 31 day period, then your stepchild's coverage will end on the same date as your coverage. This applies even if the 31-day period has not ended.
- Dependent coverage due to a court order: If you must provide coverage to a dependent because of a court order, your dependent is covered on your health plan for the first 31 days from the court order.
  - To keep your dependent covered, we must receive your completed enrollment information within 31 days of the court order.
  - You must still enroll the dependent within 31 days of the court order even when coverage does not require payment of an additional premium contribution for the dependent.
  - If you miss this deadline, your dependent will not have health benefits after the first 31 days.
  - If your coverage ends during this 31-day period, then your dependent's coverage will end on the same date as your coverage. This applies even if the 31-day period has not ended.
  - You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
  - If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
  - If your coverage ends during this 31-day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31-day period has not ended.

If you need information or have general questions on dependent enrollment, call University Health Plans at 1-833-250-9006.

Medicare Eligibility Notice

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

Termination and Refunds

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

Withdrawal from Classes – Other than Leave of Absence: If you withdraw from classes other than under a school-approved leave of absence within 31 days* after the policy effective date, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded. If the withdrawal is more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded. If you withdraw from classes to enter the armed forces of any country, coverage will terminate as of the effective date of such entry and a pro rata refund of premiums will be made if you submit a written request within 90 days of withdrawal from classes.

In-network Provider Network

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

If you need care that is covered under the Plan but not available from an In-network Provider, contact Member Services for assistance at the toll-free number on the back of your ID card. In this situation, Aetna may issue 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 www.aetna.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 admissions:	You, your physician, or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
An emergency admission:	You, your physician, or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission:	You, your physician, or the facility will need to call before you are scheduled to be admitted. 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.
Outpatient non-emergency services requiring precertification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

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 30 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.

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**
You have to meet your policy year deductible before this plan pays for benefits.		
Student	None	None
Maximum out-of-pocket limits		
Student	$6,350 per policy year	None
Family	$12,700 per policy year	None

Eligible health services	**In-network coverage**	**Out-of-network coverage**
Preventive care and wellness		
Routine physical exams		
Routine Physical exam	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the allowable amount) per visit
Covered persons through age 21: Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Covered persons age 22 and over: Maximum visits per policy year	1 visits	
Preventive care immunizations Performed in a facility or at a physician's office		
Preventive care immunizations Includes childhood immunizations	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the allowable amount) per visit
Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel will not be covered under this benefit.		
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 www.aetnastudenthealth.com or calling the toll-free number on your ID card.	

Eligible health services	In-network coverage	Out-of-network coverage
Well woman preventive visits **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	100% (of the allowable amount) 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		
Child lead poisoning screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the allowable amount) per visit
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Tobacco Products, Depression Screening, 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	100% (of the allowable amount) 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.	
Use of tobacco products counseling Maximum visits per policy year	8 visits	
Depression screening counseling Maximum visits per policy year	1 visit	
Sexually transmitted infection counseling Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations	
Substance use counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the allowable amount) per visit
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the allowable amount) per visit

Maximums One baseline mammogram for females age 35 but less than age 40 age 40 and older 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. For details, contact your physician or Member Services by logging in to your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Eligible health services	**In-network coverage**	**Out-of-network coverage**
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.		
Prenatal care -Preventive care services only	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the allowable amount) 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 amount) per visit
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 amount) per item
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		

Eligible health services	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	100% (of the allowable amount) 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	100% (of the allowable amount) per item
Female Voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	100% (of the allowable amount)
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the allowable amount) per visit
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		
Physicians and other health professionals		
Physician & specialist (non-surgical and non-preventive care by a physician and specialist, includes telemedicine and/or telehealth consultations) Includes treatment for child lead poisoning	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
Allergy testing performed at a physician's or specialist's office	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
Allergy injections treatment performed at a physician's, or specialist office	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
Allergy sera and extracts administered via injection, are not covered under this benefit.		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	85% (of the negotiated charge)	75% (of the allowable amount)

