Student Health Insurance

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

Schedule of Benefits

Prepared exclusively for:

Policyholder: The College of New Jersey - Early Arrival
Policyholder number: 686165
Student policy effective date: 08/01/2020
Plan effective date: 08/01/2020
Plan issue date: 12/25/2020
Actuarial value and metallic level: 85.04% - Gold

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

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
Schedule of benefits

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

How to read your schedule of benefits

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

Important note:
All covered benefits are subject to the policy year deductible, copayment and coinsurance unless otherwise noted in the schedule of benefits below.

How to contact us for help

We are here to answer your questions.

• Log onto your Aetna secure website at www.aetnastudenthealth.com.
• Call Member Services at the toll-free number on your ID card 1-800-481-8814.

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

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
**Important note about your cost sharing:**
The way the cost sharing works under this plan, you pay the **policy year deductible** first. Then you pay your **copayment** and then you pay your **coinsurance**. Your **copayment** does not apply towards any **policy year deductible**.

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

Here’s an example of how cost sharing works:

<table>
<thead>
<tr>
<th>You pay your policy year deductible</th>
<th>Your physician charges</th>
<th>Your physician collects the copayment from you</th>
<th>The plan pays 80% coinsurance</th>
<th>You pay 20% coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000</td>
<td>$120</td>
<td>$20</td>
<td>$80</td>
<td>$20</td>
</tr>
</tbody>
</table>

**Plan features**

<table>
<thead>
<tr>
<th>Policy year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-network coverage</strong>*</td>
</tr>
</tbody>
</table>

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

| Student | $150 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 and Vision Care Services*
- In-network care and out-of-network care for *Immunizations for Children, Lead Poisoning Screening for Children, Well newborn nursery care, and outpatient prescription drugs*

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th></th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum out-of-pocket limits (MOOP)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum out-of-pocket limit per policy year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>$5,000 per policy year</td>
<td>$10,000 per policy year</td>
</tr>
</tbody>
</table>

**Precertification covered benefit penalty**

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

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

- A $500 benefit penalty will be applied separately to each type of eligible health services

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

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
Coinsurance listed in the schedule of benefits
The coinsurance listed in the schedule of benefits below reflects the plan coinsurance percentage. This is the coinsurance amount that the plan pays. You are responsible for paying any remaining coinsurance.

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Preventive care and wellness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine physical exams</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed at a physician’s office</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td><strong>Covered persons through age 21:</strong></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Maximum age and visit limits per policy year</td>
<td>For details, contact your physician or Member Services by logging onto your Aetna secure website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or calling the toll-free number on your ID card.</td>
<td></td>
</tr>
<tr>
<td><strong>Covered persons age 22 &amp; over:</strong></td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
**Eligible health services** | **In-network coverage** | **Out-of-network coverage**
--- | --- | ---

**Health wellness promotion programs**

<table>
<thead>
<tr>
<th></th>
<th>100% of the negotiated charge per visit</th>
<th>50% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed in a facility or at a <strong>physician</strong>'s office</td>
<td>No <strong>copayment</strong> or <strong>policy year deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td>Recommended immunizations for all adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Blood tests and lifestyle behavior counseling for <strong>covered persons</strong> age 20 and over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A Pap smear for female <strong>covered persons</strong> age 20 and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Stool examination for presence of blood for <strong>covered persons</strong> age 40 or older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A mammogram including a digital tomosynthesis for female <strong>covered persons</strong> age 40 or older</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Every 5 years:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Glaucoma test for <strong>covered persons</strong> age 35 and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A left-sided colon examination of 35 or 60 centimeters for <strong>covered persons</strong> age 45 and older</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive care immunizations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed in a facility or at a physician’s office</td>
<td>100% (of the <strong>negotiated charge</strong>) per visit</td>
<td>50% (of the <strong>recognized charge</strong>) per visit</td>
</tr>
<tr>
<td></td>
<td>No <strong>copayment</strong> or <strong>policy year deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td><strong>Maximums</strong></td>
<td><strong>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</strong></td>
<td><strong>For details, contact your physician or Member Services by logging onto your Aetna secure website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or calling the toll-free number on your ID card.</strong></td>
</tr>
</tbody>
</table>

**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 | 50% (of the **recognized charge**) per visit |
|                                                                                     | No **copayment** or **policy year deductible** applies |                                               |
| **Maximums**                                                                        | **Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration Women’s Preventive Services Guidelines.** |                                               |
| **Maximum visits per **policy year**                                               | 1 visit                                      |                                               |

**Preventive screening and counseling services**

| Obesity and/or healthy diet counseling office visits | 100% (of the **negotiated charge**) per visit | 50% (of the **recognized charge**) per visit |
|                                                      | No **copayment** or **policy year deductible** applies |                                               |
| **Maximum visits per **policy year**               | 26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* |                                               |
| (This maximum applies only to **covered persons** age 22 and older)               |                                               |                                               |

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

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance use counseling office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>5 visits*</td>
<td></td>
</tr>
<tr>
<td>*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of tobacco products counseling office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>8 visits*</td>
<td></td>
</tr>
<tr>
<td>*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression screening counseling office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>1 visit*</td>
<td></td>
</tr>
<tr>
<td>*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted infection counseling office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>2 visits*</td>
<td></td>
</tr>
<tr>
<td>*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Genetic risk counseling for breast and ovarian cancer office visits</strong></td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

**Age limitations**
Not subject to any age limitations

**Routine cancer screenings**
**Performed at a physician’s office, specialist’s office or facility.**

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine cancer screenings</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

**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.

For details, contact your physician or Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.

**Lung cancer screening maximums**
1 screening 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.

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prenatal care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive care services only</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Comprehensive lactation support and counseling services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactation counseling services - facility or office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the actual charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Breast feeding durable medical equipment</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast pump supplies and accessories</td>
<td>100% (of the negotiated charge) per item</td>
<td>100% (of the actual charge) per item</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

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

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family planning services – female contraceptives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female contraceptive counseling services office visit</td>
<td>100% (of the <strong>negotiated charge</strong>) per visit</td>
<td>50% (of the <strong>recognized charge</strong>) per visit</td>
</tr>
<tr>
<td></td>
<td>No <strong>copayment</strong> or <strong>policy year deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td>Contraceptive counseling services maximum visits per <strong>policy year</strong> either in a group or individual setting</td>
<td>2 visits*</td>
<td></td>
</tr>
<tr>
<td><strong>Important note:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any visits that exceed the contraceptive counseling services maximum are covered under <strong>Physician services</strong> office visits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contraceptives (prescription drugs and devices)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female contraceptive <strong>prescription drugs</strong> and devices provided, administered, or removed, by a <strong>physician</strong> during an office visit</td>
<td>100% (of the <strong>negotiated charge</strong>) per item</td>
<td>50% (of the <strong>recognized charge</strong>) per item</td>
</tr>
<tr>
<td></td>
<td>No <strong>copayment</strong> or <strong>policy year deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td><strong>Female voluntary sterilization</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient <strong>provider</strong> services</td>
<td>100% (of the <strong>negotiated charge</strong>) per visit</td>
<td>50% (of the <strong>recognized charge</strong>)</td>
</tr>
<tr>
<td></td>
<td>No <strong>copayment</strong> or <strong>policy year deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td>Outpatient <strong>provider</strong> services</td>
<td>100% (of the <strong>negotiated charge</strong>) per visit</td>
<td>50% (of the <strong>recognized charge</strong>) per visit</td>
</tr>
<tr>
<td></td>
<td>No <strong>copayment</strong> or <strong>policy year deductible</strong> applies</td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2. Physicians and other health professionals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physician and specialist services (non-surgical and non-preventive)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office hours visits (non-surgical and non-preventive care by a physician and specialist, includes telemedicine and/or telehealth consultations)</td>
<td>$30 copayment per visit then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td><strong>Allergy testing and treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy testing performed at a physician’s or specialist’s office</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Allergy injections treatment performed at a physician’s or specialist’s office</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Allergy sera and extracts administered via injection at a physician’s or specialist’s office</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Physician and specialist – inpatient surgical services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td><strong>Physician and specialist – outpatient surgical services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery performed at a physician’s or specialist’s office or outpatient department of a hospital or surgery center by a surgeon</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

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<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-hospital non-surgical physician services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-hospital non-surgical physician services</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td><strong>Consultant services (non-surgical and non-preventive)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office hours visits (non-surgical and non-preventive care),</td>
<td>$30 copayment per visit then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td><strong>Telemedicine and/or telehealth consultation by a consultant</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Second surgical opinion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second surgical opinion</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Alternatives to physician office visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Walk-in clinic visits (non-emergency visit)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walk-in clinic (non-emergency visit)</td>
<td>$30 copayment per visit then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

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

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
### Eligible health services

<table>
<thead>
<tr>
<th></th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
</table>

#### 3. Hospital and other facility care

**Hospital care (facility charges)**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital (room and board) and other miscellaneous services and supplies</td>
<td>80% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board intensive care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For physician charges, refer to the Physician and specialist-inpatient surgical services benefit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Preadmission testing

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preadmission testing</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

#### Anesthesia and related facility charges for a dental procedure

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

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia and related facility charges for a dental procedure</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
</tbody>
</table>

#### Alternatives to hospital stays

**Outpatient surgery (facility charges)**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility charges for surgery performed in the outpatient department of a hospital or surgery center</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>In-network coverage*</td>
<td>Out-of-network coverage*</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>Home health care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Maximum visits per <strong>policy year</strong></td>
<td>Unlimited visits</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient facility (room and board and other miscellaneous services and supplies)</td>
<td>80% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td><strong>Outpatient private duty nursing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient private duty nursing</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td><strong>Skilled nursing facility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient facility (room and board) and miscellaneous inpatient care services and supplies</td>
<td>80% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board includes intensive care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
### Eligible health services

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Emergency services and urgent care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Emergency services</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital emergency room</td>
<td>80% (of the negotiated charge) per visit</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td>Non-emergency care in a hospital emergency room</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**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 1-800-481-8814 and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- 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.

<table>
<thead>
<tr>
<th>Urgent care</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent medical care provided by an urgent care provider</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Non-urgent use of urgent care provider</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5. Pediatric dental care</strong></td>
<td><strong>Limited to covered persons through the end of the month in which the person turns age 19</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Type A services: Preventive and diagnostic services</td>
<td>100% (of the <strong>negotiated charge</strong>) per visit</td>
</tr>
<tr>
<td></td>
<td>No <strong>copayment</strong> or deductible applies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Type B services: Restorative Services</td>
<td>70% (of the <strong>negotiated charge</strong>) per visit</td>
</tr>
<tr>
<td></td>
<td>No <strong>policy year deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Type C services: Endodontic, periodontal, prosthodontic and oral and maxillofacial surgical services</td>
<td>50% (of the <strong>negotiated charge</strong>) per visit</td>
</tr>
<tr>
<td></td>
<td>No <strong>policy year deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Orthodontic services</td>
<td>50% (of the <strong>negotiated charge</strong>) per visit</td>
</tr>
<tr>
<td></td>
<td>No <strong>policy year deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adjunctive general services includes dental emergency treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

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.

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.
### Eligible health services

<table>
<thead>
<tr>
<th>Important Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Dental services are available from birth with an age one dental visit encouraged.</td>
</tr>
<tr>
<td>(2) A second opinion is allowed.</td>
</tr>
<tr>
<td>(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.</td>
</tr>
<tr>
<td>(4) Diagnostic and preventive services are linked to the <strong>dental provider</strong>, thus allowing you to transfer to a different <strong>dental provider/practice</strong> and receive these services. The new <strong>dental provider</strong> 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.</td>
</tr>
<tr>
<td>(5) Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.</td>
</tr>
<tr>
<td>(6) Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.</td>
</tr>
<tr>
<td>(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.</td>
</tr>
</tbody>
</table>

*See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefits.*
Pediatric dental care schedule

<table>
<thead>
<tr>
<th>Diagnostic and preventive care (type A services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Preventive Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.</td>
</tr>
<tr>
<td>• Dental prophylaxis once every 6 months*</td>
</tr>
<tr>
<td>• Topical fluoride treatment once every 6 months in conjunction with prophylaxis as a separate service*</td>
</tr>
<tr>
<td>• Fluoride varnish once every 3 months for children under the age of 6</td>
</tr>
<tr>
<td>• Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.</td>
</tr>
<tr>
<td>• Space maintainers to maintain space for eruption of permanent tooth/teeth. Includes placement and removal:</td>
</tr>
<tr>
<td>- Fixed-unilateral and bilateral</td>
</tr>
<tr>
<td>- Removable-bilateral only</td>
</tr>
<tr>
<td>- Recementation of fixed space maintainer</td>
</tr>
<tr>
<td>- Removal of fixed space maintainer. Considered for provider that did not place appliance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Diagnostic Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>* Indicates diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.</td>
</tr>
<tr>
<td>• Clinical oral evaluations once every 6 months*</td>
</tr>
<tr>
<td>- Comprehensive oral evaluation-- complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation</td>
</tr>
<tr>
<td>- Periodic oral evaluation – subsequent thorough evaluation of an established patient*</td>
</tr>
<tr>
<td>- Oral evaluation for patient under the age of 3 and counseling with primary caregiver*</td>
</tr>
<tr>
<td>- Limited oral evaluations that are problem focused</td>
</tr>
<tr>
<td>- Detailed oral evaluations that are problem focused</td>
</tr>
<tr>
<td>• Diagnostic Imaging with interpretation</td>
</tr>
<tr>
<td>- A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views</td>
</tr>
<tr>
<td>- An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit</td>
</tr>
<tr>
<td>- Additional films/views needed for diagnosing can be provided as needed</td>
</tr>
<tr>
<td>- Bitewings, periapicals, panoramic and cephlometric radiographic images</td>
</tr>
<tr>
<td>- Intraoral and extraoral radiographic images Oral/facial photographic images Maxillofacial MRI, ultrasound</td>
</tr>
<tr>
<td>- Cone beam image capture</td>
</tr>
</tbody>
</table>

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
- Tests and examinations
- Viral culture Collection and preparation of saliva sample for laboratory diagnostic testing
- Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
- Oral pathology laboratory
  - Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
  - Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
  - Other oral pathology procedures, by report

**Basic restorative care (type B services)**

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

**Diagnostic Services**
* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.
- Clinical oral evaluations once every 6 months*
  - Comprehensive oral evaluation – complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
  - Periodic oral evaluation – subsequent thorough evaluation of an established patient*
  - Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
  - Limited oral evaluations that are problem focused
- Detailed oral evaluations that are problem focused
- Diagnostic Imaging with interpretation
  - A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views
  - An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.*
- Additional films/views needed for diagnosing can be provided as needed
- Bitewings, periapicals, panoramic and cephlometric radiographic images
- Intraoral and extraoral radiographic images
- Oral/facial photographic images
- Maxillofacial MRI, ultrasound
- Cone beam image capture
- Tests and examinations
- Viral culture
- Collection and preparation of saliva sample for laboratory diagnostic testing
- Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
- Oral pathology laboratory
  - Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
  - Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
- Other oral pathology procedures, by report

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
## Major restorative care (type C services)

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

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

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

- Surgical services:
  - Gingivectomy and gingivoplasty
  - Gingival flap including root planning
  - Apically positioned flap
  - Clinical crown lengthening
  - Osseous surgery
  - Bone replacement graft – first site and additional sites
  - Biologic materials to aid soft and osseous tissue regeneration
  - Guided tissue regeneration
  - Surgical revision
  - Pedicle and free soft tissue graft
  - Subepithelial connective tissue graft
  - Distal or proximal wedge
  - Soft tissue allograft

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
- Combined connective tissue and double pedicle graft
- Non-surgical periodontal service:
  - Provisional splinting – intracoronal and extracoronal. Can be considered for treatment of dental trauma.
  - Periodontal root planing and scaling. With prior authorization, can be considered every 6 months for individuals with special healthcare needs.
  - Full mouth debridement to enable comprehensive evaluation
  - Localized delivery of antimicrobial agents
  - Periodontal maintenance

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

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
Prosthodontic services to include:

- Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature.

- Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion:
  - Resin base and cast frame dentures including any conventional clasps, rests and teeth
  - Flexible base denture including any clasps, rests and teeth
  - Removable unilateral partial dentures or dentures without clasps are not considered

- Overdenture-complete and partial

- Denture adjustments-6 months after insertion or repair

- Denture repairs-includes adjustments for first 6 months following service

- Denture rebase-following 12 months post denture insertion and subject to precertification denture rebase is covered and includes adjustments for first 6 months following service

- Denture relines-following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service

- Precision attachment, by report

- Maxillofacial prosthetics-includes adjustments for first 6 months following service:
  - Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis-initial, interim and replacement
  - Obturator prosthesis: surgical, definitive and modifications
  - Mandibular resection prosthesis with and without guide flange
  - Feeding aid
  - Surgical stents
  - Radiation carrier
  - Fluoride gel carrier
  - Commissure splint
  - Surgical splint
  - Topical medicament carrier
  - Adjustments, modification and repair to a maxillofacial prosthesis
  - Maintenance and cleaning of maxillofacial prosthesis

- Implant Services are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years. Covered services include implant body, abutment and crown.

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
• Fixed prosthodontics (fixed bridges)-are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists:
  - The replacement of an existing defective fixed bridge is also allowed when noted criteria are met
  - A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge
  - Considerations and requirements noted for single crowns apply
  - Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth
  - Abutment teeth must be periodontally sound and have a good long term prognosis
  - Repair and recementation
• Pediatric partial denture for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth. Subject to precertification.

Oral and Maxillofacial Surgical Services
Local anesthesia, suturing and routine post op visit for suture removal are included with service.
• Extraction of teeth:
  - Extraction of coronal remnants – deciduous tooth
  - Extraction, erupted tooth or exposed root
  - Surgical removal of erupted tooth or residual root
  - Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
• Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
• Other surgical Procedures
  - Oroantral fistula
  - Primary closure of sinus perforation and sinus repairs
  - Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
  - Surgical access of an unerupted tooth
  - Mobilization of erupted or malpositioned tooth to aid eruption
  - Placement of device to aid eruption
  - Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
  - Surgical repositioning of tooth/teeth
  - Transseptal fiberotomy/supra crestal fiberotomy
  - Surgical placement of anchorage device with or without flap 11. Harvesting bone for use in graft(s).

