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Aetna Student Health

Plan Design and Benefits Summary

Open Choice PPO

Cal State Fullerton

CALIFORNIA STATE UNIVERSITY FULLERTON

Policy Year: 2019 - 2020
Policy Number: 867863
www.aetnastudenthealth.com
(877) 480-4161

This is a brief description of the Student Health Plan. The Plan is available for Cal State Fullerton students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate of Coverage issued to you and may be viewed online at **www.aetnastudenthealth.com.** If there is a difference between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

HEALTH SERVICES

Health Services (HS) is the organization responsible for the health care of the students on campus. HS is fully accredited by the Accreditation Association of Ambulatory Health Care and their hours are Monday through Friday 7:30 a.m. to 5:00 p.m.

For more information, call (657) 278-2800. In the event of an emergency, call 911 or the Campus Police at (657) 278-2515.

Coverage Periods

Students: Coverage for all insured students enrolled for coverage in the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated.

Eligible Dependents: Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

International Program

Coverage Period	Coverage Start Date	Coverage End Date
Annual	08/01/2019	07/31/2020
Fall	08/01/2019	12/31/2019
Spring/Summer	01/01/2020	07/31/2020

Non-degree USA/Exchange

Coverage Period	Coverage Start Date	Coverage End Date
Fall	08/01/2019	12/31/2019
Spring	01/01/2020	05/31/2020
Summer	06/01/2020	07/31/2020

Rates

The rates below reflect premiums for the Plan underwritten by Aetna Health and Life Insurance Company (Aetna), as well as Cal State Fullerton administrative fee.

International Program Students and Dependents

	Annual	Fall Semester	Spring/Summer Semester
Student	$2,011.20	$842.30	$1,167.90
Spouse	$1,986.20	$830.30	$1,155.90
One Child	$1,986.20	$830.30	$1,155.90
2 or More Children	$3,972.40	$1,660.60	$2,311.80

Non-degree USA/Exchange

	Fall Semester	Spring Semester	Summer Semester
Student	$842.30	$836.87	$343.03
Spouse	$830.30	$824.87	$331.03
One Child	$830.30	$824.87	$331.03
2 or More Children	$1,660.60	$1,649.74	$662.06

Student Coverage

Eligibility

All international students, visiting faculty, scholars or other persons possessing and maintain a current passport and valid status (F-1, J-1, or M-1) engaged in educational activities at Cal State Fullerton who are temporarily located outside their home country and have not been granted permanent residency status, are eligible to be insured under the Policy. Students must actively attend classes for at least the first 45 days after the date for which coverage is purchased.

Coverage is available for students engaged in "Practical Training". OPT students may purchase a maximum of 12 consecutive months of coverage from the OPT effective date. OPT extension coverage beyond 12 months is not allowed. Enrollment must be completed within 30 days of the expiration of prior coverage on the schools student health insurance plan. A gap in coverage is not allowed. A copy of a valid EAD or OPT application or receipt (I-765 or I-797c) is required to enroll.

Home study, correspondence, Internet classes, and television (TV) courses, do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

Enrollment

Eligible students can enroll in the insurance plan online at www.jcbins.com. For enrollment questions, please call JCB Insurance Solutions customer service at 714-869-2961.

Exception: A Covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro rata refund of premium will be made for such person, and any covered dependents, upon written request received by JCB within 90 days of withdrawal from school.

If you withdraw from school within the first 31 days of a coverage period, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After 31 days, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Dependent Coverage

Eligibility

Dependent eligibility date is same date as student eligibility date. Dependent eligibility expires concurrently with that of the student insured.

Enrollment

To enroll your dependent(s) visit www.jcbins.com and select your school from the homepage and follow the enrollment steps for adding your dependent(s).

Medicare Eligibility Notice

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.

In-network Provider Network

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

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

Precertification

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification.

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 additional details on requirements in the Certificate of Coverage.

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 pre-certify there may be a penalty. Refer to your schedule of benefits for this information. The list of services and supplies requiring precertification appears later in this 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:

Non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
An emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.
Outpatient non-emergency services requiring precertification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Written notification of precertification decisions
We will provide a written notification to you and your **physician** of the **precertification** decision**,** within:

- 5 business days for a non-urgent requests
- 72 hours for urgent requests
- 30 days for retrospective requests

If your **precertified** services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

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 of Certificate of Coverage.