The following are not covered under this benefit: • The services of any other physician who helps the operating physician • 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		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
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)	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • 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	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
Consultant office visits includes telemedicine and/or telehealth consultations) Includes treatment for child lead poisoning	85% (of the negotiated charge) per visit	75% (of the allowable amount) 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.
Hospital care (facility charges)		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Subject to semi-private room rate unless int care unit required Room and board includes intensive care Includes birthing center facility charges	85% (of the negotiated charge) per admission	75% (of the allowable amount) per admission
Anesthesia and related facility charges for a dental procedure	85% (of the negotiated charge)	75% (of the allowable amount)
Outpatient surgery (facility charges) Facility charges for surgery performed in the outpatient department of a hospital or surgery center	85% (of the negotiated charge)	75% (of the allowable amount)
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • 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

Eligible health services	In-network coverage	Out-of-network coverage
Home health care	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
The following are not covered under this benefit: • Services for infusion therapy • 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 • Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present • Homemaker or housekeeper services • Maintenance therapy		
Hospice care -Inpatient	85% (of the negotiated charge) per admission	75% (of the allowable amount) per admission
Hospice care -Outpatient	85% (of the negotiated charge) per visit	75% (of the allowable amount) 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		
Outpatient private duty nursing	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
Skilled nursing facility -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	85% (of the negotiated charge) per admission	75% (of the allowable amount) per admission
Hospital emergency room	85% (of the negotiated charge) per visit	Paid the same as in-network coverage
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, or call Member Services for an address at 1-877-480-4161 and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • A separate hospital emergency room copayment 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 hospital 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 hospital emergency room copayment.
- Separate copayment amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment amounts may be different from the hospital emergency room copayment. They are based on the specific service given to you.
- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment amounts that are different from the hospital emergency room copayment amounts.

Eligible health services	**In-network coverage**	**Out-of-network coverage**
Non-emergency care in a hospital emergency room	Not covered	Not covered
Non-emergency services in a hospital emergency room facility, is not covered under this benefit.		
Urgent medical care provided by an urgent care provider	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
Non-urgent use of urgent care provider	Not covered	Not covered
Non-urgent care in an urgent care facility (at a non-hospital freestanding facility), is not covered under this benefit.		
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	75% (of the allowable amount) per visit
Type B services: Restorative services	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
Type C services: Endodontic, periodontal, prosthodontic and oral and maxillofacial surgical services	50% (of the negotiated charge) per visit	50% (of the allowable amount) per visit
Orthodontic services	50% (of the negotiated charge) per visit	50% (of the allowable amount) 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.

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.

Eligible health services	In-network coverage	Out-of-network coverage
Birthing center (facility charges)	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)	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	85% (of the negotiated charge)	75% (of the allowable amount)
Voluntary sterilization for males Outpatient physician or specialist surgical services	85% (of the negotiated charge)	75% (of the allowable amount)
The following are not covered under this benefit: • Abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger • Reversal of voluntary sterilization procedures, including related follow-up care • Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care		
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.
Dental implants, are not covered under this benefit.		
Impacted wisdom teeth	85% (of the negotiated charge)	75% (of the allowable amount)
Accidental injury to sound natural teeth	85% (of the negotiated charge)	75% (of the allowable amount)
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	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.		

Eligible health services	In-network coverage	Out-of-network coverage
Well newborn nursery care in a hospital or birthing center	85% (of the negotiated charge)	75% (of the allowable amount)
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.
The following are not eligible health services under this benefit: Any treatment, surgery, service or supply that is not listed in the certificate as eligible health services		
Mental health -Inpatient hospital (room and board and other miscellaneous hospital services & supplies)	85% (of the negotiated charge) per admission	75% (of the allowable amount) per admission
Outpatient mental health conditions treatment office visits to a physician or behavioral health provider (includes telemedicine and/or telehealth cognitive behavioral therapy consultations)	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
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.
Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity. To include morbid obesity except as described above and in the *Eligible health services and exclusions – Preventive care and wellness* 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: – 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		
Autism spectrum disorder diagnosis and testing (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.
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.