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.
• Alveoloplasty in conjunction or not in conjunction with extractions
• Vestibuloplasty
• Excision of benign and malignant tumors/lesions
• Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
• Destruction of lesions by electrosurgery
• Removal of lateral exostosis, torus palatinus or torus madibularis
• Surgical reduction of osseous tuberosity
• Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
• Surgical Incision
  – Incision and drainage of abscess-intraoral and extraoral
  – Removal of foreign body
  – Partial ostectomy/sequestrectomy
  – Maxillary sinusotomy
• Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
• Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider
  – Reduction, open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
  – Manipulation under anesthesia
  – Condylectomy, discectomy, synovectomy
  – Joint reconstruction
  – Services associated with TMJD treatment require prior authorization
• Arthrotenomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
• Arthroscopy
- Occlusal orthotic device – includes placement and removal to same provider
- Surgical and other repairs
  - Repair of traumatic wounds – small and complicated
  - Skin and bone graft and synthetic graft
  - Collection and application of autologous blood concentrate
  - Osteoplasty and osteotomy
  - LeFort I, II, III with or without bone graft
  - Graft of the mandible or maxilla-autogenous or nonautogenous
  - Sinus augmentations
  - Repair of maxillofacial soft and hard tissue defects
  - Frenectomy and frenoplasty
  - Excision of hyperplastic tissue and pericoronal gingiva
  - Skin and bone graft and synthetic graft
  - Collection and application of autologous blood concentrate
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  - Osteoplasty and osteotomy
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  - Sinus augmentations
  - Repair of maxillofacial soft and hard tissue defects
  - Frenectomy and frenoplasty
  - Excision of hyperplastic tissue and pericoronal gingiva

**Adjunctive general services (includes dental emergency treatment)**

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

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
• Consultation by specialist or non-primary care provider
• Professional visits
  - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
  - Hospital or ambulatory surgical center call:
    o For cases that are treated in a facility
    o For cases taken to the operating room. Dental services are provided for patient with a medical condition covered by this policy which requires this admission as in-patient or out-patient. **Precertification** is required.
    o General anesthesia and outpatient facility charges for dental services are covered
    o Dental services rendered in these settings by a dentist not on staff are considered separately
  - Office visit for observation (during regular hours). No other service performed.
• Drugs:
  - Therapeutic parenteral drug:
    o Single administration
    o Two or more administrations not to be combined with single administration
  - Other drugs and/or medicaments by report
• Application of desensitizing medicament per visit
• Occlusal guard for treatment of bruxism, clenching or grinding
• Athletic mouth guard covered once per year
• Occlusal adjustment
  - Limited - (per visit)
  - Complete (regardless of the number of visits), once in a lifetime
• Odontoplasty
• Internal bleaching

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### Orthodontic services

*(Medically necessary orthodontic services include the removal of appliances and construction of retainer.)*

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

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

Orthodontic service to include:

- Limited treatment for the primary, transitional and adult dentition
- Interceptive treatment for the primary and transitional dentition
- Minor treatment to control harmful habits
- Continuation of transfer cases or cases started outside of the program
- Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
- Orthognathic surgical cases with comprehensive orthodontic treatment
- Repairs to orthodontic appliances
- Replacement of lost or broken retainer
- Rebonding or recementing of brackets and/or bands

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

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

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<th>Out-of-network coverage*</th>
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</thead>
<tbody>
<tr>
<td><strong>6. Specific conditions</strong></td>
<td></td>
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<tr>
<td><strong>Birthing center (facility charges)</strong></td>
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<tr>
<td>Inpatient (room and board and other miscellaneous services and supplies)</td>
<td>Paid at the same cost-sharing as hospital care.</td>
<td>Paid at the same cost-sharing as hospital care.</td>
</tr>
<tr>
<td><strong>Diabetic services and supplies (including equipment and training)</strong></td>
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<tr>
<td>Diabetic services and supplies (including equipment and training)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Family planning services – other</strong></td>
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<tr>
<td><strong>Voluntary sterilization for males</strong></td>
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<tr>
<td>Inpatient physician or specialist surgical services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Outpatient physician or specialist surgical services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Abortion</strong></td>
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</tr>
<tr>
<td>Inpatient physician or specialist surgical services</td>
<td>80% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Outpatient physician or specialist surgical services</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td><strong>Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment</strong></td>
<td></td>
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</tr>
<tr>
<td>TMJ and CMJ treatment</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td><strong>Impacted wisdom teeth</strong></td>
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<td></td>
</tr>
<tr>
<td>Impacted wisdom teeth</td>
<td>80% (of the negotiated charge)</td>
<td>80% (of the recognized charge)</td>
</tr>
<tr>
<td><strong>Accidental injury to sound natural teeth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental injury to sound natural teeth</td>
<td>80% (of the negotiated charge)</td>
<td>80% (of the recognized charge)</td>
</tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Blood and body fluid exposure</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Blood and body fluid exposure</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Dermatological treatment</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Dermatological treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Maternity care</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Maternity care (includes delivery and postpartum care services in a hospital or birthing center)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Well newborn nursery care</strong></td>
<td>80% (of the negotiated charge) No policy year deductible applies</td>
<td>50% (of the recognized charge) No policy year deductible applies</td>
</tr>
<tr>
<td>Well newborn nursery care in a hospital or birthing center</td>
<td>80% (of the negotiated charge) No policy year deductible applies</td>
<td>50% (of the recognized charge) No policy year deductible applies</td>
</tr>
<tr>
<td><strong>Note:</strong> 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.</td>
<td></td>
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</tr>
<tr>
<td><strong>Pregnancy complications</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Inpatient (room and board and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Gender reassignment (sex change) treatment</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Surgical, hormone replacement therapy, and counseling treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
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<tbody>
<tr>
<td><strong>Autism spectrum disorder</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Autism spectrum disorder diagnosis and testing</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Autism spectrum disorder treatment (includes physician and specialist office visits)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Applied behavior analysis</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Mental health treatment</strong></td>
<td></td>
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<tr>
<td><strong>Mental health treatment – inpatient</strong></td>
<td></td>
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</tr>
<tr>
<td>Inpatient hospital mental disorders treatment (room and board and other miscellaneous hospital services and supplies)</td>
<td>80% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies)</td>
<td></td>
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</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
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<tr>
<td>Mental disorder room and board intensive care</td>
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<tr>
<td><strong>Mental health treatment – outpatient</strong></td>
<td></td>
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</tr>
<tr>
<td>Outpatient mental disorder treatment office visits to a physician or behavioral health</td>
<td>$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>provider (includes telemedicine and/or telehealth cognitive behavioral therapy consultations)</td>
<td></td>
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</tr>
<tr>
<td>Other outpatient mental disorders treatment (includes skilled behavioral health services in the home)</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Partial hospitalization treatment</td>
<td></td>
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<tr>
<td>Intensive outpatient program</td>
<td></td>
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<tr>
<td><strong>Substance use disorders treatment-inpatient</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Detoxification – inpatient</strong></td>
<td></td>
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</tr>
<tr>
<td>Inpatient hospital substance use disorders detoxification (room and board and other miscellaneous hospital services and supplies)</td>
<td>80% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Inpatient hospital substance use disorders rehabilitation (room and board and other miscellaneous hospital services and supplies)</td>
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</tr>
<tr>
<td>Inpatient residential treatment facility substance use disorders (room and board and other miscellaneous residential treatment facility services and supplies)</td>
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</tr>
<tr>
<td>Subject to semi-private room rate unless intensive care unit is required</td>
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<tr>
<td>Substance use disorders room and board intensive care</td>
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<tr>
<td><strong>Substance use disorders treatment-outpatient: detoxification and rehabilitation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient substance use disorders office visits to a physician or behavioral health provider (includes telemedicine and/or telehealth cognitive behavioral therapy consultations)</td>
<td>$30 copayment per visit then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Other outpatient substance use disorders services (includes skilled behavioral health services in the home)</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Partial hospitalization treatment</td>
<td></td>
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<tr>
<td>Intensive Outpatient Program</td>
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<tr>
<td><strong>Reconstructive surgery and supplies</strong></td>
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</tr>
<tr>
<td>Reconstructive surgery and supplies (includes reconstructive breast surgery)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Eligible health services</strong></td>
<td><strong>In-network coverage</strong>*</td>
<td><strong>In-network coverage</strong>*</td>
</tr>
<tr>
<td></td>
<td>(IOE facility)</td>
<td>(Non-IOE facility)</td>
</tr>
<tr>
<td><strong>Transplant services</strong></td>
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</tr>
<tr>
<td>Inpatient and outpatient transplant facility services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Includes transplants for treatment of Wilm’s tumor</td>
<td></td>
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<tr>
<td>Inpatient and outpatient transplant physician and specialist services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
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<tr>
<td>Includes transplants for treatment of Wilm’s tumor</td>
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<thead>
<tr>
<th>Transplant services-travel and lodging</th>
<th>Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Benefit payable for Lodging Expenses per IOE patient</td>
<td>$50 per night</td>
</tr>
<tr>
<td>Maximum Benefit payable for Lodging Expenses per companion</td>
<td>$50 per night</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of infertility</td>
<td></td>
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</tbody>
</table>

| Comprehensive infertility services (includes basic and advanced reproductive technology (ART) services) | Inpatient and outpatient care - comprehensive infertility services | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

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<tr>
<td>7. Specific therapies and tests</td>
<td></td>
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<tr>
<td><strong>Outpatient diagnostic testing</strong></td>
<td></td>
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<tr>
<td>Diagnostic complex imaging services</td>
<td></td>
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</tr>
<tr>
<td>Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td>Diagnostic lab work</td>
<td></td>
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</tr>
<tr>
<td>Diagnostic lab work services performed in the outpatient department of a hospital or other facility</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td>Radiological services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiological services performed in a physician’s office, the outpatient department of a hospital or other facility</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Outpatient infusion therapy</strong></td>
<td></td>
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</tr>
<tr>
<td>Outpatient infusion therapy performed in a covered person’s home, physician’s office, outpatient department of a hospital or other facility</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
</tr>
<tr>
<td><strong>Outpatient radiation therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient radiation therapy</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
</tr>
<tr>
<td><strong>Specialty prescription drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Purchased and injected or infused by your provider in an outpatient setting)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
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<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient respiratory therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory therapy</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
</tr>
<tr>
<td><strong>Transfusion or kidney dialysis of blood</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfusion or kidney dialysis of blood</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Short-term cardiac and pulmonary rehabilitation services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
</tr>
<tr>
<td><strong>Pulmonary rehabilitation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary rehabilitation</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
</tr>
<tr>
<td><strong>Short-term rehabilitation and habilitation therapy services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient physical, occupational, speech, and cognitive therapies</td>
<td>$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Combined for short-term rehabilitation services and habilitation therapy services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Therapeutic manipulation services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic manipulation services</td>
<td>$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td><strong>Diagnostic testing for learning disabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic testing for learning disabilities</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
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<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Other services and supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acupuncture in lieu of anesthesia</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Emergency ground, air or water ambulance</td>
<td>80% (of the negotiated charge) per trip</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td>(includes non-emergency ambulance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical trial therapies (experimental or investigational)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Clinical trials (routine patient costs)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Durable medical equipment (DME)</td>
<td>80% (of the negotiated charge) per item</td>
<td>50% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Enteral formulas and nutritional supplements</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Infant formulas</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Infant pasteurized donated breast milk</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

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<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orthotic and prosthetic devices</strong></td>
<td><strong>In-network coverage</strong> 80% (of the negotiated charge) per item</td>
<td><strong>Out-of-network coverage</strong> 50% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Cochlear implants limited to covered persons age 18 and older</td>
<td>80% (of the negotiated charge) per item</td>
<td>50% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Orthotic and prosthetic devices</td>
<td>80% (of the negotiated charge) per item</td>
<td>50% (of the recognized charge) per item</td>
</tr>
</tbody>
</table>

**Hearing aids and exams**

| Hearing aid exams                        | $30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit | 50% (of the recognized charge) per visit                 |
| Hearing aids                              | 80% (of the negotiated charge) per item                                                | 50% (of the recognized charge) per item                   |

**Podiatric (foot care) treatment**

| Physician and Specialist non-routine foot care treatment | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

**Sickle cell anemia**

| Sickle cell anemia treatment              | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

**Home hemophilia treatment**

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

**Wilm’s tumor**

| 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. |

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<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric vision care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to covered persons through the end of the month in which the person turns age 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric routine vision exams (including refraction)</strong></td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Performed by a legally qualified ophthalmologist or optometrist</td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per <strong>policy year</strong></td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric comprehensive low vision evaluations</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Performed by a legally qualified ophthalmologist or optometrist</td>
<td>One comprehensive low vision evaluation every <strong>policy year</strong></td>
<td></td>
</tr>
<tr>
<td>Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric vision care services and supplies</strong></td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Office visit for fitting of contact lenses</td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Eyeglass frames, <strong>prescription</strong> lenses or <strong>prescription</strong> contact lenses</td>
<td>100% (of the negotiated charge) per item</td>
<td>50% (of the recognized charge) per item</td>
</tr>
<tr>
<td>No policy year deductible applies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum number of eyeglass frames per <strong>policy year</strong></td>
<td>One set of eyeglass frames</td>
<td></td>
</tr>
<tr>
<td>Maximum number of <strong>prescription</strong> lenses per <strong>policy year</strong></td>
<td>One pair of <strong>prescription</strong> lenses</td>
<td></td>
</tr>
<tr>
<td>Maximum number of <strong>prescription</strong> contact lenses per <strong>policy year</strong> (includes non-conventional <strong>prescription</strong> contact lenses and aphakic lenses prescribed after cataract surgery)</td>
<td>Daily disposables: up to 3 month supply</td>
<td>Extend wear disposable: up to 6 month supply</td>
</tr>
<tr>
<td></td>
<td>Extended wear disposable: up to 6 month supply</td>
<td>Non-disposable lenses: one set</td>
</tr>
</tbody>
</table>

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

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<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optical devices</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Maximum number of optical devices per <strong>policy year</strong></td>
<td>One optical device</td>
<td></td>
</tr>
</tbody>
</table>

**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.

Coverage does not include the office visit for the fitting of **prescription** contact lenses.

*See the *How to read your schedule of benefits, Important note about your cost sharing and Important notices* sections of this schedule of benefits.*
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### Eligible health services

<table>
<thead>
<tr>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
</table>

#### 9. Outpatient prescription drugs

**Plan features**

Outpatient prescription drug benefits are subject to the medical plan’s policy year deductibles maximum out-of-pocket limits as explained in this schedule of benefits.

**NOTE** Preventive female contraceptives: After the first 3 month fill, a 6 month supply is allowed for subsequent fills of the same contraceptive. The cost share for the 6 month supply will be the same as each 30 day supply from a retail pharmacy and each 90 day supply from a mail order pharmacy.

**Outpatient prescription drug Policy year deductible waiver**

The Outpatient prescription drug policy year deductible is waived for all prescription drugs filled at an in-network and out-of-network retail pharmacy or mail order pharmacy.

**Outpatient prescription drug policy year deductible and copayment waiver for risk reducing breast cancer**

The policy year deductible and the prescription drug copayment 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%.

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

**Outpatient prescription drug policy year deductible and copayment waiver for contraceptives**

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

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

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

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*

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<table>
<thead>
<tr>
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<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred generic prescription drugs (including specialty drugs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$20 copayment per supply then the plan pays 100% (of the balance of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>More than a 60 day supply but less than a 91 day supply filled at a mail order pharmacy</td>
<td>$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td><strong>Non-preferred generic prescription drugs (including specialty drugs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$60 copayment per supply then the plan pays 100% (of the balance of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>More than a 60 day supply but less than a 91 day supply filled at a mail order pharmacy</td>
<td>$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

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<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred brand-name prescription drugs (including specialty drugs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$40 copayment per supply then the plan pays 100% (of the balance of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>More than a 60 day supply but less than a 91 day supply filled at a mail order pharmacy</td>
<td>$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td><strong>Orally administered anti-cancer prescription drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>100% (of the negotiated charge) per prescription or refill</td>
<td>100% (of the recognized charge) per prescription or refill</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td><strong>Preventive care drugs and supplements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive care drugs and supplements filled at a retail pharmacy</td>
<td>100% (of the negotiated charge) per prescription or refill</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
</tr>
<tr>
<td>For each 30 day supply</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td><strong>Maximums</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by calling the toll-free number on your ID card.</td>
<td></td>
</tr>
</tbody>
</table>

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<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk reducing breast cancer prescription drugs</strong></td>
<td>100% (of the negotiated charge) per prescription or refill</td>
<td>Paid according to the type of drug per the schedule of benefits, above.</td>
</tr>
<tr>
<td>Risk reducing breast cancer prescription drugs filled at a pharmacy</td>
<td>No copayment or policy year deductible applies</td>
<td>For example, if you have a generic prescription drug, refer to the generic prescription drug section of the schedule of benefits.</td>
</tr>
<tr>
<td>For each 30 day supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximums:</strong></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, contact Member Services by calling the toll-free number on your ID card.</td>
<td></td>
</tr>
<tr>
<td><strong>Tobacco cessation prescription and over-the-counter drugs</strong></td>
<td>100% (of the negotiated charge) per prescription or refill</td>
<td>Paid according to the type of drug per the schedule of benefits, above.</td>
</tr>
<tr>
<td>Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy</td>
<td>No copayment or policy year deductible applies</td>
<td>For example, if you have a generic prescription drug, refer to the generic prescription drug section of the schedule of benefits.</td>
</tr>
<tr>
<td>For each 30 day supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximums</strong></td>
<td>Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits above.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For details on the guidelines and the current list of covered tobacco cessation prescription drugs, contact Member Services by calling the toll-free number on your ID card.</td>
<td></td>
</tr>
</tbody>
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General coverage provisions

This section provides detailed explanations about the:

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

that are listed in the first part of this schedule of benefits.

<table>
<thead>
<tr>
<th>Policy year deductible provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible health services</strong> applied to the out-of-network <strong>policy year deductibles</strong> will not be applied to satisfy the in-network <strong>policy year deductibles</strong>. <strong>Eligible health services</strong> applied to the in-network <strong>policy year deductibles</strong> will not be applied to satisfy the out-of-network <strong>policy year deductibles</strong>.</td>
</tr>
<tr>
<td>The in-network and out-of-network <strong>policy year deductible</strong> may not apply to certain <strong>eligible health services</strong>. You must pay any applicable <strong>copayments</strong>, <strong>coinsurance</strong> for <strong>eligible health services</strong> to which the <strong>policy year deductible</strong> does not apply.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services.</strong> This <strong>policy year deductible</strong> applies separately to you. After the amount you pay for <strong>eligible health services</strong> reaches the <strong>policy year deductible</strong>, this plan will begin to pay for <strong>eligible health services</strong> for the rest of the <strong>policy year</strong>.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Copayments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-network coverage</strong></td>
</tr>
<tr>
<td>This is a specified dollar amount or percentage that must be paid by you when you receive <strong>eligible health services</strong> from an <strong>in-network provider</strong>. If Aetna compensates <strong>in-network providers</strong> on the basis of the <strong>negotiated charge</strong> amount, your percentage <strong>copayment</strong> is based on this amount.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a specified dollar amount or percentage that must be paid by you when you receive <strong>eligible health services</strong> from an <strong>out-of-network provider</strong>. If Aetna compensates <strong>out-of-network providers</strong> on the basis of the <strong>recognized charge</strong> amount, your percentage <strong>copayment</strong> is based on this amount.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coinsurance</strong> is both the percentage of <strong>eligible health services</strong> that the plan pays and what you pay. The specific percentage that we have to pay for <strong>eligible health services</strong> is listed earlier in the schedule of benefits.</td>
</tr>
</tbody>
</table>

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.*
### Maximum out-of-pocket limits provisions

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

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

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

**Individual**

Once the amount of the copayments, coinsurance and policy year deductibles you have paid for eligible health services during the policy year meets the individual maximum out-of-pocket limits, this plan will pay:

- 100% of the negotiated charge for in-network covered benefits
- 100% of the recognized charge for out-of-network covered benefits

that apply for the rest of the policy year for that person.

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

The maximum out-of-pocket limit may not apply to certain eligible health services. If the maximum out-of-pocket limit does not apply to a covered benefit, your copayment and coinsurance for that covered benefit will not count toward satisfying the maximum out-of-pocket limit amount.

### Medical and Outpatient Prescription Drugs

**In-network care**

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

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

- All costs for non-covered services

### Calculations; determination of recognized charge; determination of benefits provisions

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

*See the How to read your schedule of benefits, Important note about your cost sharing and Important notices sections of this schedule of benefits.*
Student Health Insurance

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

Certificate of Coverage

Prepared exclusively for:

Policyholder: The College of New Jersey - Early Arrival
Policyholder number: 686165
Student policy effective date: 08/01/20
Plan effective date: 08/01/20
Plan issue date: 12/25/20

Underwritten by Aetna Health and Life Insurance Company

IMPORTANT NOTICES:
• Notice of Non-Discrimination: Aetna Health and Life Insurance Company does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.
• Sanctioned Countries: If coverage provided under this student policy violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for eligible health services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.
Welcome

Thank you for choosing Aetna.

This is your certificate of coverage. It is one of three documents that together describe the benefits covered by your Aetna plan for in-network and out-of-network coverage.

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

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

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

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

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- Claim procedures
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### Coordination of benefits (COB)
- Key terms
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### Other health coverage updates – contact information
- Right to receive and release needed information
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### When coverage ends
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- Some other money issues
- Your health information
- Effect of benefits under other plans

### Glossary

### Schedule of benefits
Issued with your certificate of coverage
Let’s get started!

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

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

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

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

What your plan does – providing covered benefits

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

This plan provides in-network and out-of-network covered benefits for medical and pharmacy insurance coverage.

How your plan works – starting and stopping coverage

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

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

Ending coverage under the plan doesn’t necessarily mean you lose coverage with us.

Eligible health services

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

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

- They are listed in the Eligible health services under your plan section.
- They are not carved out in the What your plan doesn’t cover – eligible health service exceptions and exclusions section. We refer to this entire section as the “Exceptions” section.
- They are not beyond any limits in the schedule of benefits.
Paying for eligible health services— the general requirements
There are several general requirements for the plan to pay any part of the expense for an eligible health service. They are:

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

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

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

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

Disagreements
We know that people sometimes see things differently.

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

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

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

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

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

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

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

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

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

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

You will find details on:

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

How to contact us for help

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

- Logging onto your Aetna secure website at www.aetnastudenthealth.com
- Registering for Aetna , our secure Internet access to reliable health information, tools and resources.

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

You can also contact us by:

- Calling our Member Services at the toll-free number 1-800-481-8814
- Writing us at Aetna Health and Life Insurance Company, 151 Farmington Ave, Hartford, CT 06156

Your ID card

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

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

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

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

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

Who is eligible?

You are eligible if you are a:
- All full-time undergraduate students taking 12 or more credit hours are automatically enrolled in this insurance plan at registration, unless proof of comparable coverage is furnished.
- All matriculated graduate students taking 9 or more credit hours are automatically enrolled in this insurance plan at registration, unless proof of comparable coverage is furnished.

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)

If we find out that you do not meet this eligibility requirement, we are only required to refund any premium contribution minus any claims that we have paid.

Medicare eligibility

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

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

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

When you can join the plan

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

If you do not enroll yourself when you first qualify for medical benefits, you may have to wait until the next enrollment period to join.
Notification of change in status
It is important that you notify us and the policyholder of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us and the policyholder as soon as possible of status changes such as:

- Change of address or phone number
- Change in marital status
- Enrollment in Medicare
- You enroll in any other health plan

Special times you can join the plan
You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another health plan. You previously declined coverage with Aetna in writing, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
- You become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your premium contribution for coverage under this plan.
- When you are a victim of domestic abuse or spousal abandonment and you don’t want to be enrolled in the perpetrator’s health plan.

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

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

If you enroll after the effective date of the student policy and you are eligible for health benefits at the time, your coverage will take effect as of that date as long as:

- We agree
- We receive your completed request for enrollment
- You pay any premium contribution

Late enrollment
If we receive your enrollment application and premium contribution more than 31 days after the date you become eligible, coverage will only become effective if, and when:

- We agree to enroll you
- You enroll during the policyholder’s late enrollment period, or
- You enroll because you lost coverage for any reason under another health plan with similar health coverage
Medical necessity and precertification requirements

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

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

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

This section addresses the medical necessity and precertification requirements.

Medically necessary; medical necessity

As we said in the Let’s get started! section, the medical necessity of an eligible health service is a requirement for you to receive a covered benefit under this plan.

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

Precertification

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

You need precertification from us for some eligible health services. Precertification is not required for an emergency medical condition or treatment of an urgent condition. Precertification is not required for substance use disorders treatments for the first 180 days of treatment.

Precertification for medical services and supplies

In-network care

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

Out-of-network care

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

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

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<tr>
<th>Non-emergency admissions:</th>
<th>You, your <em>physician</em> or the facility will need to call and request <em>precertification</em> at least 14 days before the date you are scheduled to be admitted.</th>
</tr>
</thead>
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<tr>
<td>An emergency admission:</td>
<td>You, your <em>physician</em> or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted. An emergency 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.</td>
</tr>
<tr>
<td>An urgent admission:</td>
<td>You, your <em>physician</em> 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.</td>
</tr>
<tr>
<td>Outpatient non-emergency services requiring precertification:</td>
<td>You or your <em>physician</em> must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.</td>
</tr>
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</table>

Notification calls for certain medical conditions

You must notify us for certain medical conditions within the timeframe specified below. No penalty will apply if you fail to notify us. To notify us, call the Member Services toll-free number on your ID card.

| Notification call for an emergency medical condition: | You, your *physician* or the facility must call us within 24 hours or as soon as reasonably possible after receiving emergency outpatient care, treatment or procedure. |

Written notification of precertification decisions

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

Inpatient and outpatient precertification

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

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

If *precertification* determines that the stay or outpatient services and supplies are not *covered benefits*, the notification will explain why and how you can appeal our decision. You or your *provider* may request a review of the *precertification* decision. See the *When you disagree - claim decisions and appeals procedures* section.
What if you don’t obtain the required precertification?
If you don’t obtain the required precertification:
• Benefits may be reduced. See the schedule of benefits Precertification covered benefit penalty section.
• You will be responsible for the unpaid balance of the bills.
• Any additional out-of-pocket expenses incurred will not count toward your out-of-network policy year deductibles or maximum out-of-pocket limits.

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

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<tr>
<th>Inpatient services and supplies</th>
<th>Outpatient services and supplies</th>
</tr>
</thead>
<tbody>
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<td>ART services</td>
<td>Applied behavior analysis**</td>
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<td>Obesity (bariatric) surgery</td>
<td>Certain prescription drugs and devices*</td>
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<tr>
<td><strong>Stays in a hospice facility</strong></td>
<td>Complex imaging</td>
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<tr>
<td><strong>Stays in a hospital</strong></td>
<td>Comprehensive infertility services</td>
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<tr>
<td><strong>Stays in a rehabilitation facility</strong></td>
<td>Cosmetic and reconstructive surgery</td>
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<tr>
<td><strong>Stays in a residential treatment facility</strong> for treatment of mental disorders and substance use disorders**</td>
<td>Emergency transportation by airplane</td>
</tr>
<tr>
<td><strong>Stays in a skilled nursing facility</strong></td>
<td>Intensive outpatient program (IOP) – mental disorder and substance use disorders**</td>
</tr>
<tr>
<td>Kidney dialysis</td>
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<tr>
<td>Knee surgery</td>
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<tr>
<td>Medical injectable drugs, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, botox, hepatitis C medications)*</td>
<td>Outpatient back surgery not performed in a physician’s office</td>
</tr>
<tr>
<td>Outpatient detoxification**</td>
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<tr>
<td><strong>Partial hospitalization treatment – mental disorder and substance use disorders</strong></td>
<td>Privacy duty nursing services</td>
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<tr>
<td>Psychological testing/neuropsychological testing**</td>
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<tr>
<td>Sleep studies</td>
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<tr>
<td>Transcranial magnetic stimulation (TMS)</td>
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<tr>
<td>Wrist surgery</td>
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</table>

*For a current listing of the prescription drugs and medical injectable drugs that require precertification, contact Member Services by calling the toll-free number on your ID card or by logging onto the Aetna website at www.aetnastudenthealth.com.

**Services for substance use disorders require precertification beginning on the 181st day of the policy year whether the days are consecutive or intermittent, partial days or full days.
Precertification for prescription drugs and devices
Certain prescription drugs and devices are covered under the medical plan when they are given to you by your physician or health care facility and not obtained at a pharmacy. The following precertification information applies to these prescription drugs and devices.

For certain prescription drugs and devices, your prescriber or your pharmacist needs to get approval from us before we will agree to cover the prescription drug or device for you. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain prescription drugs and devices and makes sure there is a medically necessary need for the prescription drug or device. For the most up-to-date information, call Member Services at the toll-free number on your ID card or log on to your Aetna secure website at www.aetnastudenthealth.com.

If you do not precertify a prescription drug or device, a penalty will apply. See the schedule of benefits. Contact your prescriber or pharmacist if a prescription drug or device requires precertification.

How can I request a medical exception?
Sometimes you or your prescriber may ask for a medical exception to get health care services for prescription drugs that are not listed in the drug guide or for which health care services are denied through precertification. You or your prescriber can contact us. You will need to provide us with the required clinical documentation. We will make a coverage determination within 72 hours after we receive your request and any information. We will tell you and your prescriber of our decision. Any exception granted is based upon an individual, case by case decision, and will not apply to other covered persons. If approved by us, you will receive the non-preferred benefit level and the exception will apply for the entire time of the prescription.

You, someone who represents you, or your prescriber may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-preferred drug. You, someone who represents you or your prescriber may submit a request for a quicker review for an urgent situation by:
- Contacting our Precertification Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716
- Submitting the request in writing to CVS/pharmacy® Health ATTN: Aetna PA 1300 E Campbell Road Richardson, TX 75081

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your prescriber of our decision. If approved by us, the exception will apply for the entire time you have an urgent situation.

If you are denied a medical exception based on the above processes, you may have the right to a third party review by an independent external review organization. If our claim decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send you. That notice also will describe the external review process. We will tell you, someone who represents you or your prescriber of the coverage determination of the external review no later than 72 hours after we receive your request. If the medical exception is approved, coverage will be provided for the entire time of the prescription. For quicker medical exceptions in urgent situations, we will tell you, someone who represents you or your prescriber of the coverage determination no later than 24 hours after we receive your request. If the quicker medical exception is approved, coverage will be provided for the entire time you have an urgent situation.
Eligible health services under your plan

The information in this section is the first step to understanding your plan’s eligible health services.

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

For example,

- Physician care generally is covered but physician care for cosmetic surgery is never covered. This is an exception (exclusion).
- Home health care is generally covered but it is a covered benefit only up to a set number of visits a year. This is a limitation.

You can find out about these exceptions in the Exceptions section and about the limitations in the schedule of benefits.

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

<table>
<thead>
<tr>
<th>Important note:</th>
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<tbody>
<tr>
<td>Sex-specific eligible health services are covered when medically appropriate, regardless of identified gender.</td>
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</table>

1. Preventive care and wellness

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

<table>
<thead>
<tr>
<th>Important notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You will see references to the following recommendations and guidelines in this section:</td>
</tr>
<tr>
<td>• Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>• United States Preventive Services Task Force</td>
</tr>
<tr>
<td>• Health Resources and Services Administration</td>
</tr>
<tr>
<td>• American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents</td>
</tr>
</tbody>
</table>

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

2. Diagnostic testing for the treatment or diagnosis of a medical condition will not be covered under the preventive care and wellness benefit. For those types of tests and treatment, you will pay the cost sharing specific to eligible health services for diagnostic testing and treatment.
3. Gender-specific preventive care and wellness benefits include eligible health services described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your physician or contact Member Services by logging on to your Aetna secure website at www.aetnastudenthealth.com or by calling the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.

5. We may use reasonable medical management techniques to determine the frequency, method, treatment, or setting of preventive care and wellness benefits when not specified in the recommendations and guidelines of the:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
   - United States Preventive Services Task Force
   - Health Resources and Services Administration
   - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

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

Health wellness promotion programs
Eligible health expenses include charges made in a health promotion program through health wellness exams and counseling for the services listed below.
   - Blood tests to determine:
     - Blood hemoglobin
     - Blood glucose
     - Blood pressure
     - Blood cholesterol
• Stool exam for the presence of blood
• Colon exams:
  – A left-sided colon exam of 35 to 60 centimeters
  – A routine diagnostic exam, including but not limited to, a digital rectal exam and a prostate-specific antigen test
• A glaucoma eye test
• A Pap smear
• A mammogram
• A digital tomosynthesis if you are age 40 or older
• Recommended immunizations
• Lifestyle behavior counseling including:
  – Smoking control
  – Nutrition and diet recommendations
  – Exercise plans
  – Lower back protection
  – Weight control
  – Immunizations practices
  – Breast self-examination
  – Testicular self-examination
  – Seatbelt usage in motor vehicles

These services are recommended at certain time periods of your life which are shown on your schedule of benefits.

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

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment.

Well woman preventive visits
Eligible health services include your routine:
• Well woman preventive exam office visit to your physician, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes Pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury.
• Preventive care breast cancer (BRCA) gene blood testing by a physician and lab.
• Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.

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

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

- **Substance use disorders**
  
  **Eligible health services** include the following screening and counseling services to help prevent or reduce the **substance use disorders**:
  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment

- **Use of tobacco products**
  
  **Eligible health services** include the following screening and counseling services to help you to stop the use of tobacco products:
  - Preventive counseling visits
  - Treatment visits
  - Class visits

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

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

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

**Routine cancer screenings**

**Eligible health services** include the following routine cancer screenings:

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

These benefits will be subject to any age, family history and frequency guidelines that are:
• Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
• Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration
• The New Jersey state laws and regulations that govern this plan

Prenatal care

Eligible health services include your routine prenatal physical exams as Preventive Care and wellness, which is the initial and subsequent history and physical exam such as:
• Maternal weight
• Blood pressure
• Fetal heart rate check
• Fundal height
• Preeclampsia screening

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

Important note:
You should review the benefit under Eligible health services under your plan Maternity care, Well newborn nursery care and the Exceptions sections of this certificate of coverage for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services

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

Breast feeding durable medical equipment

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

Breast pump

Eligible health services include:
• Renting a hospital grade electric pump while your newborn child is confined in a hospital
• The buying of:
  - An electric breast pump (non-hospital grade, cost is covered by your plan once every one year) or
  - A manual breast pump (cost is covered by your plan once per pregnancy)
If an electric breast pump was purchased within the previous one year period, the purchase of another electric breast pump will not be covered until a one year period has elapsed since the last purchase.

**Breast pump supplies and accessories**

*Eligible health services* include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

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

**Family planning services – female contraceptives**

*Eligible health services* include family planning services such as:

- **Counseling services**
  *Eligible health services* include counseling services provided by a physician OB, GYN, or OB/GYN on contraceptive methods. These will be covered when you get them in either a group or individual setting.

- **Contraceptives**
  *Eligible health services* include contraceptive prescription drugs and devices (including any related services or supplies) when they are provided by, administered, or removed by a physician during an office visit.

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

**Important note:**

See the following sections for more information:

- *Family planning services - other*
- *Maternity care*
- *Well newborn nursery care*
- *Infertility treatment*
- *Outpatient prescription drugs*
2. Physicians and other health professionals

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

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

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

Important note:

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

Allergy testing and treatment

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

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

Physician and specialist – inpatient surgical services

Eligible health services include the services of:

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

When your surgery requires two or more surgical procedures:

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

we will pay for the one that costs the most.

Your surgeon may perform two or more surgical or bilateral procedures on you during one operation but in separate operative fields. When this happens, we will pay:

- 100% of the surgery for the primary procedures
- 50% of the surgery for the secondary procedure
- 25% of the surgery for each of the other procedures, if any

If the surgeon performs both the surgical procedure and the anesthesia service, we will reduce the benefit that the plan pays for anesthesia by 50%.

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

Anesthetist

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

Surgical assistant

Covered benefits for your surgery include the services of a surgical assistant. A “surgical assistant” is a health professional trained to assist in surgery and during the periods before and after surgery. A surgical assistant is under the supervision of a physician.
Physician and specialist – outpatient surgical services

Eligible health services include the services of:

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

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

Anesthetist

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

Surgical assistant

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

In-hospital non-surgical physician services

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

Consultant services (non-surgical and non-preventive)

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

Covered benefits include treatment by the consultant.

The consultation may happen by way of telemedicine and/or telehealth.

Important note:

Your student policy covers telemedicine and/or telehealth. All in-person consultant office visits that are covered benefits are also covered if you use telemedicine and/or telehealth instead.

Second surgical opinion

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

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

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

Alternatives to physician and specialist office visits

Walk-in clinic (non-emergency visit)

Eligible health services include health care services provided at walk-in clinics for:

- Unscheduled, non-medical emergency illnesses and injuries
- The administration of immunizations administered within the scope of the clinic’s license
3. Hospital and other facility care

Hospital care (facility charges)
Eligible health services include inpatient and outpatient hospital care.

The types of hospital care services that are eligible for coverage include:
- **Room and board** charges up to the hospital’s semi-private room rate. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of health professionals employed by the hospital
- Operating and recovery rooms
- Intensive care units of a hospital
- Administration of blood and blood derivatives, but not the expense of the blood or blood product
- Radiation therapy
- Inhalation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a hospital

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

For your preadmission testing to be eligible for coverage, the following conditions must be met:
- The testing is related to the scheduled surgery
- The testing is done within the 7 days before the scheduled surgery and
- The testing is not repeated in, or by, the hospital or surgery center where the surgery is done

Anesthesia and related facility charges for dental care
Eligible health services include:
- General anesthesia
- Charges made by an anesthetist
- Related hospital or surgery center charges

for your dental care.

The following conditions must be met:
- Your dental provider cannot safely perform the oral surgery in a dental office setting, and
- All other non-facility charges are covered under the Pediatric dental care section if you are eligible for that coverage.
Alternatives to hospital stays

Outpatient surgery (facility charges)
Eligible health services include facility services provided and supplies used in connection with outpatient surgery performed in a surgery center or a hospital’s outpatient department.

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

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

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

Home health care services do not include custodial care.

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

The types of hospice care services that are eligible for coverage include:
- Room and board
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a hospital
- Part-time or intermittent nursing care by a R.N. or L.P.N. for up to eight hours a day
- Part-time or intermittent home health aide services to care for you up to eight hours a day
- Medical social services under the direction of a physician such as:
  - Assessment of your social, emotional and medical needs, and your home and family situation
  - Identification of available community resources
  - Assistance provided to you to obtain resources to meet your assessed needs
- Bereavement counseling
- Respite care
Hospice care services provided by the providers below may be covered, even if the providers are not an employee of the hospice care agency responsible for your care:

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

Outpatient private duty nursing
Eligible health services include private duty nursing care provided by an R.N. or L.P.N. for non-hospitalized acute illness or injury if your condition requires skilled nursing care and visiting nursing care is not adequate.

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

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

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

For your stay in a skilled nursing facility to be eligible for coverage, the following conditions must be met:

- The skilled nursing facility admission will take the place of:
  - An admission to a hospital or sub-acute facility or
  - A continued stay in a hospital or sub-acute facility
- There is a reasonable expectation that your condition will improve enough to go home within a reasonable amount of time
- The illness or injury is severe enough to require constant or frequent skilled nursing care on a 24-hour basis
4. Emergency services and urgent care

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

Emergency services coverage for an emergency medical condition includes your use of:
- An ambulance
- The emergency room facilities
- The emergency room staff physician services
- The hospital nursing staff services
- The staff radiologist and pathologist services

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

The in-network coverage cost-sharing for emergency services and urgent care from out-of-network providers ends when Aetna and the attending physician determine that you are medically able to travel or to be transported to an in-network provider if you need more care.

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

In case of a medical emergency

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

Non-emergency condition

If you go to an emergency room for what is not an emergency medical condition, the plan will not cover your expenses. See the schedule of benefits and the Emergency services and urgent care and Precertification covered benefit penalty sections for specific plan details.

In case of an urgent condition

Urgent condition

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

Non-urgent care

If you go to an urgent care facility for what is not an urgent condition, the plan will not cover your expenses. See the Emergency services and urgent care and Precertification covered benefit penalty sections in the schedule of benefits for specific plan details.

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

Eligible health services include dental services and supplies provided by an in-network or out-of-network dental provider.

The eligible health services are those listed in the Pediatric dental care section of the schedule of benefits. We have grouped them as:

- **Type A services**: Preventive and diagnostic services
- **Type B services**: Restorative services
- **Type C services**: Endodontic, periodontal, prosthodontic and oral and maxillofacial surgical services
- **Orthodontic services**
- **Adjunctive general services (includes dental emergency treatment)**

Dental emergencies

Eligible dental services include dental services provided during the initial dental visit for the speedy relief of a dental emergency. The care provided must be a covered benefit.

If you have a dental emergency, you should consider calling your dental in-network provider who may be more familiar with your dental needs. However, you can get treatment from any dentist including one that is an out-of-network provider. If you need help in finding a dentist, call Member Services at the toll-free number on your ID card.

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

For follow-up care to treat the dental emergency, you should consider using your in-network dental provider so that you can get the maximum level of benefits. Follow-up care will be paid at the cost-sharing level that applies to the type of provider that gives you the care.

What rules and limits apply to dental care?

Several rules apply to the dental benefits. Following these rules will help you use the plan to your advantage by avoiding expenses that are not covered by the plan.

When does your plan cover orthodontic treatment?

Orthodontic treatment is covered if you have a severe, dysfunctional, disabling condition, such as:

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

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

- Pre-orthodontic treatment visit
- Comprehensive orthodontic treatment
- Orthodontic retention (removal of appliances, construction and placement of retainers(s)
When does your plan cover replacements?
Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan’s “replacement rule”. The replacement rule is that certain replacements of, or additions to, existing crowns, inlays, onlays and veneers, dentures or bridges are covered only when you give us proof that:

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

When does your plan cover missing teeth that are not replaced?
The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

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

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

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

1. Ask your dental provider to write down a full description of the treatment you need, using either an Aetna claim form or an American Dental Association (ADA) approved claim form
2. Before treating you, your dental provider should send the form to us
3. We may request supporting images and other diagnostic record.
4. Once all of the information has been gathered, we will review the proposed treatment plan and provide you and your dental provider with a statement outlining the benefits payable
5. You and your dental provider can then decide how to proceed
The advance claim review is voluntary. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

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

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

Birthing center (facility charges)

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

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

Refer to the Eligible health services under your plan-Maternity care and Well newborn nursery care sections for more information.

Diabetic services and supplies (including equipment and training)

Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Insulin preparations
  - Hypodermic needles and syringes used for the treatment of diabetes
  - Injection aids and cartridges for the legally blind
  - Diabetic test agents including test strips for glucose monitors and visual reading and urine test strips
  - Lancets/lancing devices
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Injectable glucagons
  - Glucagon emergency kits

- Equipment
  - External insulin pumps including insulin infusion devices
  - Blood glucose meters without special features, unless required due to blindness

- Training
  - Self-management training provided by
    - A health care provider certified in diabetes self-management training
    - An in-network dietician registered by a nationally recognized Professional Association of Dietitians or
    - A health professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators
  - Information on proper diet
  - Re-education or refresher training if you are diagnosed with significant changes in self-management

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

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

Family planning services – other

Eligible health services include certain family planning services provided by your physician such as:

- Voluntary sterilization for males
- Abortion
Temporomandibular joint dysfunction treatment (TMJ) and craniomandibular joint dysfunction treatment (CMJ)

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

for TMJ and CMJ by a provider.

Impacted wisdom teeth

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

Accidental injury to sound natural teeth

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

Blood and body fluid exposure

When you are acting as a student in a clinical capacity, eligible health services include services and supplies for the treatment of your clinical related injury.

Eligible health services under this covered benefit only include those needed for your immediate treatment of a wound and the diagnosis of an illness that results from your clinical related injury such as:
- Prophylactic medications
- Physician and specialist office visits
- Outpatient department of a hospital visits
- Walk-in clinic visits
- Urgent care services
- Emergency services
- Diagnostic lab work and radiological services
- Any other eligible health services

Eligible health services for the person who is the source of the clinical related injury only include those diagnostic lab work and radiological services needed for your diagnosis.

If you come down with an illness due to the wound, eligible health services to treat the illness will be covered under the plan according to the type of service or supply and the place where you receive them.