Eligible health services	In-network coverage	Out-of-network coverage
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.
Inpatient hospital substance use disorders detoxification (room and board and other miscellaneous h services & supplies) Inpatient hospital substance use disorders rehabilitation (room and board and other miscellaneous hospital services and supplies) Inpatient residential treatment facility subst use 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 use disorders room and board intensive care	85% (of the negotiated charge) per admission	75% (of the allowable amount) per admission
Outpatient substance use disorders office visits to a physician or behavioral health provider (includes telemedicine and/or telehealth cognitive behavioral therapy consultations)	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
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.

Excluded

Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity. This is regardless of the existence of other medical conditions. Examples of these are:

- 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

Eligible health services	**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.
Eligible health services	**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.	
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.	

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

Comprehensive infertility services (includes basic and advanced reproductive technology (ART) services		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Inpatient and outpatient care - comprehensive infertility services (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.

The following are not eligible health services

- Cryopreservation (freezing), storage or of eggs, embryos, sperm or reproductive tissue, unless due to iatrogenic infertility.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate where the surrogate is not covered under this plan. 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 oocytes 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.
- Egg retrievals if you are over 45 years of age.

Eligible health services	In-network coverage	Out-of-network coverage
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	85% (of the negotiated charge)	75% (of the allowable amount)
Diagnostic lab work services performed in a physician's office, the outpatient department of a hospital or other facility	95% (of the negotiated charge)	75% (of the allowable amount)
Radiological services performed in a physician's office, the outpatient department of a hospital or other facility	95% (of the negotiated charge)	75% (of the allowable amount)
Chemotherapy	85% (of the negotiated charge) per visit	75% (of the allowable amount) 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		
Outpatient radiation therapy	85% (of the negotiated charge) per visit	75% (of the allowable amount) 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	85% (of the negotiated charge) per visit	75% (of the allowable amount) 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.
Cardiac rehabilitation	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
Pulmonary rehabilitation	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
Outpatient physical, occupational, speech, and cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
Therapeutic manipulation services	85% (of the negotiated charge) per visit	75% (of the allowable amount) 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.
Acupuncture in lieu of anesthesia	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.

Eligible health services	In-network coverage	Out-of-network coverage
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	85% (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 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.
Durable medical equipment	85% (of the negotiated charge) per item	75% (of the allowable amount) 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	85% (of the negotiated charge) per item	75% (of the allowable amount) per item
Infant formulas	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.
Infant pasteurized donated breast milk	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.		
Cochlear implants	85% (of the negotiated charge) per item	75% (of the allowable amount) per item
Orthotic and prosthetic devices	85% (of the negotiated charge) per item	75% (of the allowable amount) 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		

Eligible health services	In-network coverage	Out-of-network coverage
Hearing aids	85% (of the negotiated charge) per item	75% (of the allowable amount) 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: • Replacement parts or repairs for a hearing aid • Batteries or cords • Cochlear implants • 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	85% (of the negotiated charge) per visit	75% (of the allowable amount) per visit
Hearing exam maximum	1 hearing exam every policy year	
Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay, are not covered under this benefit.		
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.
Wilm's tumor 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.
Eligible health services	**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	75% (of the allowable amount) per visit
Maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
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	75% (of the allowable amount) 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	
Outpatient prescription drugs		
Policy year deductible and copayment waiver for risk reducing breast cancer		
The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
Policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs		
The policy year deductible and the per prescription copayment/coinsurance 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 in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your policy year deductible and any prescription copayment/coinsurance 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 per prescription copayment/coinsurance 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 drug or device for that method paid at 100%. The policy year deductible prescription drug policy year deductible and the per prescription copayment/coinsurance 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.		

Preferred generic prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
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)	$15 copayment per supply then the plan pays 100% (of the balance of the allowable amount)
More than a 30 day supply but less than a 90 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)	$37.50 copayment per supply then the plan pays 100% (of the balance of the allowable amount)
Preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	$30 copayment per supply then the plan pays 100% (of the balance of the allowable amount)
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	$75 copayment per supply then the plan pays 100% (of the balance of the allowable amount)
Non-preferred generic prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	$60 copayment per supply then the plan pays 100% (of the balance of the allowable amount)
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	$150 copayment per supply then the plan pays 100% (of the balance of the allowable amount)
Non-preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	$60 copayment per supply then the plan pays 100% (of the balance of the allowable amount)
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	$150 copayment per supply then the plan pays 100% (of the balance of the allowable amount)
Infertility treatment prescription 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. For example, if you have a generic prescription drug, refer to the generic prescription drug section of the schedule of benefits.
Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	100% (of the negotiated charge)	100% (of the allowable amount)
Preventive care drugs and supplements		
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	100% (of the allowable amount)