Dermatological treatment

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

Maternity care

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

After your child is born, eligible health services include:
- 48 hours of inpatient care in a hospital or birthing center after a vaginal delivery
- 96 hours of inpatient care in a hospital or birthing center after a cesarean delivery
- A shorter stay if the attending physician, with the consent of the mother, discharges the mother or newborn earlier
- The mother could be discharged earlier. If so, the plan will pay for 1 post-delivery home visit by a health care provider

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

**Well newborn nursery care**

Eligible health services include routine care of your well newborn child in a hospital or birthing center such as:
- Well newborn nursery care during the mother’s stay but for not more than four days for a normal delivery
- Services and supplies needed for circumcision by a provider
- Hospital or birthing center visits and consultations for the well newborn by a physician but for not more than 1 visit per day

**Pregnancy complications**

Eligible health services include services and supplies from your provider for pregnancy complications.

Pregnancy complications means problems caused by pregnancy that pose a significant threat to the health of the mother or baby, including:
- Hyperemesis gravidarum (pernicious vomiting of pregnancy); toxemia with convulsions; severe bleeding before delivery due to premature separation of the placenta from any cause; bleeding after delivery severe enough to need a transfusion or blood
- Amniotic fluid tests, analyses, or intra-uterine fetal transfusion made for Rh incompatibility
- An emergency medical cesarean section due to pregnancy complications
- Miscarriage if not elective or therapeutic

**Gender reassignment (sex change) treatment**

Eligible health services include services and supplies for gender reassignment (sometimes called sex change) treatment.

Eligible health services include:
- The surgical procedure
- Physician pre-operative and post-operative hospital and office visits
- Inpatient and outpatient services (including outpatient surgery)
- Skilled nursing facility care
- Administration of anesthetics
- Outpatient diagnostic testing, lab work and radiological services
- Blood transfusions and the cost of un-replaced blood and blood products as well as the collection, processing and storage of self-donated blood after the surgery has been scheduled
- Gender reassignment counseling by a behavioral health provider
- Injectable and non-injectable hormone replacement therapy
Important Note:
As a reminder, gender reassignment (sex change) treatment requires precertification by Aetna. Your in-network provider is responsible for obtaining precertification. You are responsible for obtaining precertification when you use an out-of-network provider. Just log into your Aetna secure website at www.aetnastudenthealth.com for detailed information about this covered benefit, including eligibility requirements. You can also call Member Services at the toll-free number on your ID card.

Autism spectrum disorder and other developmental disabilities

Eligible health services include charges for the screening and diagnosis of autism and other developmental disabilities. This means a severe, chronic disability that:

- Is attributable to a mental or physical impairment or a combination of mental and physical impairments
  - Is manifested before you attain age 26 for all other provisions excluding diagnosis and treatment of autism spectrum disorder
- Is likely to continue indefinitely
- Results in substantial functional limitations in three or more of the following areas of major life activity:
  - Self-care
  - Receptive and expressive language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living
  - Economic self-sufficiency
- Reflects your need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to:
  - Intellectual disability
  - Autism
  - Cerebral palsy
  - Epilepsy
  - Spina-bifida
  - Other neurological impairments where the above criteria is met

A physician may prescribe therapies if your primary diagnosis is autism or another developmental disability. These therapies are eligible health services subject to any limits shown on the schedule of benefits:

- Occupational therapy means treatment to develop the ability to perform the ordinary tasks of daily living
- Physical therapy means treatment to develop physical function
- Speech therapy means treatment of a speech impairment

These therapy services are covered whether or not the therapies are restorative. They do not reduce the available therapy visits under the Short-term rehabilitation services section of this certificate.
If the primary diagnosis is autism, we will also cover behavioral interventions. These must be based upon principles of applied behavior analysis and related structured behavioral programs. A physician must prescribe behavior intervention through a treatment plan.

Applied behavior analysis requires precertification by Aetna. The in-network provider is responsible for obtaining precertification. You are responsible for obtaining precertification if you are using an out-of-network provider.
The treatment plan(s) must be in writing, signed by the **physician**, and must include all of following:

- A diagnosis
- Proposed treatment, by type, frequency, and duration
- The anticipated outcomes stated as goals
- The frequency by which the treatment plan will be updated

We may request additional information if necessary to determine the coverage under the plan. We may require the submission of an updated treatment plan once every six (6) months unless we and the **physician** agree to more frequent updates.

**Important note:**

As a reminder, applied behavior analysis requires **precertification** by Aetna. Your in-network provider is responsible for obtaining **precertification**. You are responsible for obtaining **precertification** when you use an out-of-network provider.

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**Mental health treatment**

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

- **Inpatient room and board** at the semi-private room rate, and other services and supplies related to your condition that are provided during your stay in a general medical hospital, psychiatric hospital, or residential treatment facility.

A general medical hospital is not usually equipped to treat mental disorders. Once it has stabilized your condition, it will either:

- Admit you to its separate psychiatric section or unit or
- Transfer you to a psychiatric hospital or residential treatment facility

Treatment of a mental disorder in a general medical hospital is only covered if you are transferred to its separate psychiatric section or unit.

If the general medical hospital cannot transfer you to a psychiatric hospital or residential treatment facility or to its own separate psychiatric section or unit, then we will cover any eligible health services provided by the general medical hospital for the treatment of a mental disorder.

- **Outpatient treatment** received while not confined as an inpatient in a general medical hospital, psychiatric hospital, or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine and/or telehealth consultations)
  - Individual, group and family therapies for the treatment of mental health
  - Other outpatient mental health treatment such as:
    - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a physician
    - **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a physician
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your physician orders them
      - The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications
- Electro-convulsive therapy (ECT)
- Mental health injectables
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- 23 hour observation

**Substance use disorders treatment**

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

- **Inpatient room and board** at the semi-private room rate and other services and supplies that are provided during your **stay** in a general medical hospital, psychiatric hospital or residential treatment facility.

A general medical hospital is not usually equipped to treat **substance use disorders**. Once a general medical hospital has stabilized your condition, it will either:

- Admit you to its separate **substance use disorders** section or unit
- Transfer you to a psychiatric hospital or residential treatment facility

Treatment of **substance use disorders** in a general medical hospital is only covered if you are:

- Admitted for the treatment of medical complications of **substance use disorders**
- Transferred to its separate **substance use disorders** section or unit

If the general medical hospital cannot transfer you to a psychiatric hospital or residential treatment facility or to its own separate psychiatric section or unit, then we will cover any eligible health services provided by the general medical hospital for the treatment of **substance use disorders**.

As used here, “medical complications” mean conditions such as electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- **Outpatient treatment** received while not confined as an inpatient in a general medical hospital, psychiatric hospital or residential treatment facility, including:
  - **Office visits** to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine and/or telehealth consultations)
  - Individual, group and family therapies for the treatment of **substance use disorders**
  - Other outpatient **substance use disorders** treatment such as:
    - **Outpatient detoxification**
    - **Partial hospitalization treatment** provided in a facility or program for treatment of **substance use disorders** provided under the direction of a physician
    - **Intensive outpatient program** provided in a facility or program for treatment of **substance use disorders** provided under the direction of a physician
    - Ambulatory **detoxification** which are outpatient services that monitor withdrawal from alcohol or other **substance use disorders**, including administration of medications
    - **Skilled behavioral health services** provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your physician orders them
      - The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications
Treatment of withdrawal symptoms
- Substance use disorder injectables
- 23 hour observation

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

**Reconstructive surgery and supplies**

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

**Transplant services**

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

Organ means:
- Solid organ
- Hematopoietic stem cell
- Bone marrow

**Wilm’s tumor**

**Eligible health services** include the following inpatient and outpatient transplant services for the treatment of Wilm’s tumor:
- Autologous bone marrow transplants when standard chemotherapy is unsuccessful
- Treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants
- Peripheral blood stem cell transplants when performed by institutions approved by the National Cancer Institute or identified in the guidelines of the American Society of Clinical Oncologists

**Aetna’s network of transplant specialist facilities**
When you get transplant services from an in-network provider, the amount you will pay for covered transplant services is determined by where you get the in-network transplant services.
For in-network services, you must get services from an **Institutes of Excellence™ (IOE) facility** we designate to perform the transplant you need. Coverage is not available for services from an in-network non-IOE facility.

You can choose in-network transplant services from either:
- An **Institutes of Excellence™ (IOE) facility** we designate to perform the transplant you need or
- A Non-IOE facility

The National Medical Excellence Program® will coordinate all solid organ and bone marrow transplants and other specialized care you need.

**Travel and lodging expenses**
If an IOE patient lives 100 or more miles from the IOE facility, eligible health services include travel and lodging expenses for the IOE patient and a companion to travel between the IOE patient’s home and the IOE facility. **Eligible health services** will be reimbursed by the plan and include coach class round-trip air, train, or bus travel and lodging costs.

You will not be reimbursed unless we have approved you for the travel and lodging program before you incur the costs.

When we approved you for this program, the approval letter will describe the process to follow for reimbursement. You must send us the receipts of your expenses.

For details about this program, contact Member Services at the toll-free number on your ID card.

**Infertility treatment**
**Eligible health services** include seeing a network provider:
- To diagnose the underlying medical cause of **infertility** including up to 12 intrauterine insemination (IUI) for female members without a male partner as limited under the definition of Infertility/infertile. Covered benefits are dependent on age and prior care received.

Once you are diagnosed as infertile you could be eligible for the following benefits:
- Artificial insemination with ovulation induction with no limit on the number of cycles,
- To provide assisted reproductive technology (ART)
- To do any surgery needed to treat the underlying medical cause of **infertility**.

For help using your infertility health care services you may enroll with our National infertility unit. To enroll you can reach our dedicated national infertility unit at 1-800-575-5999.

You are eligible for **infertility** services if:
- You are covered under this plan as:
  - A covered student
- There exists a condition that:
  - Is demonstrated to cause the disease of **infertility**
  - Has been recognized by your physician or infertility specialist and documented in your medical records
- You are unable to carry a pregnancy to live birth
- You have not had a voluntary sterilization 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
- You do not have infertility that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause)
• A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan
• You have clinical need to move on to ART procedures based on our clinical policy bulletin and:
  – Previous services did not result in a documented fetal heartbeat
  – The infertile female is 45 years of age or younger and has not reached the limit of four completed egg retrievals while you are covered under this plan or any other Aetna plan with this policyholder. An infertile female over 45 years of age is not eligible for egg retrievals.
  – ART services include, but are not limited to:
    ▪ In vitro fertilization (IVF)
    ▪ Zygote intrafallopian transfer (ZIFT)
    ▪ Gamete intrafallopian transfer (GIFT)
    ▪ Cryopreserved embryo transfers (Frozen Embryo Transfers)
    ▪ Intracytoplasmic sperm injection (ICSI) or ovum microsurgery
    ▪ Charges associated with your care when you will receive a donor egg or embryo in a donor IVF cycle. These services include donor egg retrieval, culture and fertilization of the egg from the donor and transfer of the embryo into you or into a gestational carrier.
    ▪ The procedures are done while not confined in a hospital or any other facility as an inpatient.
• You have met the requirement for the number of months trying to conceive:

<table>
<thead>
<tr>
<th>You are</th>
<th>Number of months of unprotected timed sexual intercourse or IUI:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A female under 35 years of age with a male partner</td>
<td>12 months or more</td>
</tr>
<tr>
<td>A female under 35 years of age without a male partner</td>
<td>Number of months of unprotected timed sexual intercourse does not apply. The female must have 12 failed attempts of intrauterine insemination under medical supervision.</td>
</tr>
<tr>
<td>A female 35 years of age or older with a male partner</td>
<td>6 months or more</td>
</tr>
<tr>
<td>A female 35 years of age or older without a male partner</td>
<td>Number of months of unprotected timed sexual intercourse does not apply. The female must have 6 failed attempts of intrauterine insemination under medical supervision.</td>
</tr>
</tbody>
</table>

• If you have been diagnosed with premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services through age 45 regardless of FSH level

**Fertility preservation**
Fertility preservation involves the retrieval of mature eggs and/or sperm or the creation of embryos that are frozen for future use. You are eligible for fertility preservation only when you:
• Are believed to be fertile
• Have planned services that will result in infertility such as:
  – Chemotherapy
  – Pelvic radiotherapy
  – Other gonadotoxic therapies
  – Ovarian or testicular removal
Along with the eligibility requirements above, you are eligible for fertility preservation benefits if, for example:

- You have a diagnosis of cancer and you are planning cancer treatment that is demonstrated to result in infertility. Planned cancer treatments include:
  - Bilateral orchiectomy (removal of both testicles)
  - Bilateral oophorectomy (removal of both ovaries)
  - Hysterectomy (removal of the uterus)
  - Chemotherapy or radiation therapy that is established in medical literature to result in infertility

- The eggs that will be retrieved for use are reasonably likely to result in a successful pregnancy by meeting the criteria below and you are not over 45 years of age:

<table>
<thead>
<tr>
<th>You are</th>
<th>You need to have an unmedicated day 3 FSH test done within the past:</th>
<th>The results of your unmedicated day 3 FSH test:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A female under 35 years of age</td>
<td>12 months</td>
<td>Must be less than 19 mIU/mL in your most recent lab test to use your own eggs</td>
</tr>
<tr>
<td>A female 35 years of age or older</td>
<td>6 months</td>
<td>If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test to use your own eggs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If you are age 40 and older, must be less than 19 mIU/mL in all prior tests to use your own eggs</td>
</tr>
</tbody>
</table>

**Eligible health services** for fertility preservation will be paid on the same basis as other ART services benefits for individuals who are infertile.

Our National Infertility Unit (NIU) is here to help. It is staffed by a dedicated team of registered nurses and infertility coordinators with expertise in all areas of infertility who can help:

- Enroll in the infertility program.
- Assist with precertification of eligible health services.
- Coordinate precertification for ART services and fertility preservation services when these services are eligible health services. Your provider should obtain precertification for fertility preservation services through the NIU either directly or through a reproductive endocrinologist.
- Evaluate medical records to determine whether ART services and fertility preservation services are reasonably likely to result in success.
- Determine whether ART services and fertility preservation services are eligible health services.
- Case manage for the provision of ART services and fertility preservation services for an eligible covered person.

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

Outpatient diagnostic testing

Diagnostic complex imaging services
Eligible health services include complex imaging services by a provider, including:
- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans

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

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

Outpatient infusion therapy
Eligible health services include infusion therapy you receive in an outpatient setting including but not limited to:
- A free-standing outpatient facility
- The outpatient department of a hospital
- A physician in their office
- A home care provider in your home

You can access the list of preferred infusion locations by contacting Member Services at the toll-free number on your ID card or by logging onto your Aetna secure website at www.aetnastudenthealth.com.

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

Certain infused medications may be covered under the outpatient prescription drug coverage. You can access the list of specialty prescription drugs by contacting Member Services at the toll-free number on your ID card or by logging onto your Aetna secure website at www.aetnastudenthealth.com to determine if coverage is under the outpatient prescription drug benefit of this certificate of coverage.

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

Outpatient radiation therapy
Eligible health services include the following radiology services provided by a health professional:
- Radiological services
- Gamma ray
- Accelerated particles
- Mesons
- Neutrons
- Radium
- Radioactive isotopes
**Specialty prescription drugs**

Eligible health services include specialty prescription drugs when they are:

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

You can access the list of specialty prescription drugs by contacting Member Services at the toll-free number on your ID card or by logging onto your Aetna secure website at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) to determine if coverage is under the outpatient prescription drug benefit of this certificate of coverage.

**Outpatient respiratory therapy**

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

**Transfusion or kidney dialysis of blood**

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

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

**Short-term cardiac and pulmonary rehabilitation services**

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

**Cardiac rehabilitation**

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

**Pulmonary rehabilitation**

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

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

Short-term rehabilitation therapy services

Short-term rehabilitation therapy services help you restore or develop skills and functioning for daily living.

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

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

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

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

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

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

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

Short-term habilitation therapy services

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

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

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

Short-term habilitation therapy services have to follow a specific treatment plan, ordered by your physician.
Outpatient physical, occupational, and speech habilitation therapy

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

Therapeutic manipulation services

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

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

Diagnostic testing for learning disabilities

Eligible health services include diagnostic testing for:
- Attention deficit disorder
- Attention deficit hyperactive disorder

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

Acupuncture in lieu of anesthesia
Eligible health services include acupuncture treatment (manual or electroacupuncture) provided by your physician, if the service is performed as a form of anesthesia in connection with a covered surgical procedure.

Ambulance service
Eligible health services include transport by professional ambulance services.

For emergency services:
- To the first hospital to provide emergency services
- From one hospital to another hospital if the first hospital cannot provide the emergency services you need

For non-emergency services:
- From hospital to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a hospital if an ambulance is the only safe way to transport you. Transport is limited to 200 miles

Your plan also covers transportation to a hospital by professional air or water ambulance when:
- Professional ground ambulance transportation is not available
- Your condition is unstable, and requires medical supervision and rapid transport
- You are travelling from one hospital to another and
  - The first hospital cannot provide the emergency services you need
  - The two conditions above are met

Clinical trial therapies (experimental or investigational)
Eligible health services include experimental or investigational drugs, devices, treatments or procedures from a provider under an “approved clinical trial” only when you have cancer or terminal illnesses and all of the following conditions are met:
- Standard therapies have not been effective or are not appropriate
- We determine based on published, peer-reviewed scientific evidence that you may benefit from the treatment

An "approved clinical trial" is a clinical trial that meets all of these criteria:
- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)
Eligible health services include "routine patient costs" incurred by you from a provider in connection with participation in an "approved clinical trial" as a “qualified individual” for cancer or other life-threatening illness or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.
**Durable medical equipment (DME)**

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

Coverage includes:

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

We:

- Assume no responsibility
- Make no express or implied warranties

concerning the outcome of any covered DME items.

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

Your plan only covers the same type of DME that Medicare covers. But there are some DME items Medicare covers that your plan does not. We list examples of those in the *Exceptions* section.

**Enteral formulas and nutritional supplements**

**Eligible health services** include enteral formulas and nutritional supplements used to treat malabsorption of food caused by:

- Crohn’s Disease
- Ulcerative colitis
- Gastroesophageal reflux
- Gastrointestinal motility;
- Chronic intestinal pseudo-obstruction
- Phenylketonuria
- Eosinophilic gastrointestinal disorders
- Inherited diseases of amino acids and organic acids (inherited metabolic illness)

**Covered benefits** also include food products modified to be low in protein for inherited diseases of amino acids and organic acids. For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of any inherited metabolic illness. Low protein modified food products do not include foods that are naturally low in protein.

Your physician must give you a written order for these supplies.
Infant Formulas
Certain infant (birth through 12 months) formulas are covered when:
- There is a diagnosis as having multiple food protein intolerance and a physician has prescribed specialized, non-standard, formulas, and
- There has not been a responsive result to trials of standard non-cow milk-based formulas including soybean and goat milk

Specialized, non-standard, infant formulas will be provided under the same terms and conditions as provided for any other prescription drug under the Outpatient prescription drug section.

Infant pasteurized donated breast milk
Pasteurized donated breast milk which may include human milk fortifiers for infants under the date of six months is covered when:
- A provider prescribed the milk because the infant is medically or physically unable to receive maternal breast milk in sufficient quantities or breast feed despite optimal lactation support and the infant meets any of the following:
  - A body weight below health levels
  - The infant is at a high risk of developing necrotizing enterocolitis due to a congenital or acquired condition
  - The infant has a congenital or acquired condition that may benefit from the use of donor breast milk
- The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America, or that is licensed by the Department of Health

Orthotic and prosthetic devices
Eligible health services include the expenses for obtaining orthotic or prosthetic devices ordered by your physician, a licensed orthoptist or prosthétist for the treatment of weak or muscle deficient feet.

Orthotic device means:
- A brace or support

Prosthetic device means:
- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness or injury or congenital defects such as:
  - Artificial limbs
  - Hands
  - Fingers
  - Feet
  - Toes

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

Eligible health services include hearing care that includes hearing exams, prescribed hearing aids and hearing aid services as described below.

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

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

**Hearing Aids Alternate Treatment Rule**

Sometimes there are several types of hearing aids that can be used to treat a medical condition, all of which provide acceptable results. When alternate hearing aids can be used, the plan’s coverage may be limited to the cost of the least expensive device that is:
- Customarily used nationwide for treatment and
- Deemed by the medical profession to be appropriate for treatment of the condition in question. The device must meet broadly accepted standards of medical practice for your physical condition.

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

**Home hemophilia treatment**

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

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

**Loss of designated status**

When a designated health care provider loses their designation, we shall not continue to refer you to that health care provider. If you have been using such a provider, we will continue to provide services at an in-network level until:
- A new designated health care provider arrangement is made or
- Four months following the date of the loss of designation

whichever occurs first.
We shall not be required to continue to provide services at an in-network level when the provider’s loss of designation is the result of:

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

**Termination of the agreement**

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

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

whichever occurs first

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

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

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

**Podiatric (foot care) treatment**

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

Non-routine treatment means:

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

**Sickle cell anemia treatment**

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

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

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

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

Wilm’s tumor treatment
Eligible health services include inpatient and outpatient treatment of Wilm’s tumor. Coverage includes treatment received in a home setting. See the Transplant services benefit for more information about coverage.
9. Outpatient prescription drugs

What you need to know about your outpatient prescription drug benefits

Read this section carefully so that you know:

- How to access in-network pharmacies
- How to access out-of-network pharmacies
- Eligible health services under your outpatient prescription drug benefit
- What outpatient prescription drugs are covered
- Other services
- How you get an emergency prescription filled
- Where your schedule of benefits fits in
- What precertification requirements apply
- How do I request a medical exception

Some prescription drug coverage may be limited. For more information see the Where your schedule of benefits fits in section, and see the schedule of benefits.

A pharmacy may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled. In this situation, the pharmacist will call the prescriber for guidance. Examples include but are not limited to, concerns regarding drug interaction, opioids or the prescriber.

How to access in-network pharmacies

How do you find an in-network pharmacy?

You can find an in-network pharmacy in two ways:

- Online: By logging onto your Aetna secure website at www.aetnastudenthealth.com.
- By phone: Call Member Services at the toll-free number on your ID card. During regular business hours, a Member Services representative can assist you. Our automated telephone assistant can give you this information 24 hours a day.

Pharmacies include in-network retail, mail order and specialty pharmacies.

How to access out-of-network pharmacies

You can directly access an out-of-network pharmacy to get covered outpatient prescription drugs.

If you use an out-of-network pharmacy to obtain outpatient prescription drugs, you are subject to a higher out-of-pocket expense and are responsible for:

- Your out-of-network copayment
- Your out-of-network coinsurance
- Any charges over our recognized charge

Eligible health services under your outpatient prescription drug benefit

What does your outpatient prescription drug benefit cover?

Eligible health services under your outpatient prescription drug benefit include:

Any pharmacy service that meets these three requirements:

- They are listed in the Eligible health services under your plan section
- They are not carved out in the What your plan doesn’t cover - eligible health service exceptions and exclusions section
- They are not beyond any limits in the schedule of benefits
Your plan benefits are covered when you follow the plan’s general rules:

- You need a **prescription** from your **prescriber**
- Your drug needs to be **medically necessary** for your **illness** or **injury**. See the **Medical necessity and precertification requirements** section
- You need to show your ID card to the **pharmacy** when you get a **prescription filled**

Your outpatient **prescription drug** benefit is based on drugs in the **preferred drug guide**. The **preferred drug guide** includes both **brand-name prescription drugs** and **generic prescription drugs**. Your out-of-pocket costs may be higher if your **prescriber** prescribes a **prescription drug** not listed in the **preferred drug guide**.

Your outpatient **prescription drug** benefit includes drugs listed in the **preferred drug guide**. **Prescription drugs** listed on the **formulary exclusions list** are excluded from preferred cost sharing unless a medical exception is approved by us prior to the **prescription drug** being picked up at the **pharmacy**. If it is **medically necessary** for you to use a **prescription drug** on the **formulary exclusions list**, you or your **prescriber** must request a medical exception. See the *How can I request a medical exception* section.

**Generic prescription drugs** may be substituted by your pharmacist for **brand-name prescription drugs**. Your out-of-pocket costs may be less if you use a **generic prescription drug** when available.

**Prescription drugs** covered by this plan are subject to misuse, waste, and/or abuse utilization review by us, your **provider**, and/or your in-network **pharmacy**. The outcome of this review may include: limiting coverage of the applicable drug(s) to one prescribing **provider** and/or one in-network **pharmacy**, limiting the quantity, dosage, day supply, requiring a partial-fill or denial of coverage.

**What outpatient prescription drugs are covered**
Your **prescriber** may give you a **prescription** in different ways, including:

- Writing out a **prescription** that you then take to a **pharmacy**
- Calling or e-mailing a **pharmacy** to order the medication
- Submitting your **prescription** electronically to a **pharmacy**

Once you receive a **prescription** from your **prescriber**, you may fill the **prescription** at an in-network retail, mail order or specialty or out-of-network **pharmacy**.

**Types of pharmacies start here**

**Retail pharmacy**
Generally, retail **pharmacies** may be used for up to a 90 day supply of **prescription drugs**. You should show your ID card to the in-network **pharmacy** every time you get a **prescription filled**. The in-network **pharmacy** will submit your claim. You will pay any cost sharing directly to the in-network **pharmacy**.

If you receive medication for a chronic condition, refills may be able to be synchronized. Synching medication means fewer trips to the **pharmacy** for refills. To see if you qualify, contact Member Services at the toll-free number on your ID card in the *How to contact us for help* section or by logging onto your Aetna secure website at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

You do not have to complete or submit claim forms. The in-network **pharmacy** will take care of claim submission. You may have to complete or submit claim forms when you use an out-of-network **pharmacy**.
Mail order pharmacy
If you choose, you may purchase outpatient prescription drugs and insulin through an in-network mail order pharmacy. Each prescription is limited to a maximum 90 day supply. Prescriptions for less than a 31 day supply or more than a 90 day supply are not eligible for coverage when dispensed by an in-network mail order pharmacy.

Specialty pharmacy
Specialty prescription drugs often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. Each prescription is limited to a maximum 30 day supply. You can access the list of specialty prescription drugs by contacting Member Services at the toll-free number on your ID card or by logging onto your Aetna secure website at www.aetnastudenthealth.com.

Specialty prescription drugs are covered when dispensed through an in-network specialty pharmacy or in-network retail pharmacy.

Other services
Preventive contraceptives
For females who are able to reproduce, your outpatient prescription drug plan covers certain prescription drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing. Your outpatient prescription drug plan also covers related services and supplies needed to administer covered devices. You can access the list of contraceptive prescription drugs by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.

We cover over-the-counter (OTC) and generic prescription drugs and devices for each of the methods identified by the FDA at no cost share. If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug for that method at no cost share.

After an initial 3-month supply is dispensed, a 6 month supply of the same contraceptive is covered regardless of whether the initial prescription was covered under this plan. For specific cost sharing, see the schedule of benefits.

Important Note:
You may qualify for a medical exception if your provider determines that the contraceptives covered standardly as preventive are not medically appropriate. Your prescriber may request a medical exception and submit the exception to us.

Diabetic supplies
Eligible health services include but are not limited to the following diabetic supplies upon prescription by a prescriber:
- Injection devices including insulin syringes, needles and pens
- Test strips - blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs

See your medical plan and the Diabetic services and supplies (including equipment and training) section for coverage of blood glucose meters and external insulin pumps.
Immunizations
Under the outpatient prescription drugs benefit, eligible health services include preventive immunizations for infectious diseases as required by the federal Affordable Care Act (ACA) guidelines when administered at an in-network pharmacy.

You should contact:
- Member Services at the toll-free number on your ID card to find a participating in-network pharmacy

You should contact the pharmacy for availability as not all pharmacies will stock all available vaccines.

Your medical plan also provides coverage for preventive immunizations as required by the federal Affordable Care Act (ACA) guidelines. For details, refer to the Preventive care and wellness section.

Infertility drugs
Eligible health services include oral and injectable prescription drugs used primarily for the purpose of treating the underlying cause of infertility.

Off-label use
U.S. Food and Drug Administration (FDA) approved prescription drugs may be covered when the off-label use of the drug has not been approved by the FDA for your condition(s). Eligibility for coverage is subject to the following:
- The drug must be accepted as safe and effective to treat your condition(s) in one of the following standard compendia:
  - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information)
  - Thomson Micromedex DrugDex System (DrugDex)
  - Clinical Pharmacology (Gold Standard, Inc.) or
  - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium
- Use for your condition(s) has been proven as safe and effective by at least one well-designed controlled clinical trial, (i.e., a Phase III or single center controlled trial, also known as Phase II). Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
  - The dosage of a drug for your condition(s) is equal to the dosage for the same condition(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above or
  - The dosage has been proven to be safe and effective for your condition(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

Health care services related to off-label use of these drugs may be subject to precertification or other requirements or limitations.

Orally administered anti-cancer drugs, including chemotherapy drugs
Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

Over-the-counter drugs
Eligible health services include certain over-the-counter medications. In addition to contraceptives, proton pump inhibitors and second generation H1 receptor antagonists may be covered. Consideration for coverage of the selected over-the-counter medications requires a prescription which must be given to the pharmacist for processing at the time of payment. The pharmacist will process a prescription for over-the-counter drugs in the same manner as a prescription drug. You will be responsible for the appropriate cost share. You can access the list by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling Member Services at the toll-free number on your ID card.
Preventive care drugs and supplements
Eligible health services include preventive care drugs and supplements (including over-the-counter drugs and supplements) as required by the Affordable Care Act (ACA) guidelines when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing.

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

Tobacco cessation prescription and over-the-counter drugs
Eligible health services include FDA-approved prescription drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing.

How you get an emergency prescription filled
Try to access an in-network pharmacy in an emergency or urgent care situation. You may not have access to an in-network pharmacy in an emergency or urgent care situation, or you may be traveling outside of the plan’s service area. Call Member Services at the toll-free number on your ID card in the How to contact us for help section for help in finding an in-network pharmacy. If you must fill a prescription in either situation, we will reimburse you as shown in the table below.

<table>
<thead>
<tr>
<th>Type of pharmacy</th>
<th>Your cost share</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network pharmacy</td>
<td>• You pay the copayment.</td>
</tr>
</tbody>
</table>
| Out-of-network pharmacy     | • You pay the pharmacy directly for the cost of the prescription. Then you fill out and send a prescription drug refund form to us, including all itemized pharmacy receipts.  
                                • Submission of a claim doesn’t guarantee payment. If your claim is approved, you will be reimbursed the cost of your prescription less your copayment. |

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

Your outpatient prescription drug costs are based on:
- The type of prescription drug you are prescribed
- Where you fill your prescription

The plan may, in certain circumstances, make some brand-name prescription drugs available to covered persons at the generic prescription drug cost share level.
How your copayment works
Your copayment is the amount you pay for each prescription fill or refill. Your schedule of benefits shows you which copayments you need to pay for specific prescription fill or refill. You will pay any cost sharing directly to the in-network pharmacy.

How your outpatient prescription drug maximum out-of-pocket limit works
You will pay your outpatient prescription drug policy year deductible, copayments and coinsurance up to the outpatient prescription drug maximum out-of-pocket limit for your plan.

Your schedule of benefits shows the outpatient prescription drug maximum out-of-pocket limits that apply to your plan. Once you reach your outpatient prescription drug maximum out-of-pocket limit, your plan will pay for outpatient prescription drug covered benefits for the remainder of that policy year.

What precertification requirements apply?
Precertification
For certain drugs, you, your prescriber or your pharmacist needs to get approval from us before we will cover the drug. This is called "precertification". The requirement for getting approval in advance guides appropriate use of precertified drugs and makes sure they are medically necessary. For the most up-to-date information, call Member Services at the toll-free number on your ID card or by logging on to your Aetna secure website at www.aetnastudenthealth.com.

Medical exceptions
Sometimes you or your prescriber may ask for a medical exception to get health care services for drugs not covered or for brand-name, specialty or biosimilar prescription drugs or for which health care services are denied through precertification. You, someone who represents you or your prescriber can contact us. You will need to provide us with the required clinical documentation. We will make a coverage determination within 72 hours after we receive your request and any information and will tell you and your prescriber of our decision. Any exception granted is based upon an individual, case by case decision, and will not apply to other members. If approved by us, you will receive the preferred or non-preferred drug benefit level and the exception will apply for the entire time of the prescription.

You, someone who represents you or your prescriber may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-preferred drug. You, someone who represents you or your prescriber may submit a request for a quicker review for an urgent situation by:
• Contacting our Precertification Department at 1-855-582-2025
• Faxes the request to 1-855-330-1716
• Submitting the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road Richardson, TX 75081

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your prescriber of our decision. If approved by us, the exception will apply for the entire time you have an urgent situation.
If you are denied a medical exception based on the above processes, you may have the right to a third party review by an independent external review organization. If our claim decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send you. That notice also will describe the external review process. We will tell you, someone who represents you or your prescriber of the coverage determination of the external review no later than 72 hours after we receive your request. If the medical exception is approved, coverage will be provided for the entire time of the prescription. For quicker medical exceptions in urgent situations, we will tell you, someone who represents you or your prescriber of the coverage determination no later than 24 hours after we receive your request. If the quicker medical exception is approved, coverage will be provided for the entire time you have an urgent situation.

Prescribing units
Some outpatient prescription drugs are subject to quantity limits. These quantity limits help your prescriber and pharmacist check that your outpatient prescription drug is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these quantity limits.

Any outpatient prescription drug that has duration of action extending beyond one (1) month shall require the number of copayments per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) copayments.
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 exceptions and exclusions
The following are not eligible health services under your plan except as described in:

- The Eligible health services under your plan section of this certificate of coverage or
- A rider or amendment issued to you for use with this certificate of coverage

Accidental injury to sound natural teeth
- 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

Acupuncture therapy
- Maintenance treatment
- Acupuncture when provided for the following conditions:
  - Acute low back pain
  - Addiction
  - AIDS
  - Amblyopia
  - Allergic rhinitis
  - Asthma
  - Autism spectrum disorders
  - Bell’s Palsy
  - Burning mouth syndrome
  - Cancer-related dyspnea
  - Carpal tunnel syndrome
  - Chemotherapy-induced leukopenia
  - Chemotherapy-induced neuropathic pain
  - Chronic pain syndrome (e.g., RSD, facial pain)
  - Chronic obstructive pulmonary disease
  - Diabetic peripheral neuropathy
  - Dry eyes
- Erectile dysfunction
- Facial spasm
- Fetal breech presentation
- Fibromyalgia
- Fibrotic contractures
- Glaucoma
- Hypertension
- Induction of labor
- Infertility (e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
- Insomnia
- Irritable bowel syndrome
- Menstrual cramps/dysmenorrhea
- Mumps
- Myofascial pain
- Myopia
- Neck pain/cervical spondylosis
- Obesity
- Painful neuropathies
- Parkinson’s disease
- Peripheral arterial disease (e.g., intermittent claudication)
- Phantom leg pain
- Polycystic ovary syndrome
- Post-herpetic neuralgia
- Psoriasis
- Psychiatric disorders (e.g., depression)
- Raynaud’s disease pain
- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

**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

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

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.

Ambulance services
- Non-emergency fixed wing air ambulance from an out-of-network provider
- Non-emergency ambulance transports except as covered under the Eligible health services under your plan section of this certificate of coverage

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.

Artificial organs
- Any device that would perform the function of a body organ

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 and body fluid exposure
- Services and supplies provided for the treatment of an illness that results from your clinical related injury as these are covered elsewhere in the student policy

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.
Breasts
- Services and supplies given by a **provider** for breast reduction or gynecomastia except as specifically provided in the *Eligible health services under your plan – Reconstructive surgery and supplies* section.

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

Clinical trial therapies (routine patient costs)
- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with Aetna’s claim policies)

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. Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.

This exclusion does not apply to:
- Surgery after an accidental injury when performed as soon as medically feasible
- Coverage that may be provided under the *Eligible health services under your plan - Gender reassignment (sex change) treatment* section.

Counseling
- Marriage, religious, family, career, social adjustment, pastoral, or financial counseling

Court-ordered services and supplies
- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

Custodial care
Examples are:
- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- **Respite care** adult (or child) day care or convalescent care except in connection with **hospice 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

Dermatological treatment
• Cosmetic treatment and procedures

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.

Durable medical equipment (DME)
Examples of these items are:
• 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

Early intensive behavioral interventions
Examples of these services are:
• Certain early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions
Educational services
Examples of these services are:
- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment program
  - Job training
  - Job hardening programs
- Services provided by a governmental school district

Elective treatment or elective surgery
- Elective treatment or elective surgery except as specifically covered under the student policy and provided while the student policy is in effect

Enteral formulas and nutritional supplements
- Any food item, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the Eligible health services under your plan – Enteral formulas and nutritional supplements section

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

Emergency services and urgent care
- Non-emergency services in a hospital emergency room facility
- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

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

Family planning services - other
- Reversal of voluntary sterilization procedures, including related follow-up care
- Family planning services received while confined as an inpatient in a hospital or other facility
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care
Felony

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

Foot care

- 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

Gender reassignment (sex change) treatment

- Cosmetic services and supplies such as:
  - Rhinoplasty
  - Face-lifting
  - Lip enhancement
  - Facial bone reduction
  - Blepharoplasty
  - Liposuction of the waist (body contouring)
  - Reduction thyroid chondroplasty (tracheal shave)
  - Hair removal (including electrolysis of face and neck)
  - Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which are used in feminization
  - Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic

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

Hearing aids and exams

The following services or supplies:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 12 month period
- 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 given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
• Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries, amplifiers, and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

**Home health care**
- 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
- Food or home delivered services
- Maintenance therapy

**Hospice care**
- Funeral arrangements
- Pastoral 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

**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.

**Infertility treatment**
- Any charges associated with:
  - Surrogacy 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 where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - Cryopreservation (freezing) of eggs, embryos, or sperm
  - Storage of eggs, embryos, or sperm
  - Thawing of cryopreserved eggs, embryos or sperm
  - Nonmedical costs of an approved egg or sperm donor
  - Any medical or psychological prescreening of any prospective donors
- 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
- Members age 45 years or under may not have more than four completed egg retrievals while you are covered under this plan or any other Aetna plan with this policyholder
- Members over 45 years of age are not covered for egg retrievals
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 under your plan – 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 under your plan – Habilitation therapy services section

Maternity and related newborn care

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

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 treatment

- Mental health services for the following categories (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association:
  - Stays in a facility for treatment of dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders except as described in the Eligible health services under your plan – Preventive care and wellness section
  - Pathological gambling, kleptomania, pyromania
  - School and/or education service including special educational, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation
Non-medically necessary services and supplies

- Services and supplies which are not medically necessary for the diagnosis, care, or treatment of an illness or injury or the restoration of physiological functions. This includes behavioral health services that are not primarily aimed at the treatment of illness, injury, restoration of physiological functions or that do not have a physiological or organic basis. This applies even if they are prescribed, recommended, or approved by your physician, dental provider, or vision care provider. This exception does not apply to Preventive care and wellness benefits.

Non-U.S. citizen

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

Obesity (bariatric) surgery

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the Eligible health services under your plan – 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

Organ removal

- Services and supplies given by a provider to remove an organ from your body for the purpose of donating or selling the organ except as described in the Eligible health services under your plan section. This does not apply if you are donating the organ to a spouse, domestic partner, civil union partner, child, brother, sister, or parent.

Outpatient infusion therapy

- 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 except as specifically provided in the Home hemophilia treatment section

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

Preventive care and wellness
- Services for diagnosis or treatment of a suspected or identified illness or injury
- Exams given during your stay for medical care
- Services not given by or under a physician’s direction
- Psychiatric, psychological, personality or emotional testing or exams
- 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 or devices
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Female voluntary sterilization procedures that were not billed separately by the provider or were not the primary purpose of a confinement

Prosthetic devices
- 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
- Cochlear implants

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 under your plan 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 and enhancement
- Any treatment, prescription drug, service, 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 or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Not eligible for coverage are prescription drugs in 90 day supplies

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

Sleep apnea
- Any services or supplies given by providers for the treatment of obstructive sleep apnea and sleep disorders

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

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

Temporomandibular joint dysfunction treatment (TMJ) and craniomandibular joint dysfunction treatment (CMJ)
- Orthodontia, crowns or bridgework
- Dental implants

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

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

Transplant services
- 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, or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness
- Travel and lodging expenses for transplants that are not obtained at an IOE facility

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

Use of drugs, alcohol or intoxicants
- Services and supplies to treat an injury resulting from the use of:
  - Drugs (except as prescribed by a physician)
  - Alcohol
  - Intoxicants
Vision Care

Pediatric vision care services and supplies
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Adult vision care
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Adult vision care services and supplies
Your plan does not cover adult vision care services and supplies, except as described in the Eligible health services under your plan – Other services section.
- Special supplies such as non-prescription sunglasses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a hospital or other facility for health care
- Eye exams for contact lenses or their fitting
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Wilderness Treatment Programs
- Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

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.
Exceptions and exclusions that apply to outpatient prescription drugs

Allergy sera and extracts administered via injection

Any services related to the dispensing, injection or application of a drug

Biological sera

Compounded prescriptions
• Compound prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones

Cosmetic drugs
• Medications or preparations used for cosmetic purposes

Devices, products and appliances, except those that are specially covered

Dietary supplements including medical foods

Drugs or medications
• Administered or entirely consumed at the time and place it is prescribed or dispensed
• 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 in the Eligible health services under your plan – Outpatient prescription drugs section
• Not approved by the FDA or not proven safe and effective
• Provided under your medical plan while an inpatient of a healthcare facility
• That includes 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, 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
• 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
Implantable drugs and associated devices except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs section.

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 self-administration of an injectable drug.
- 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.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as specifically provided in the Eligible health services under your plan – Diabetic equipment, supplies and education section

Prescription drugs:
- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this rider.
- Dispensed by a mail order pharmacy that 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 are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the preferred drug guide.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not medically necessary, or otherwise improper, and drugs obtained for use by anyone other than the person identified on the ID card.

Refills
- 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

Tobacco cessation
- Tobacco cessation products unless recommended by the United States Preventive Services Task Force (USPSTF)
Who provides the care

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

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

- Emergency services – refer to the description of emergency services and urgent care in the Eligible health services under your plan section
- Urgent care – refer to the description of emergency services and urgent care in the Eligible health services under your plan section

You may select an in-network provider from the directory through your Aetna secure website at www.aetnastudenthealth.com. You can search our online directory, DocFind®, for names and locations of providers or contact Member Services at the toll-free number on your ID card.