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 onto your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	
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.
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 onto your Aetna website at 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.
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 onto your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	

The following are not covered under the outpatient prescription drugs benefit:

- Allergy sera and extracts administered via injection
- Any services related to the dispensing, injecting or application of a drug
- Biological sera unless specified on the preferred drug guide
- Compounded prescriptions containing bulk chemicals not approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones
- Cosmetic drugs including medications and preparations used for cosmetic purposes
- Devices, products and appliances, except those that are specially covered
- Dietary supplements including medical foods, except those defined under *Nutritional support*
- Drugs or medications
  - Which do not, by federal or state law, require a prescription order i.e. over-the-counter (OTC) drugs), even if a prescription is written except as specifically provided above in the *Over-the-counter drugs* section
  - Not approved by the FDA (except those provided under the Anti-cancer drugs taken by mouth, including chemotherapy drugs provision) or not proven safe or effective
  - Provided under your medical plan while an inpatient of a healthcare facility

- That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
- 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
- That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications 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 (e.g. two antihistamine drugs)
- Genetic care
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects
- 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 provided above
- Injectables
  - Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us.
  - 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. This exception does not apply to Depo Provera and other injectable drugs used for contraception.
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - Packaged in a unit dose form.
  - Filled prior to the effective date or after the termination date of coverage under this plan.
  - Dispensed by a mail order pharmacy and include prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
  - That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug as determined by the plan.
  - 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 to a dental condition.
  - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the preferred drug guide.
  - That are non-preferred drugs, unless non-preferred drugs are specifically covered as described in your schedule of benefits. However, a non-preferred drug will be covered if in the judgment of the prescriber there is no equivalent prescription drug on the preferred drug guide or the product on the preferred drug guide is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
  - 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.

- Refills dispensed more than one year from the date the latest prescription order was written
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents

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

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 except as described in:

- The *Eligible health services* and exclusions section of this certificate of coverage or
- A rider or amendment issued to you for use with this certificate of coverage

Acupuncture

- Acupuncture
  - Acupressure

Air or space travel

- Traveling in, on or descending from any aircraft, including a hang glider, while the aircraft is in flight. This includes descending by a parachute, wingsuit or any other similar device.

  This exclusion does not apply if:
  - You are traveling solely as a fare-paying passenger
  - You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
  - You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
    - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved
    - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the **policyholder** performing duties for the **policyholder**
  - You are enrolled in the **policyholder's** "Bachelor of Science in Aviation" program

Alternative health care

- Services and supplies given by a **provider** for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and traditional Chinese medicine.

Armed forces

- Services and supplies received from a **provider** as a result of an **injury** sustained, or **illness** contracted, while in the service of the armed forces of any country. When you enter the armed forces of any country, we will refund any unearned pro-rata **premium** to the **policyholder**.

Beyond legal authority

- Services and supplies provided by a **health professional** or other **provider** that is acting beyond the scope of its legal authority

Blood, blood plasma, synthetic blood, blood derivatives or substitutes
Examples of these are:

- The provision of blood to the **hospital**, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered

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

Clinical trial therapies (experimental and investigational)

- Your plan does not cover clinical trial therapies (**experimental** and **investigational**), except as described in the *Eligible health services and exclusions - Clinical trial therapies (**experimental** and **investigational**)* section

Cornea or cartilage transplants

- Cornea (corneal graft with amniotic membrane)
- Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

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, whether or not for psychological or emotional reasons.

This exclusion does not apply to:

- **Surgery** after an accidental **injury** when performed as soon as medically feasible. (**Injuries** that occur during medical treatments are not considered accidental **injuries** even if unplanned or unexpected.)
- Coverage that may be provided under the *Eligible health services and exclusions - Gender affirming treatment* 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. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training
- For behavioral health (mental health treatment and substance usedisorders 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

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

Educational services

Examples of these services are:

- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services and exclusions – Diabetic services and supplies (including equipment and training)* section. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment program(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 are, examinations to get or keep a job, or 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 and investigational

- **Experimental** and **investigational** drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (**experimental** and **investigational**) or covered under clinical trials (routine patient costs). See the *Eligible health services and exclusions – Other services* section.