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

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

- Paying your out-of-network policy year deductible
- Your out-of-network coinsurance
- Any charges over our recognized charge
- Submitting your own claims and getting precertification for services received outside of New Jersey

You can get eligible health services under your plan that are provided by an out-of-network provider if an appropriate network provider is not reasonably available. You must request access to the out-of-network provider in advance and we must agree. If we do not agree and you disagree with our decision, see the When you disagree - claim decisions and appeals procedures section.
Keeping a provider you go to now (continuity of care)

You may have to find a new provider when:

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

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

<table>
<thead>
<tr>
<th>Request for approval</th>
<th>If you are a new enrollee and your provider is an out-of-network provider</th>
<th>When your provider stops participation with Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You need to complete a Transition Coverage Request form and send it to us. You can get this form by contacting Member Services at the toll-free number on your ID card.</td>
<td>You or your provider should call us for approval to continue any care.</td>
</tr>
</tbody>
</table>

Length of transitional period

Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.

Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. This date is based on the date the provider terminated their participation with us.

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

We will authorize coverage for the transitional period only if the provider agrees to our usual terms and conditions for contracting providers.
What the plan pays and what you pay

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

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

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

The general rule
When you get eligible health services:
- You pay for the entire expense up to any policy year deductible limit

And then

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

And then

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

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

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

Important exceptions – when you pay all
You pay the entire expense for an eligible health service:
- When you get a health care service or supply that is not medically necessary. See the Medical necessity and precertification requirements section.

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

In all these cases, the provider may require you to pay the entire charge. Any amount you pay will not count towards your policy year deductible or towards your maximum out-of-pocket limit.
Special financial responsibility
You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

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

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

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

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

Important note:
See the schedule of benefits for any policy year deductibles, copayments, coinsurance, maximum out-of-pocket limits and maximum age, visits, days, hours, admissions that may apply.
When you disagree - claim decisions and appeals procedures

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

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

**Claim procedures**

For claims involving **out-of-network providers**:

<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit a claim</td>
<td>• You should notify and request a claim form from the <strong>policyholder</strong>.</td>
<td>• You must send us notice and proof as soon as reasonably possible.</td>
</tr>
<tr>
<td></td>
<td>• The claim form will provide instructions on how to complete and where to send the form(s).</td>
<td>• If you are unable to complete a claim form, you may send us:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- A description of services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Bill of charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Any medical documentation you received from your provider</td>
</tr>
<tr>
<td>Proof of loss (claim)</td>
<td>• A completed claim form and any additional information required by us.</td>
<td>• You must send us notice and proof as soon as reasonably possible.</td>
</tr>
<tr>
<td>Benefit payment</td>
<td>• Written proof must be provided for all benefits.</td>
<td>• Benefits will be paid as soon as the necessary proof to support the claim is received.</td>
</tr>
<tr>
<td></td>
<td>• If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss.</td>
<td></td>
</tr>
</tbody>
</table>

**Types of claims and communicating our claim decisions**

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

**Urgent care claim**

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

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.
**Pre-service claim**
A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them.

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Urgent care claim</th>
<th>Pre-service claim</th>
<th>Post-service claim</th>
<th>Concurrent care claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial determination (us)</td>
<td>72 hours</td>
<td>15 days</td>
<td>30 days</td>
<td>24 hours for urgent request*&lt;br&gt;15 calendar days for non-urgent request</td>
</tr>
<tr>
<td>Extensions</td>
<td>None</td>
<td>15 days</td>
<td>15 days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Additional information request (us)</td>
<td>72 hours</td>
<td>15 days</td>
<td>30 days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Response to additional information request (you)</td>
<td>48 hours</td>
<td>45 days</td>
<td>45 days</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

*We have to receive the request at least 24 hours before the previously approved health care services end.

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

If we make an adverse benefit determination, we will tell you in writing.
The difference between a complaint and an appeal

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

An appeal
You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us by calling Member Services at the toll-free number on your ID card.

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

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination or by calling Member Services at the toll-free number on your ID card. For a written appeal, you need to include:

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

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

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Important note:
If you want to appeal an adverse benefit decision regarding an inpatient substance use disorders treatment claim, go to the Appeals of inpatient substance use disorders treatment claims section.

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

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

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Urgent care claim</th>
<th>Pre-service claim</th>
<th>Post-service claim</th>
<th>Concurrent care claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal determinations at each level (us)</td>
<td>36 hours</td>
<td>15 days</td>
<td>30 days</td>
<td>As appropriate to type of claim</td>
</tr>
<tr>
<td>Extensions</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Appeals of inpatient substance use disorders claims**

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

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

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

**Exhaustion of appeals process**

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

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

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

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

External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO).

You have a right to external review only if:
- Our claim decision involved medical judgment
- We decided the service or supply is not medically necessary or not appropriate
- We decided the service or supply is experimental or investigational
- You have received an adverse determination

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

You must submit the Request for External Review Form:
- To Aetna
  - Within 123 calendar days of the date you received the decision from us
  - And you must include a copy of the notice from us and all other important information that supports your request

You will pay for any information that you send and want reviewed by the ERO. We will pay for information we send to the ERO plus the cost of the review.

Aetna will:
- Contact the ERO that will conduct the review of your claim
- The ERO will:
  - Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
  - Consider appropriate credible information that you sent
  - Follow our contractual documents and your plan of benefits
  - Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

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

**How long will it take to get an ERO decision?**

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

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

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

**For initial adverse determinations**

Your provider tells us that a delay in your receiving health care services would:
- Jeopardize your life, health or ability to regain maximum function or
- Be much less effective if not started right away (in the case of experimental or investigational treatment)
For final adverse determinations
Your provider tells us that a delay in your receiving health care services would:

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

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.

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

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

Fees and expenses
We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.
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).

In this section, we explain how we determine which is the primary plan and which is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits. It is also intended to preserve your rights to coverage under all plans under which you are covered.

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

Allowable expense means:
- A health care expense that any of your health plans cover to any degree except where a law requires another definition, or as stated below. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, cosmetic surgery generally is not an allowable expense under this plan.

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

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

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

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

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

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

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

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

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

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

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

Determining who pays
The benefits of the plan that covers you as an employee, member, subscriber or retiree will be determined before those of the plan that covers you as a dependent. The coverage as an employee, member, subscriber or retiree is the primary plan.
The benefits of the plan that covers you as an employee who is neither laid off nor retired, or as a dependent of such person, will be determined before those for the plan that covers you as a laid off or retired employee, or as such a person's dependent. If the other plan does not contain this rule, and as a result, the plans do not agree on the order of benefit determination, this portion of this provision is ignored.

The benefits of the plan that covers you as an employee, member, subscriber or retiree, or dependent of such person, will be determined before those of the plan that covers the person under a federal or state continuation law. If the other plan does not contain this rule, and as a result, the plans do not agree on the order of benefit determination, this portion of this provision is ignored.

If the above order of benefits does not establish which plan is the primary plan, the benefits of the plan that covers the employee, member or subscriber for a longer period of time will be determined before the benefits of the plan(s) that covered the person for a shorter period of time.

**How are benefits paid**

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

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

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

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

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

A plan determined to be a secondary plan may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. Where a benefit is payable by both the primary and secondary plans on the basis of usual, customary and reasonable fees (UCR), the secondary plan will pay the difference between billed charges for allowable expenses and the amount paid by the primary plan as long as the amount is no greater than the amount the secondary plan would have paid if primary. The amount by which the secondary plan's benefits have been reduced will be used by the secondary plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by you. As each claim is submitted, the secondary plan will determine its obligation to pay for allowable expenses based on all claims which were submitted up to that time during the claim determination period.
The benefits of the secondary plan will be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of this COB provision, and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds those allowable expenses in a claim determination period. In this case, the benefits of the secondary plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

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

**Primary plan is R & C plan and secondary plan is R & C plan**
The secondary plan will pay the lesser of:

- The difference between the amount of the billed charges and the amount paid by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

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

**Primary plan is fee schedule plan and Secondary plan is fee schedule plan**
If the provider is a network provider in both the primary plan and the secondary plan, the allowable expense will be the fee schedule of the primary plan. The secondary plan will pay the lesser of:

- The amount of any deductible, coinsurance or copayment required by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

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

**Primary plan is R & C plan and secondary plan is fee schedule plan**
If the provider is a network provider in the secondary plan, the secondary plan will pay the lesser of:

- The difference between the amount of the billed charges for the allowable expenses and the amount paid by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

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

**Primary plan is fee schedule plan and secondary plan is R & C plan**
If the provider is a network provider in the primary plan, the allowable expense considered by the secondary plan will be the fee schedule of the primary plan. The secondary plan will pay the lesser of:

- The amount of any deductible, coinsurance or copayment required by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

**Primary plan is fee schedule plan and secondary plan is R & C plan or fee schedule plan**
If the primary plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency services and the service or supply you receive from a non-network provider is not considered as urgent care or emergency services, the secondary plan will pay benefits as if it were the primary plan.
Primary plan is capitation plan or fee schedule plan or R&C plan and secondary plan is capitation plan
If you receive services or supplies from a provider who is in the network of the secondary plan, the secondary plan will be responsible to pay the capitation to the provider and will not be responsible to pay the deductible, coinsurance or copayment imposed by the primary plan. You will not be responsible to pay any deductible, coinsurance or copayments of either the primary plan or the secondary plan.

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

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

• Online: Log on to your Aetna secure member website at www.aetnastudenthealth.com. Select Find a Form, then select Your Other Health Plans.
• By phone: Call Member Services at the toll-free number on your ID card.

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

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

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

• Any person we paid or for whom we paid or
• Any other plan that is responsible under these COB rules
When coverage ends

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

When will your coverage end?
Your coverage under this plan will end on the date of the first to occur:

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

If your coverage ends because you withdraw from school for reasons other than entering the armed forces, we will not refund premium contributions. You are covered for the policy term for which you enrolled and paid the premium contribution.

If you withdraw from school because you have entered the armed forces, premiums will be refunded, on a pro-rata basis, when we receive your application within 90 days from the date of the withdrawal.

Why would we suspend paying claims or end your coverage?
We will give you 30 days advance written notice if we suspend paying your claims because:

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

We may immediately end your coverage if:

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

On the date your coverage ends, we will refund to the policyholder any prepayments for periods after the date your coverage ended.
General provisions – other things you should know

Entire student policy
The student policy consists of several documents taken together. These documents are:
- The policyholder’s application
- Your enrollment form, if the policyholder requires one
- The student policy
- The certificate(s) of coverage
- The schedule of benefits
- Any riders, endorsement, inserts, attachments, and amendments to the student policy, the certificate of coverage, and the schedule of benefits

Administrative provisions

How you and we will interpret this certificate of coverage
We prepared this certificate of coverage according to federal laws and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this certificate of coverage when we administer your coverage, so long as we use reasonable authority. Our interpretation can be reversed by an internal utilization review organization, a court of law, arbitrator or administrative agency having jurisdiction. See the When you disagree-claim decisions and appeal procedures section.

How we administer this plan
We apply policies and procedures we’ve develop to administer this plan.

Who’s responsible to you
We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your providers. Even in-network providers are not our employees or agents.

Coverage and services

Your coverage can change
Your coverage is defined by the student policy. This document may have amendments or riders too. Under certain circumstances, we or the policyholder or the law may change your plan according to requirements of the student policy. Only Aetna may waive a requirement of your plan. No other person – including the policyholder or provider – can do this.

If your student status changes the amount of your coverage or benefit levels, the change will take effect on the date of the status change and the amount of coverage or benefit level will be changed to the new amount.

A retroactive change in your student status will not cause a retroactive change in your coverage.

If a service cannot be provided to you
Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can’t, we may refund you or the policyholder any unearned premium contribution.
Legal action
You must complete the appeal process before you take any legal action against us for any expense or bill. See the When you disagree - claim decisions and appeals procedures section. You cannot take any action until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Physical examinations and evaluations
At our expense, we have the right and opportunity to have a physician of our choice examine you. This will be done at all reasonable times while certification or a claim for benefits is pending or under review.

Records of expenses
You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:
- Names of physicians, dental providers and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes
You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won’t make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception
If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:
- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

If we have a reason to believe that a claim has been submitted fraudulently, we shall:
- Investigate the claim in accordance with our fraud prevention plan
- Refer the claim and supporting documentation to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to New Jersey law

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage as follows:
- We will give you 30 days advanced written notice of any rescission of coverage
- You have the right to an Aetna appeal
- You have the right to a third party review conducted by an independent external review organization
Some other money issues

When you submit a claim for an emergency medical condition or treatment for an urgent condition situation and you assign your rights to receive reimbursement for covered services to an out-of-network provider, we are required to pay benefits in line with the assignment of benefits. We will directly pay the health care provider in the form of a check payable:

- To the health care provider or
- To the health care provider and you as a joint payee

with signature lines for each.

Any payment made solely to you rather than the health care provider under these circumstances shall be considered unpaid, and unless remitted to the health care provider within the time frames established by New Jersey Law, shall be considered overdue and subject to an interest charge as provided in that act.

Grace period

You will be allowed a grace period of 31 days after the due date for the payment of each contribution due after the first contribution payment. If contributions are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period.

Payment of premiums

The first premium payment for this policy is due on or before your effective date of coverage. Your next premium payment will be due the 1st of each month (“premium due date”). Each premium payment is to be paid to us on or before the premium due date.

Recovery of overpayments

We sometimes pay too much for eligible health services or pay for something that this plan doesn’t cover. If we do, we can require the person we paid – you or your provider – to return what we paid. If we don’t do that we have the right to reduce any future benefit payments by the amount we paid by mistake.

We have to request reimbursement no more than 18 months following the date the first payment on the particular claim was made. We can only request one reimbursement per particular claim.

We will work directly with your provider throughout the reimbursement process.

Your health information

We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your providers’ claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call Member Services at the toll-free number on your ID card.

When you accept coverage under this plan, you agree to let your providers share information with us. We need information about your physical and mental condition and care.

Effect of benefits under other plans

Effect of a Health Maintenance Organization plan (an HMO Plan) or a Preferred Provider Organization plan (PPO plan) on coverage

If you have coverage under another group medical plan (such as an HMO or PPO plan) and that other plan denies coverage of benefits because you received the services or supplies outside of the plan’s network geographic area, this student plan will cover those denied benefits as long as they are covered benefits under this plan. Covered benefits will be paid at the applicable level of benefits under the student plan.
Glossary

Accident or accidental
An injury to you that is not planned or anticipated. An illness does not cause or contribute to an accident.

Aetna
Aetna Health and Life Insurance Company, an affiliate, or a third party vendor under contract with Aetna.

Ambulance
A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Autism/Autism spectrum disorder means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:
- Autistic disorder
- Rett’s disorder
- Childhood disintegrative disorder
- Asperger’s syndrome
- Pervasive developmental disorder-not otherwise specified

Behavioral health provider
An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for mental disorders and substance use disorder under the laws of the jurisdiction where the individual practices.

Brand-name prescription drug
A U.S. Food and Drug Administration (FDA) approved prescription drug marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Calendar year
A period of 12 months beginning January 1st and ending on December 31st.

Clinical related injury
As used within the Blood and body fluid exposure covered benefit, this is any incident which exposes you, acting as a student in a clinical capacity, to an illness that requires testing and treatment. Incident means unintended:
- Needlestick pricks
- Exposure to blood and body fluid
- Exposure to highly contagious pathogens

Coinsurance
Coinsurance is both the percentage of eligible health services that the plan pays and what you are obligated to pay. The specific percentage that we have to pay for eligible health services is listed in the schedule of benefits.

Copayments
The specific dollar amount or percentage you have to pay for a health care service listed in the schedule of benefits.
Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible health services that meet the requirements for coverage under the terms of this plan, including:
- They are medically necessary
- You received precertification if required

Covered person
A covered student for whom all of the following applies:
- The person is eligible for coverage as defined in the certificate of coverage
- The person has enrolled for coverage and paid any required premium contribution
- The person’s coverage has not ended

Covered student
A student who is insured under the student policy.

Craniomandibular joint dysfunction (CMJ)
This is a disorder of the jaw joint.

Custodial care
Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be custodial care even if it prescribed by a physician or given by trained medical personnel.

Dental emergency
Any dental condition that:
- Occurs unexpectedly
- Requires immediate diagnosis and treatment in order to stabilize the condition, and
- Is characterized by symptoms such as severe pain and bleeding

Dental emergency services
Services and supplies given by a dental provider to treat a dental emergency.

Dental provider
Any individual legally qualified to provide dental services or supplies. This may be any of the following:
- Any dentist
- Group
- Organization
- Dental facility
- Other institution or person

Dentist(s)
A legally qualified dentist licensed to do the dental work he or she performs.
Detoxification
The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:
- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This can be done by metabolic or other means as determined by a physician or a nurse practitioner working within the scope of their licenses. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Directory
The list of in-network providers for your plan. The most up-to-date directory for your plan appears at www.aetnastudenthealth.com under the DocFind® label. When searching DocFind®, you need to make sure that you are searching for providers that participate in your specific plan. In-network providers may only be considered for certain Aetna plans. When searching for in-network dental providers, you need to make sure you are searching under Pediatric Dental plan.

Durable medical equipment (DME)
Equipment and the accessories needed to operate it, that is:
- Made to withstand prolonged use
- Mainly used in the treatment of an illness or injury
- Suited for use in the home
- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

Effective date of coverage
The date your coverage begins under this certificate of coverage as noted in Aetna’s records.

Elective treatment
Services and supplies provided to you when there is no evidence of pathology, dysfunction, or illness in any part of your body. Examples of elective treatment are:
- Breast reduction
- Sub mucous resection and/or other surgical correction for deviated nasal septum, other than for the treatment of a covered medical condition

Eligible health services
The health care services and supplies and outpatient prescription drugs listed in the Eligible health services under your plan section and not carved out or limited in the Exceptions section of this certificate of coverage or in the schedule of benefits.

Emergency admission
An admission to a hospital or treatment facility ordered by a physician within 24 hours after you receive emergency services.
Emergency medical condition
A recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, illness, or injury is of a severe nature. And that if you don’t get immediate medical care it could result in:
- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus
- In the case of a pregnant woman:
  - Serious jeopardy to the health of the fetus
  - One who is having contractions and there is inadequate time to effect a safe transfer to another hospital before delivery or
  - A transfer may pose a threat to the health or safety of the woman or unborn child

Emergency services
Treatment given in an ambulance and a hospital’s emergency room for an emergency medical condition. This includes evaluation of, and treatment to stabilize an emergency medical condition.

Extended care facility
A facility which mainly provides full-time skilled nursing care for an ill or injured person who does not need to be in a hospital. An extended care facility will be recognized if it carries out its stated purpose under all relevant state and local laws and is either:
- Accredited for its stated purpose by the Joint Commission or
- Approved for its stated purpose by Medicare.

An extended care facility may also be referred to as a skilled nursing facility.

Experimental or investigational
A drug, device, procedure, or treatment that we find is experimental or investigational because:
- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility provider state that it is experimental or investigational.

Formulary exclusions list
A list of prescription drugs not listed in the preferred drug guide. This list is subject to change.

Generic prescription drug
A prescription drug with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.
Health professional
A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, physicians, nurses, dental providers, vision care providers, and physical therapists.

Home health aide
A health professional that provides services through a home health care agency. The services that they provide are not required to be performed by an RN, LPN, or LVN. A home health aide primarily aids you in performing the normal activities of daily living while you recover from an injury or illness.

Home health care agency
An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

Home health care plan
A plan of services prescribed by a physician (or other health professional) to be provided in the home setting. These services are usually provided after your discharge from a hospital or if you are homebound. All plans shall be in place within 14 days following the start of home health care.

Homebound
This means that you are confined to your home because:
- Your physician has ordered that you stay at home because of an illness or injury
- The act of transport would be a serious risk to your life or health

You are not homebound if:
- You do not often travel from home because you are feeble or insecure about leaving your home
- You are confined to a wheelchair but you can be transported by a vehicle that can safely transport you in a wheelchair

Hospice benefit period
A period that begins on the date your physician certifies that you have a terminal illness. It ends after 6 months (or later for which your treatment is certified) or on your death; if sooner.

Hospice care
Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure.

Hospice care agency
An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care. These services may be available in your home or inpatient setting.

Hospice care program
A program prescribed by a physician or other health professional to provide hospice care and supportive care to their families.

Hospice facility
An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care.
**Hospital**
An institution licensed as a hospital by applicable state and federal laws, and is accredited as a hospital by The Joint Commission (TJC).

Hospital does not include a:
- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- Psychiatric hospital
- Residential treatment facility for substance use disorder
- Residential treatment facility for mental disorders
- Extended care facility
- Intermediate care facility
- Skilled nursing facility

**Hospital stay**
This is your stay of 18 or more hours in a row as a resident bed patient in a hospital.

**Illness or illnesses**
Poor health resulting from disease of the body or mind.

**In-network dental provider**
A dental provider listed in the directory for your plan.

**In-network pharmacy**
A retail pharmacy, mail order pharmacy or specialty pharmacy that has contracted with Aetna, an affiliate, or a third party vendor, to provide outpatient prescription drugs to you.

**In-network provider**
A provider listed in the directory for your plan. However, a NAP provider listed in the NAP directory is not an in-network provider.

**Infertile or infertility**
A disease defined by the failure to carry a pregnancy to live birth or to become pregnant:
- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male with or without a female partner, after:
  - Unsuccessfully being able to impregnate a female

**Injectable drug(s)**
These are prescription drugs when an oral alternative drug is not available.
Injury or injuries
Physical damage done to a person or part of their body.

Institutes of excellence™ (IOE) facility
A facility designated by Aetna in the provider directory as Institutes of Excellence in-network provider for specific services or procedures.

Intensive care unit
A ward, unit, or area in a hospital which is set aside to provide continuous specialized or intensive care services to your because your illness or injury is severe enough to require such care.

Intensive outpatient program (IOP)
The clinical treatment provided must be:
- No more than 5 days per week
- No more than 19 hours per week
- A minimum of 2 hours each treatment day

Services must be medically necessary and delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a mental disorder or substance use disorders issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder
This is:
- A disorder of the jaw joint
- A Myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

L.P.N.
A licensed practical nurse or a licensed vocational nurse.

Lifetime maximum
This is the most this plan will pay for eligible health services incurred by a covered person during their lifetime. Lifetime maximums do not apply to essential health benefits as classified by the Affordable Care Act (ACA) unless permitted.

Mail order pharmacy
A pharmacy where prescription drugs are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit
The maximum out-of-pocket amount for payment of copayments and coinsurance including any policy year deductible, to be paid by you per policy year for eligible health services.
**Medically necessary/Medical necessity**

Health care services and supplies that we determine a provider exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness or injury, or its symptoms, and that we determine are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness or injury
- Not primarily for the convenience of the patient, physician, or other health care provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness or injury
- With respect to substance use disorder, in accordance with an evidence-based and peer reviewed clinical review tool as designated in regulation by the Commissioner of Human Services

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, including physician and dental provider specialty society recommendations
- Consistent with the standards set forth in policy issues involving clinical judgment

With respect to substance use disorder your provider will determine medical necessity for the first 180 days of treatment.

**Medicare**

As used in this plan, Medicare means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

**Mental disorder**

A mental disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.

**Morbid obesity/Morbidly obese**

This means the body mass index is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea or
- Diabetes
Negotiated charge

Health coverage
This is either:

- The amount an in-network provider has agreed to accept
- The amount we agree to pay directly to an in-network provider or third party vendor (including any administrative fee in the amount paid)

for providing services, prescription drugs or supplies to covered persons in the plan. This does not include prescription drug services from an in-network pharmacy.

The negotiated charge does not reflect any amount an affiliate or we may receive under a rebate arrangement between us or an affiliate and a drug manufacturer for any prescription drug. The rebates will not change the negotiated charge under this plan.

Prescription drug coverage from an in-network pharmacy

In-network pharmacy
The amount we established for each prescription drug obtained from an in-network pharmacy under this plan. This negotiated charge may reflect amounts we agreed to pay directly to the in-network pharmacy or to a third party vendor for the prescription drug, and may include an additional service or risk charge set by us.

The negotiated charge does not reflect any amount an affiliate or we may receive under a rebate arrangement between us, an affiliate or a third party vendor and a drug manufacturer for any prescription drug, including prescription drugs on the preferred drug guide.

We may receive rebates from the manufacturers of prescription drugs and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the negotiated charge under this plan.

Non-preferred drug
A prescription drug or device that may have a higher out-of-pocket cost than a preferred drug.

Out-of-network dental provider
A dental provider who is not an in-network dental provider and does not appear in the directory for your plan.

Out-of-network pharmacy
A pharmacy that is not an in-network pharmacy, a National Advantage Program (NAP) provider and does not appear in the directory for your plan.

Out-of-network provider
A provider who is not an in-network provider or National Advantage Program (NAP) provider and does not appear in the directory for your plan.

Partial hospitalization treatment
Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. Services must be medically necessary and provided by a behavioral health provider with the appropriate license or credentials. Services are designed to address a mental disorder or substance use disorders issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Care is delivered according to accepted medical practice for the condition of the person.
Pharmacy
An establishment where prescription drugs are legally dispensed. This includes an in-network retail pharmacy, mail order pharmacy and specialty pharmacy. It also includes an out-of-network retail pharmacy.

Physician
A skilled health professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

For the purpose of applied behavior analysis (ABA) as included in the Autism spectrum disorder and other developmental disabilities section, physician also means a person who is credentialed by the national Behavior Analyst Certification Board as a:
• Board certified behavior analyst
• Doctoral
• Board certified behavior analyst

Policyholder
The school named on the front page of the student policy and your certificate of coverage and schedule of benefits for the purpose of coverage under the student policy.

Policy year
This is the period of time from anniversary date to anniversary date of the student policy except in the first year when it is the period of time from the effective date to the first anniversary date.

Policy year deductible
The amount you pay for eligible health services per policy year before your plan starts to pay as listed in the schedule of benefits.

Precertification, precertify
A requirement that you or your physician contact Aetna before you receive coverage for certain services. This may include a determination by us as to whether the service is medically necessary and eligible for coverage.

Preferred drug
A prescription drug or device that may have a lower out-of-pocket cost than a non-preferred drug.

Preferred drug guide
A list of prescription drugs and devices established by Aetna or an affiliate. It does not include all prescription drugs and devices. This list can be reviewed and changed by Aetna or an affiliate. A drug may be excluded if it has not been proven as safe and effective to treat your symptom(s) and does not have a therapeutic advantage over other drugs in the preferred drug guide. The decision is based on the American Hospital Formulary Service Drug Information or the United States Pharmacopoeia - Drug Information. Call Member Services at the toll-free number on your ID card in the How to contact us for help section to ask for a written explanation of the reason the drug is not covered. A copy of the preferred drug guide is available at your request. You can also find it on the Aetna website at www.aetnastudenthealth.com/formulary.

Preferred in-network pharmacy
A network retail pharmacy that Aetna has identified as a preferred in-network pharmacy.
Premium
The amount you or the policyholder are required to pay to Aetna to continue coverage.

Prescriber
Any provider acting within the scope of his or her license, who has the legal authority to write an order for outpatient prescription drugs.

Prescription
As to hearing care:
A written order for the dispensing of prescription electronic hearing aids by otolaryngologist, otologist or audiologist.

As to prescription drugs:
A written order for the dispensing of a prescription drug or device by a prescriber. If it is a verbal order, it must promptly be put in writing by the in-network pharmacy.

As to vision care:
A written order for the dispensing of prescription lenses or prescription contact lenses by an ophthalmologist or optometrist.

Prescription drug
An FDA approved drug or biological which can only be dispensed by prescription.

Proton pump inhibitors (PPI)
These are medications that work by reducing the amount of stomach acid made by glands in the lining of your stomach.

Provider(s)
A physician, other health professional, hospital, skilled nursing facility, home health care agency, pharmacy, or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric hospital
An institution specifically licensed as a psychiatric hospital by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of substance use disorders and mental disorders.

Mental disorder includes related substance use disorders.

Psychiatrist
A psychiatrist generally provides evaluation and treatment of mental, emotional, or behavioral disorders including substance use disorders.
Recognized charge
The amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The recognized charge depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the recognized charge for specific services or supplies:

<table>
<thead>
<tr>
<th>Service or supply</th>
<th>Recognized charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional services and other services or supplies not mentioned below</td>
<td>105% of the Medicare allowed rate</td>
</tr>
<tr>
<td>Services of hospitals and other facilities</td>
<td>105% of the Medicare allowed rate</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>100% of the average wholesale price (AWP)</td>
</tr>
<tr>
<td>Dental expenses</td>
<td>80% of the prevailing charge rate</td>
</tr>
</tbody>
</table>

Important note: If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.

Special terms used
- Average wholesale price (AWP) is the current average wholesale price of a prescription drug listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by Aetna).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other providers charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply
- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.
Our reimbursement policies
We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the recognized charge. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider

Our reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits
We have online tools to help decide whether to get care and where. Use the “Estimate the Cost of Care” tool on Aetna. Aetna’s secure website at www.aetnastudenthealth.com may contain additional information that can help you determine the cost of a service or supply. Log on to Aetna to access the “Estimate the Cost of Care” feature. Within this feature, view our “Cost of Care” and “Member Payment Estimator” tools.

R.N.
A registered nurse.

Residential treatment facility (mental disorders)

- An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by Aetna or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)
In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating mental disorders:

- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)

Residential treatment facility (substance use disorders)
An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for substance use disorders residential treatment programs. And is credentialed by Aetna or accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for substance use disorders residential treatment programs:

- A behavioral health provider or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a physician
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)

In addition to the above requirements, for substance use detoxification programs within a residential setting:

- An R.N. must be onsite 24 hours per day for 7 days a week within a residential setting
- Residential care must be provided under the direct supervision of a physician

Respite care
This is care provided to you when you have a terminal illness for the sole purpose of providing temporary relief to your family (or other care givers) from the daily demands of caring for you.

Retail pharmacy
A community pharmacy that dispenses outpatient prescription drugs at retail prices.

Room and board
A facility’s charge for your overnight stay and other services and supplies expressed as a daily or weekly rate.

School health services
Any:

- Organization
- Facility
- Clinic
- Pharmacy

that is operated, maintained, or supported by the policyholder (or other entity under contract to the policyholder) which provides health care services to covered students. School health services will either provide or coordinate the care provided to covered students.
**Semi-private room rate**
An institution’s **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, **Aetna** will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

**Service area**
The geographic area where **in-network providers** for this plan are located.

**Skilled nursing facility**
A facility specifically licensed as a **skilled nursing facility** by applicable state and federal laws to provide skilled nursing care.

**Skilled nursing facilities** also include rehabilitation **hospitals**, and portions of a rehabilitation **hospital** and a **hospital** designated for skilled or rehabilitation therapy services.

**Skilled nursing facility** does not include institutions that provide only:
- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of **mental disorders** or **substance use disorders**.

A **skilled nursing facility** may also be referred to as an **extended care facility**.

**Skilled nursing services**
Services provided by an **R.N.** or **L.P.N.** within the scope of his or her license.

**Sound natural teeth**
These are natural teeth. If there is a filling in a tooth, the major portion of the tooth must be present. A tooth cannot be decayed, abscessed, or defective. Sound natural teeth are not capped teeth, implants, crowns, bridges, or dentures.

**Specialist**
A **physician** who practices in any generally accepted medical or surgical sub-specialty and is board-certified.

**Specialty prescription drugs**
These are **prescription drugs** that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

You can access the list of these **specialty prescription drugs** by calling Member Services at the toll-free number on your ID card or by logging on to your Aetna secure website at **www.aetnastudenthealth.com**.

**Specialty pharmacy**
This is a **pharmacy** designated by Aetna as an **in-network pharmacy** to fill **prescriptions** for **specialty prescription drugs**.
Stay
A full-time inpatient confinement for which a room and board charge is made.

Student policy
The student policy consists of several documents taken together. The list of documents can be found in the Entire student policy section of this certificate of coverage.

Substance use disorders
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent including withdrawal. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a mental disorder that are a focus of attention or treatment. Or an addiction to nicotine products, food or caffeine intoxication.

Surgery center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient surgery services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Surgery, surgeries or surgical procedures
The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as:
- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution or
- Otherwise physically changing body tissues and organs

Telehealth
The use of information and communication technologies such as:
- Telephones
- Remote patient monitoring devices
- Other electronic means

to support:
- Clinical health care
- Provider consultation
- Patient and professional health-related education
- Public health
- Health administration
- Other services
Telemedicine
The delivery of health services using:
- Electronic communications
- Information technology
- Other electronic or technological means

to bridge the gap between a provider and you, either with or without the assistance of another provider in accordance with New Jersey state law.

Temporomandibular joint dysfunction (TMJ)
This is a disorder of the jaw joint.

Terminal illness
A medical prognosis that you are not likely to live more than 12 months.

Urgent care facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an urgent condition.

Urgent condition
An illness or injury that requires prompt medical attention but is not an emergency medical condition.

Urgent admission
This is an admission to the hospital due to an illness or injury that is severe enough to require a stay in a hospital within 2 weeks from the date the need for the stay becomes apparent.

Walk-in clinic
A free-standing health care facility. Neither of the following should be considered a walk-in clinic:
- An emergency room
- The outpatient department of a hospital
Aetna Health and Life Insurance Company

Student Health – Medical and Outpatient Prescription Drug PPO Insurance
Certificate of Coverage Amendment

Policyholder: The College of New Jersey - Early Arrival

Student policy number: 686165

Effective date: 08/01/2020

Your student policy has changed. The certificate of coverage and schedule of benefits is revised to reflect this. The changes are effective on the date shown above.

The changes are as follows:

1. The How your plan works while you are covered for in-network coverage section is replaced with the following:

How your plan works while you are covered for in-network coverage
Your in-network coverage helps you:
• Get and pay for a lot of – but not all – health care services
• Pay less cost share when you use an in-network provider

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

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

2. The active attendance paragraphs in the Who the plan covers – Who is eligible section are replaced with the following:

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)
3. The following changes apply to the list of services requiring precertification, as shown in the Precertification – What types of services and supplies require precertification section:
   - “Home health care” is added to the outpatient services list
   - “Hospice services” is added to the outpatient services list
   - “Outpatient detoxification” is removed from the list

4. The Preventive care immunizations benefit in the Eligible health services under your plan – Preventive care and wellness section is replaced by the following:

   **Preventive care immunizations**

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

   Your plan does not cover immunizations that are not considered preventive care.

5. The Well woman preventive visits benefit in the Eligible health services under your plan – Preventive care and wellness section is replaced by the following:

   **Well woman preventive visits**

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

6. The Physician and specialist services (non-surgical and non-preventive) provision in the Physicians and other health professionals section is replaced by the following:

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

   **Eligible health services** include services provided by your physician to treat an illness or injury such as radiological supplies, services and tests. You can get those services:
   - At the physician’s or specialist’s office
   - In your home
   - From any other inpatient or outpatient facility
   - By way of telemedicine and/or telehealth
7. The *When does your plan cover missing teeth that are not replaced* provision in the *Eligible health services under your plan – Pediatric dental care* section is replaced by the following:

**When does your plan cover missing teeth that are not replaced?**

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

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

8. The *Well newborn nursery care* provision in the *Eligible health services under your plan – Specific conditions* section is replaced by the following:

**Well newborn nursery care**

*Eligible health services* include routine care of your well newborn child in a hospital or birthing center such as:

- Well newborn nursery care during the mother’s stay but for not more than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery
- Services and supplies needed for circumcision by a provider
- Hospital or birthing center visits and consultations for the well newborn by a physician but for not more than 1 visit per day

9. The outpatient *Mental health treatment* benefit in the *Eligible health services under your plan – Specific conditions* section is replaced by the following:

**Mental health treatment**

- Outpatient treatment received while not confined as an inpatient in a general medical hospital, psychiatric hospital, or residential treatment facility, including:
  - Office visits to a provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine and/or telehealth consultations) Individual, group and family therapies for the treatment of mental health
  - Other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your physician orders them
      - The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
- Neuropsychological testing
- 23 hour observation
- Peer counseling support by a peer support specialist
  - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

10. The outpatient Substance use disorders treatment benefit in the Eligible health services under your plan – Specific conditions section is replaced by the following:

Substance use disorders treatment
- Outpatient treatment received while not confined as an inpatient in a general medical hospital, psychiatric hospital or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine and/or telehealth consultations) Individual, group and family therapies for the treatment of substance use disorder
  - Other outpatient substance use disorder treatment such as:
    - Outpatient detoxification
    - Partial hospitalization treatment provided in a facility or program for treatment of substance use disorder provided under the direction of a physician
    - Intensive outpatient program provided in a facility or program for treatment of substance use disorder provided under the direction of a physician
    - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other substance use disorder, including administration of medications
    - Treatment of withdrawal symptoms
    - 23 hour observation
    - Peer counseling support by a peer support specialist
      - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

11. The Transplant services benefit in the Eligible health services under your plan – Specific conditions section is replaced by the following:

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

This includes the following transplant types:
- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy for FDA-approved treatments

Network of transplant facilities
We designate facilities to provide specific services or procedures. They are listed as Institutes of Excellence™ (IOE) facilities in your provider directory.
The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the IOE facility we designate to perform the transplant you need. You may also get transplant services at a non-IOE facility, but your cost share will be higher.

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

**Travel and lodging expenses**
If an IOE patient lives 100 or more miles from the IOE facility, eligible health services include travel and lodging expenses for the IOE patient and a companion to travel between the IOE patient’s home and the IOE facility. Eligible health services will be reimbursed by the plan and include coach class round-trip air, train, or bus travel and lodging costs.

12. The Blood and body fluid exposure exclusion in the What your plan doesn’t cover – eligible health service exceptions and exclusions section is replaced by the following:

**Blood and body fluid exposure**
- Services and supplies provided for the treatment of an illness that results from your clinical related injury

13. The Cornea or cartilage transplants exclusion in the What your plan doesn’t cover – eligible health service exceptions and exclusions section is replaced by the following:

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

14. The Custodial care exclusion in the What your plan doesn’t cover – eligible health service exceptions and exclusions section is replaced by the following:

**Custodial care**
Examples 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
15. **Transplant services**

   The Transplant services exclusion in the *What your plan doesn’t cover – eligible health service exceptions and exclusions* section is replaced by the following:

   **Transplant services**
   - 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

16. **Immunizations related to travel or work**

   The *Immunizations related to travel or work* exclusion in the *What your plan doesn’t cover – eligible health service exceptions and exclusions – Exceptions and exclusions that apply to outpatient prescription drugs* section is replaced by the following:

   **Immunizations related to travel or work**

17. The first paragraph of the *Who provides the care* section is replaced by the following paragraphs:

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

18. **In-network providers**

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

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

   You may select an *in-network provider* from the *directory* through your *Aetna* secure website at www.aetnastudenthealth.com. You can search our online *directory*, for names and locations of *providers* or contact Member Services at the toll-free number on your ID card.

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

19. **Your coverage can change**

   **Your coverage can change** in the *General provisions – other things you should know* section is replaced by the following:

   **Your coverage can change**

   Your coverage is defined by the *student policy*. This document may have amendments or riders too. Under certain circumstances, we or the *policyholder* or the law may change your plan according to requirements of the *student policy*. When an emergency or epidemic is declared, we may modify or waive *precertification*, *prescription* quantity limits or your cost share if you are affected. Only *Aetna* may waive a requirement of your plan. No other person – including the *policyholder* or *provider* – can do this.
Definitions for the terms “Negotiated charge” in the Glossary section are replaced by the following:

**Negotiated charge**

*Health coverage*

This is either:

- The amount an in-network provider has agreed to accept
- The amount we agree to pay directly to an in-network provider or third party vendor (including any administrative fee in the amount paid)

for providing services, prescription drugs or supplies to covered persons in the plan. This does not include prescription drug services from an in-network pharmacy.

*Prescription drug coverage from an in-network pharmacy*

*In-network pharmacy*

The amount we established for each prescription drug obtained from an in-network pharmacy under this plan. This negotiated charge may reflect amounts we agreed to pay directly to the in-network pharmacy or to a third party vendor for the prescription drug, and may include a rebate, an additional service or risk charge set by us.

We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may change the negotiated charge under this plan.

This amendment makes no other changes to the student policy, certificate of coverage, or schedule of benefits.

Karen S. Lynch  
President  
Aetna Life Insurance Company  
(A Stock Company)

NJ Cert Amendment  
Amendment 1  
Issue Date 12/25/2020
Aetna Health and Life Insurance Company

Student Health – Medical and Outpatient Prescription Drug PPO Insurance Certificate of Coverage Amendment

Policyholder: The College of New Jersey - Early Arrival

Student policy number: 686165

Effective date: 08/01/2020

The student policy has changed. The certificate of coverage and schedule of benefits are revised to reflect this. The changes are effective on the date shown above.

The changes are as follows:

1. The Medically necessary; medical necessity provision in the Medical necessity and precertification requirements section is replaced by the following:

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

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

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

2. The following item is added to the list of services requiring inpatient and outpatient precertification in the What types of services and supplies require precertification provision in the Medical necessity and precertification requirements section:

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

3. The following paragraph is added to the Precertification for medical services and supplies provision in the Medical necessity and precertification requirements section:

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

Walk-in clinic (non-emergency visit)
Eligible health services include, but are not limited to, health care services provided at walk-in clinics for:

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

Gene-based, cellular and other innovative therapies (GCIT)
Eligible health services include GCIT provided by a physician, hospital or other provider.

Key Terms
Here are some key terms we use in this section. These will help you better understand GCIT.

Gene
A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Molecular
Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Therapeutic
Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. We call these “GCIT services.”

Eligible health services for GCIT include:

- Cellular immunotherapies.
- Genetically modified viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain conditions.
- All human gene therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza® (Nusinersen).
  - siRNA.
  - mRNA.
  - microRNA therapies.