Facility charges
For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Felony

- Services and supplies that you receive as a result of an **injury** due to your commission of a felony

Genetic care

- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects

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

Incidental surgeries

- Charges made by a **physician** for incidental surgeries. These are non-**medically necessary** surgeries performed during the same procedure as a **medically necessary** surgery.

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. See the *Eligible health services and exclusions – Habilitation therapy service*s section

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device except as described in the *Diabetic services and supplies* (*including equipment and training*) section. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans

- Syringes
- Blood or urine testing supplies
- Other home test kits
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Mental health conditions and substance use disorders conditions treatment

The following are not covered by the behavioral health plan.

- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs

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

Outpatient prescription or non-prescription drugs and medicines

- Outpatient **prescription drugs** or non-prescription drugs and medicines provided by the **policyholder**
- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient **prescription drug** plan

Outpatient surgery

- The services of any other **physician** who helps the operating **physician**
- A **stay** in a **hospital** (**Hospital stays** are covered in the *Eligible health services under your plan – 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

Pediatric dental care

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

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

Riot

- Services and supplies that you receive from **providers** as a result of an **injury** from your "participation in a riot". This means when you take part in a riot in any way such as inciting, or conspiring to incite, the riot. It does not include actions that you take in self-defense as long as they are not against people who are trying to restore law and order.

Routine exams

- 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** or

  by **health professionals** who:
  - Are employed by
  - Are Affiliated with
  - Have an agreement or arrangement with, or
  - Are otherwise designated by

  the **policyholder**.

Services provided by a family member

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

Sexual dysfunction/enhancement

Eligible health services include **prescription drugs** for the treatment of sexual dysfunction/enhancement. For the most up-to-date information on dosing, call Member Services at the toll-free number on your ID card in the *How to contact us for help* section.

Sinus surgery

- Any services or supplies given by **providers** for sinus surgery except for acute purulent sinusitis

Specialty prescription drugs

- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient **prescription drug** benefit

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - 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 given when you are not present at the same time as the **provider**
- Services including:
  - Telephone calls
  - **Telemedicine** and/or **telehealth** kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

- The use, in isolation, of:
  - Audio-only telephone conversation
  - Electronic mail
  - Instant messaging
  - Phone text
  - Facsimile transmission

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory 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

Wilderness Treatment Programs

See *Educational services* within 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.
- A source of coverage or reimbursement will be 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 Stevens Institute of Technology Student Health Insurance Plan is underwritten by Aetna Health and Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna Health and 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.

Language accessibility statement

Interpreter services are available for free.

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-877-480-4161** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-480-4161** (TTY: **711**).

አማርኛ**/Amharic**

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-877-480-4161** (መስማት ለተሳናቸው: **711**).

العربية**/Arabic**

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-480-4161** (رقم الهاتف النصي: **711**).

Ɓàsɔ̀ɔ̀ Wùɖù/Bassa

Dè dɛ nìà kɛ dyɛ́dɛ́ gbo: Ɔ jǔ ké m̀ dyi Ɓàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìì à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpáa.
Ɖá **1-877-480-4161** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-877-480-4161** (TTY: **711**)。

فارسی**/Farsi**

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-877-480-4161** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d'une assistance gratuite dans votre langue en composant le **1-877-480-4161** (TTY: **711**).

ગુજરાતી**/Gujarati**

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે.
કૉલ કરો **1-877-480-4161** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-480-4161** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-877-480-4161** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-877-480-4161**(TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-877-480-4161** (TTY: **711**). Estes serviços são oferecidos gratuitamente.

Русский/Russian

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-877-480-4161** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-480-4161** (TTY: **711**).

اردو/Urdu

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (TTY: **711**) **1-877-480-4161** پر کال کریں.

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị.
Gọi số **1-877-480-4161** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-877-480-4161** (TTY: **711**).

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