**Facilities/providers for gene-based, cellular and other innovative therapies**

We designate facilities to provide GCIT services or procedures. GCIT physicians, hospitals and other providers are GCIT-designated facilities/providers for Aetna and CVS Health.

**Important note:**

You must get GCIT eligible health services from the GCIT-designated facility/provider. If there are no GCIT-designated facilities/providers assigned in your local network, we will arrange for and coordinate your care at a GCIT-designated facility/provider. If you don’t get your GCIT services at the facility/provider we designate, the services will not be covered.

6. The following paragraph is added after the *What outpatient prescription drugs are covered* provision in the *Eligible health services under your plan – Outpatient prescription drugs* section:

**Prescription drug synchronization**

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

7. The *Mental health treatment* exclusion in the *What your plan doesn’t cover – Eligible health service exceptions and exclusions – General exceptions and exclusions* section is renamed as *Behavioral health treatment* and is replaced by the following:

**Behavioral health treatment**

- Services for the following categories (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association):
  - Stay in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
  - 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
  - Transportation

8. The following exclusions are removed from the *What your plan doesn’t cover – Eligible health service exceptions and exclusions – General exceptions and exclusions* section:

**Counseling**

- Marriage, religious, family, career, social adjustment, pastoral, or financial counseling

**Early intensive behavioral interventions**

Examples of these services are:

- Certain early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions
9. The “Court-ordered services and supplies,” “Educational services,” and “Wilderness treatment programs” exclusions in the What your plan doesn’t cover – Eligible health service exceptions and exclusions – General exceptions and exclusions section are replaced by the following:

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

**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 under your plan – Diabetic services and supplies (including equipment and training) section. 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.

**Wilderness treatment programs**
See Educational services within this section

10. The following exclusion is added to the What your plan doesn’t cover – Eligible health service exceptions and exclusions – General exceptions and exclusions section:

**Gene-based, cellular and other innovative therapies (GCIT)**
The following are not eligible health services unless you receive prior written approval from us:
- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the Medical necessity and precertification requirements section.

11. The following exclusion is added to the What your plan doesn’t cover – Eligible health service exceptions and exclusions – General exceptions and exclusions section:

**Mental health and substance use disorders treatment**
- The following categories (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association) are not covered when the condition is due to physical condition consistent with the DSM:
  - Sexual deviations and disorders except for gender identity disorders
  - Pathological gambling, kleptomania, pyromania
  - Specific developmental disabilities of scholastic skills (learning disorders/learning disabilities)
  - Specific developmental disabilities of motor functions
  - Specific developmental disabilities of speech and language
  - Other disorders of psychological development
12. The *Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps* exclusion in the *What your plan doesn't cover – Eligible health service exceptions and exclusions – Exceptions and exclusions that apply to outpatient prescription drugs* section is replaced by the following:

**Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps** except as specifically provided in the *Eligible health services under your plan – Diabetic services and supplies (including equipment and training)* section

13. The *When will your coverage end* provision in the *When coverage ends* section is replaced by the following:

**When will your coverage end?**

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

- This plan is discontinued
- The *student policy* ends
- You are no longer eligible for coverage
- The last day for which any required *premium* contribution has been paid
- You withdraw from school because of entering the armed forces of any country

If you withdraw from school because you have entered the armed forces, *premiums* will be refunded, on a pro-rata basis, when we receive your application within 31 days from the date of the withdrawal.

14. Definitions for the terms “Mental disorder,” “Negotiated charge,” and “Walk-in clinic” in the *Glossary* section are replaced by the following:

**Mental health condition**

A *mental health condition* as defined to be consistent with the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) Fifth Edition, and any subsequent editions published by the American Psychiatric Association.

**Negotiated charge**

*Health coverage*

This is either:

- The amount an *in-network provider* has agreed to accept
- The amount we agree to pay directly to an *in-network provider* or third party vendor (including any administrative fee in the amount paid)

for providing services, *prescription drugs* or supplies to *covered persons* in the plan. This does not include *prescription drug* services from an *in-network pharmacy*.

We may enter into arrangements with *in-network providers* or others related to:

- The coordination of care for *covered persons*
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing

These arrangements will not change the *negotiated charge* under this plan.
**Prescription drug coverage from an in-network pharmacy**

In-network pharmacy

The amount we established for each **prescription drug** obtained from an **in-network pharmacy** under this plan. This **negotiated charge** may reflect amounts we agreed to pay directly to the **in-network pharmacy** or to a third party vendor for the **prescription drug**, and may include a rebate, an additional service or risk charge set by us.

We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may change the **negotiated charge** under this plan.

**Walk-in clinic**

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near, or within a:

- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- Hospital
- Outpatient department of a **hospital**
- Physician’s office
- Urgent care facility

15. The explanation for “Medicare allowed rates” in the **Glossary – Recognized charge – Special terms used** section is replaced by the following:

- **Medicare** allowed rates are the rates CMS establishes for services and supplies provided to **Medicare** enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If **Medicare** does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set **Medicare** rates
  - What other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply

When the **recognized charge** is based on a percentage of the **Medicare** allowed rate, it is not affected by adjustments or incentives given to **providers** under **Medicare** programs.

16. The method for calculating the recognized charge for GCIT in the **Glossary – Recognized charge** is added to the following:

<table>
<thead>
<tr>
<th>Service or supply</th>
<th>Recognized charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional services and other services or supplies not mentioned below</td>
<td>105% of the <strong>Medicare</strong> allowed rate</td>
</tr>
<tr>
<td>Services of <strong>hospitals</strong> and other facilities</td>
<td>105% of the <strong>Medicare</strong> allowed rate</td>
</tr>
<tr>
<td><strong>Prescription drugs</strong></td>
<td>100% of the average wholesale price (AWP)</td>
</tr>
<tr>
<td>Dental expenses</td>
<td>80% of the prevailing charge rate</td>
</tr>
</tbody>
</table>

**Important note:** If the **provider** bills less than the amount calculated using the method above, the **recognized charge** is what the **provider** bills.
17. The *Policy year deductibles* provision of the schedule of benefits has changed as follows:

<table>
<thead>
<tr>
<th>Policy year deductibles</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have to meet your <em>policy year deductible</em> before this plan pays for benefits.</td>
</tr>
<tr>
<td><strong>Student</strong></td>
</tr>
</tbody>
</table>

18. The *Pregnancy complications* provision of the schedule of benefits provision is replaced as follows:

<table>
<thead>
<tr>
<th>Pregnancy complications</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Pregnancy complications</em> Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

19. The following *Gene-based, cellular and other innovative therapies (GCIT)* provision is added to the schedule of benefits.

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage (GCIT-designated facility/provider)*</th>
<th>Out-of-network coverage (GCIT non-designated facility/provider)*</th>
<th>Out-of-network coverage *</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gene-based, cellular and other innovative therapies (GCIT)</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

This amendment makes no other changes to the *student policy*, certificate of coverage, or schedule of benefits.

Karen S. Lynch  
President  
Aetna Life Insurance Company  
(A Stock Company)  
NJ Cert Amendment  
Amendment 2  
Issue Date 12/25/2020
Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call the number listed on your ID card at no cost.

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 complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

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

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)


Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.
<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>To access language services at no cost to you, call the number on your ID</td>
</tr>
<tr>
<td>Albanian</td>
<td>Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit.</td>
</tr>
<tr>
<td>Amharic</td>
<td>የቋንቋ ማስፋልት ያለበት እምወጣ ያቀረበ የአማርኛ የሚሰጥበት ትራንስፋርባን ይቻላል።</td>
</tr>
<tr>
<td>Arabic</td>
<td>للحصول على الخدمات اللغوية دون أي تكلفة, الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.</td>
</tr>
<tr>
<td>Armenian</td>
<td>Ձեր նախընտրած լեզվով ավաճառ խորհրդատություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հեռախոսահամարով.</td>
</tr>
<tr>
<td>Bantu-Kirundi</td>
<td>Kugira uronke serivisi z’indimi ata kiguzi, hamagara inomero iri ku karangamuntu kawe.</td>
</tr>
<tr>
<td>Bengali</td>
<td>আপনার বিনামূল্যের ভাষা সেবার প্রবেশ করতে হলে আপনার ভাষার কার্ডের নম্বর দেওয়ার জন্য টেলিফোন করুন।</td>
</tr>
<tr>
<td>Burmese</td>
<td>သင့်အားလုံးနောက်လို့ပါ အရပ္အဆိုးအပါအဝင် အနေဖြင့်-ID ကို အနီးစပ်အပ်ပါ။</td>
</tr>
<tr>
<td>Catalan</td>
<td>Per accedir a serveis lingüístics sense cap cost per a vostè, telefoni al número indicat a la seva targeta d’identificació.</td>
</tr>
<tr>
<td>Cebuano</td>
<td>Aron maakses ang mga serbisyo sa lengguwahe nga wala kay bayran, tawagi ang numero nga anaa sa imong kard sa ID.</td>
</tr>
<tr>
<td>Chamorro</td>
<td>Para un hago’i setbision lengguahí ni dibátde para hågu, ágang i numiru gi iyo-mu kard aidentifikasion.</td>
</tr>
<tr>
<td>Cherokee</td>
<td>ḏᏩᎩᏍᏗ ᎨᏬᏂᏍᎩ ᎮᏬᏂᏍᎩ Ꮽ(IServiceCollection ᏝᏗᏭᏛᏗᏛ ᏝᏗᏭᎳᏗ, ᏭᏝᏗᏭᏛᏗᏛ ᏝᏚᏗᏭᏛᏗᏛ ᏝᏇᏗᏭᏛᏗᏛ.</td>
</tr>
<tr>
<td>Chinese Traditional</td>
<td>如欲使用免費語言服務，請撥打您健康保健康保險卡上所列的電話號碼</td>
</tr>
<tr>
<td>Choctaw</td>
<td>Anumpa tosholi i toksvli ya peh pilla ho ish i payahinla kvt chi holisso kallo iskitini holhteni takanli ma i payah</td>
</tr>
<tr>
<td>Chuukese</td>
<td>Ren omw kopwe angei aninisin eman chon awewe (ese kamé), kopwe kééri ewe nampa mei mak won noum ena katen ID</td>
</tr>
<tr>
<td>Cushitic-Oromo</td>
<td>Tajaajilootta afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraqqaa eenyummma (ID) kee irraa jiruun bilbili.</td>
</tr>
<tr>
<td>Dutch</td>
<td>Voor gratis taaldiensten, bel het nummer op uw ziekteverzekeringskaart.</td>
</tr>
<tr>
<td>French</td>
<td>Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d’assurance santé.</td>
</tr>
<tr>
<td>French Creole (Haitian)</td>
<td>Pou ou jwenn sëvis gratis nan lang ou, rele nimewo telefon ki sou kat identifikasyon asirans sante ou.</td>
</tr>
<tr>
<td>German</td>
<td>Um auf den für Sie kostenlosen Sprachservice auf Deutsch zugreifen, rufen Sie die Nummer auf Ihrer-ID-Karte an.</td>
</tr>
<tr>
<td>Greek</td>
<td>Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισης σας.</td>
</tr>
<tr>
<td>Language</td>
<td>Text</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Gujarati</td>
<td>તમારે કોઇ પણ જાતના બોલ વિશે સેવાઓ મળવા માટે, તમારા આઇડિય કે ફોન નંબર પર કોલ કરો.</td>
</tr>
<tr>
<td>Hawaiian</td>
<td>No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i ka helu kelepona ma käu käleka ID. Käki ‘ole ‘ia keia kókua nei.</td>
</tr>
<tr>
<td>Hindi</td>
<td>बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।</td>
</tr>
<tr>
<td>Hmong</td>
<td>Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.</td>
</tr>
<tr>
<td>Igbo</td>
<td>Inweta enyemaka asụsụ na akwughi ugwo obula, kpoo nomba no na kaadi njirimara gi</td>
</tr>
<tr>
<td>Ilocano</td>
<td>Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.</td>
</tr>
<tr>
<td>Indonesian</td>
<td>Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.</td>
</tr>
<tr>
<td>Italian</td>
<td>Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.</td>
</tr>
<tr>
<td>Japanese</td>
<td>無料の言語サービスは、IDカードにある番号にお電話ください。</td>
</tr>
<tr>
<td>Karen</td>
<td>vXw&gt;urRM&gt;usdmw&gt;RpXRtw&gt;zH&gt;w&gt;Rwz. vXwdt.D;tyShRvXeub.h.tDRt*D}&gt;&lt;ud;b.vDwJpdeD.*H&gt;vXttd.vXecd.*DR A (ID) tvdRM.wuh&gt;I</td>
</tr>
<tr>
<td>Korean</td>
<td>무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.</td>
</tr>
<tr>
<td>Kru-Bassa</td>
<td>I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matible</td>
</tr>
<tr>
<td>Kurdish</td>
<td>بو دمسيراكيمشين بە خزمانگوزاري زمان بەی تیجوون بۆتو، پەیوەندی بێک بە زمارەی سەر نای (ID) کارتی چونتو.</td>
</tr>
<tr>
<td>Lao</td>
<td>ການ收取免費語言服務，請電話至保單上的保險識別證</td>
</tr>
<tr>
<td>Language</td>
<td>Translation</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Nilotic-Dinka</td>
<td>Të koor yïn ran de wëér de thökic ke cin wëu kor keek tênoŋ yïn. Ke yïn cäl ran ye koc kuony nê namba de abac tô nê ID kard duôn de tïït de nyin de panakim kou.</td>
</tr>
<tr>
<td>Norwegian</td>
<td>For tilgang til kostnadsfri språktenester, ring nummeret på ID-kortet ditt.</td>
</tr>
<tr>
<td>Pennsylvanian-Dutch</td>
<td>Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.</td>
</tr>
<tr>
<td>Persian Farsi</td>
<td>برای دسترسی به خدمات زبان به طور رایگان، با شماره فید شده روی کارت شناسایی خود تماس بگیرید.</td>
</tr>
<tr>
<td>Polish</td>
<td>Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.</td>
</tr>
<tr>
<td>Portuguese</td>
<td>Para acceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.</td>
</tr>
<tr>
<td>Punjabi</td>
<td>ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਬਿਸੇ ਿੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਿੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਲਈ, ਅਪਨੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਫ਼ੋਨ ਦੇਈ ਦੇਈ ਬਣੇ।</td>
</tr>
<tr>
<td>Romanian</td>
<td>Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul de membru.</td>
</tr>
<tr>
<td>Russian</td>
<td>Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.</td>
</tr>
<tr>
<td>Samoan</td>
<td>Mō le mauina o ‘au’auaga tau gagana e aunoa ma se totogi, vala’au le numera i luga o lau pepa ID.</td>
</tr>
<tr>
<td>Serbo-Croatian</td>
<td>Za besplatne prevodića usluge pozovite broj naveden na Vašoj identifikacionoj kartici.</td>
</tr>
<tr>
<td>Spanish</td>
<td>Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.</td>
</tr>
<tr>
<td>Sudanic Fulfulde</td>
<td>Heeba a naasta nder ekiitol jaangirde woldeji walla yobugo, ewnu lamba je don windi ha do dërowol maada.</td>
</tr>
<tr>
<td>Swahili</td>
<td>Kupata huduma za lugha bila malipo kwako, piga nambari iliyo kwenye kadi yako ya kitambulisho.</td>
</tr>
<tr>
<td>Syriac-Assyrian</td>
<td>ܬܘܼܢ ܥܼܲܠ ܚܸܠܡܼܲܬ ܹ̈ܐ ܕܗܼܲܝܼܲܪܬܵܐ ܒܠܸܫܵܢܵܐ ܡܼܲܓܵܢܵܐܝܼܬ، ܐܸܢ ܣܢܝܼܩܵܐ ܝ ܩܪܝܼܡܘܲܢ ܡܸܢܝܵܢܵܐ ܥܼܲܠ ܦܸܬܩܵܐ ܚܹܲܕܵܡܵܝܘܼܬܵܐ ܕܝܼܵܘܟܼܘܲܢ.</td>
</tr>
<tr>
<td>Tagalog</td>
<td>Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.</td>
</tr>
<tr>
<td>Telugu</td>
<td>भाषा सेवओं के लिए फ्री किस्म की जरूरत तो है, आप अपने ऐडी कार्ड के पर नंबर को इलेक्ट्रॉनिक करें।</td>
</tr>
<tr>
<td>Thai</td>
<td>หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน</td>
</tr>
<tr>
<td>Tongan</td>
<td>Kapau ‘oku ke fiema’u ta’etötongi ‘a e ngaahi sēvesi kotoa pê he ngaahi lea kotoa, telefoni ki he fika ‘oku ha atu ‘i ho’o ID kaati.</td>
</tr>
<tr>
<td>Turkish</td>
<td>Dil hizmetlerine ücretsiz olarak erişmek için kimlik kartınızdaki numarayı arayın.</td>
</tr>
<tr>
<td>Ukrainian</td>
<td>Щоб безкоштовні отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікаційній картці.</td>
</tr>
<tr>
<td>Urdu</td>
<td>لسانی خدمات نک مُفت رسائی کے لئی، اپنی بیاہم کے ID کا ہیڈر درج نمبر یا کال کریں.</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.</td>
</tr>
<tr>
<td>Yiddish</td>
<td>Зע באקומען שפראך סערוויסעס פריי פון אפצאל, רופט דעם נומער אוייק אידער 1D קארטלא.</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Yoruba</td>
<td>Láti ráyèsí àwọn isé ède fun ọ lọfẹ, pe nóṃbà tó wà lóri káàdì idánimọ̀ rẹ.</td>
</tr>
</tbody>
</table>
Residents of Nevada who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in the state to write these types of insurance are members of the Nevada Life and Health Insurance Guaranty Association (Association). The purpose of the Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association assesses its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is not unlimited, however, and, as noted in the box below, this protection is not a substitute for consumers’ care in selecting companies that are well-managed and financially stable.

The Nevada Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations and exclusions, and require continued residency in Nevada. A person should not rely on coverage by the Association when selecting an insurance company or when selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the Insurer or for which the policyholder has assumed the risk, such as a variable contract sold by prospectus.

Insurance companies are required by law to deliver this notice to you. However, insurance companies and their agents are prohibited by law from using the existence of the Association for sales, solicitation or to induce the purchase of any kind of insurance policy.

The state law that provides for this safety-net coverage is called the Nevada Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law’s coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone’s rights or obligations under the act or the rights or obligations of the Association. Anyone may obtain additional information from the Association or file a complaint with the Commissioner of Insurance, at the applicable address listed below, to allege a violation of any provision of the Nevada Life and Health Insurance Guaranty Association Act.

The Nevada Life and Health Insurance Guaranty Association
P.O. Box 3302
Reno, Nevada 89505

Commissioner of Insurance, State of Nevada
Department of Business and Industry, Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, Nevada 89706
**Coverage**
Generally, individuals will be protected by the Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of the insured persons are protected as well even if they live in another state.

**Exclusions from Coverage**
However, persons holding such policies are NOT protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured’s who live outside the state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a nonprofit hospital or medical service organization, a health maintenance organization (HMO), a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does NOT provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers’ plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals), other than an annuity owned by a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code 26 U.S.C. &§ 401, 403(b) and 457, respectively, or trustees of such a plan; or.
- Medicare or Medicare Advantage contracts

**Limits on Amount of Coverage**
The act also limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to life insurance policies on any one insured life, the Association will pay a maximum of $300,000, regardless of how many policies and contracts there are with the same company, and even if they provide different types of coverage. Within this overall $300,000 limit, the Association will not pay more than $100,000 in cash surrender values, or $300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

With respect to annuities, the Association will not pay more than $250,000 in the present value of benefits, including net cash surrender and withdrawal.

With respect to health insurance for any one life, the Association will not pay more than: 1) $100,000 for coverage other than disability insurance, basic hospital, medical and surgical insurance or major medical insurance, including any net cash for surrender or withdrawal; 2) $300,000 for disability insurance or long term care insurance; or 3) $500,000 for basic hospital, medical and surgical insurance or major medical insurance.

With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, the Association will not pay more than $250,000 in present values of benefits from the annuity in the aggregate, including any net cash for surrender or withdrawal.
With respect to each participant in a governmental retirement plan covered by an unallocated annuity contract as described in NRS 686C, the maximum coverage allowed is an aggregate of $250,000 in present-value annuity benefits including the value of net cash for surrender and net cash for withdrawal, regardless of the number of contracts issued by any one member company.

With respect to any one life or person, in no event will the Association be obligated to cover more than: 1) an aggregate of $300,000 in benefits, excluding benefits for basic hospital, medical and surgical insurance or major medical insurance; or 2) an aggregate of $500,000 in benefits, including benefits for basic hospital, medical or surgical insurance or major medical insurance.

With respect to one owner of several non-group policies of life insurance, whether the owner is a natural person or an organization and whether the persons insured are officers, managers, employees or other persons, the Association will not pay more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

FOR MORE INFORMATION AND ANSWERS TO MOST ASKED QUESTIONS,
PLEASE VISIT THE ASSOCIATION’S WEB SITE:

www.nvlifega.org