You do not need **precertification** for the following inpatient **stays**:

- Following a mastectomy and/or lymph node dissection (your **physician** will determine the length of your **stay**)
- Pregnancy related **stay f**ollowing the delivery of a baby that is less than 48 hours for a normal vaginal delivery or a 96 hour stay for delivery by caesarean section

What if you don't obtain the required precertification?
If you don't obtain the required **precertification**:

- There may be a benefit penalty. See the schedule of benefits *Precertification covered benefit penalty* section.
- Any benefit penalty incurred will not count toward your **policy year deductibles** or **maximum out-of-pocket limits**.

What types of services and supplies require precertification?

Precertification is required for the following types of services and supplies:

Inpatient services and supplies
Obesity (bariatric) surgery
Stays in a **hospice** facility
Stays in a **hospital**
Stays in a **rehabilitation facility**
Stays in a **residential treatment facility** for treatment of **mental disorders** and **substance abuse**
Stays in a **skilled nursing facility**

**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 in the How to contact us for help section or by logging onto the Aetna website at www.aetnastudenthealth.com.*

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).

Here's how COB works

- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid
- We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable submitted expenses

For more information about the Coordination of Benefits provision, including determining which plan is primary and which is secondary, you may call the Member Services telephone number shown on your ID card. A complete description of the Coordination of Benefits provision is contained in the Policy issued to California State University Fullerton and may be viewed online at www. aetnastudenthealth.com.

Description of Benefits

The Plan excludes coverage for certain services (referred to as exceptions in the certificate of coverage) and has limitations on the amounts it will pay. While this Plan Design and Benefit Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Certificate of Coverage issued to you, go to **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

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

Open Choice PPO

Metallic Level: Gold, Tested at 83.43%.

Policy year deductible	**In-network coverage**	**Out-of-network coverage**
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$200 per policy year (Combined)	
Spouse, domestic partner	$200 per policy year (Combined)	
Each child	$200 per policy year (Combined)	
Family	None	None
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 and Pediatric Dental Care • In-Network and Out-of-Network Well Newborn Nursery Care, Pediatric Vision Care Services and Supplies and Outpatient Prescription Drugs		
Maximum out-of-pocket limits **Maximum out-of-pocket limit** per **policy year**		
Student	$4,000 per policy year	None
Spouse	$4,000 per policy year	None
Each child	$4,000 per policy year	None
Family	$8,000 per policy year	None
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 penalties: - 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 policy year deductible amount or the maximum out-of-pocket limit, if any.		

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.

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care and wellness		
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit
Covered persons through age 21: Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. 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.	
Covered persons age 22 and over: Maximum visits per policy year	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	75% (of the recognized charge) per visit
Maximums	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	

Eligible health services	In-network coverage	Out-of-network coverage
Well woman preventive visits Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit
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 No copayment or policy year deductible applies	75% (of the recognized charge) per visit
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)	
Misuse of alcohol and/or drugs counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit
Maximum	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.	
Use of tobacco products counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Maximum visits per policy year	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.	
Depression screening counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit
Maximum visits per policy year	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.	
Sexually transmitted infection counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit
Maximum visits per policy year	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.	
Genetic risk counseling for breast and ovarian cancer counseling office visits This insurance Plan provides coverage for the screening, diagnosis, and treatment of breast cancer.	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit
Age limitations	Not subject to any age limitations	

Eligible health services	In-network coverage	Out-of-network coverage
Stress Management	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit
Chronic Conditions	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit
Routine cancer screenings performed at a physician's office, specialist's office or facility.		
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit
Maximums	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.		
Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
Preventive care services only (includes participation in the California Prenatal Screening Program)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit
Important note: You should review the *Maternity care and Well newborn nursery care* sections. They will give you more information on coverage levels for maternity care under this plan.		

Eligible health services	In-network coverage	Out-of-network coverage
Comprehensive lactation support and counseling services		
Lactation counseling services - facility or office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	75% (of the recognized charge) per item
Important note: See the *Breast feeding durable medical equipment* section of the certificate of coverage for limitations on breast pump and supplies.		
Family planning services – female contraceptives		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit
Contraceptives (prescription drugs and devices)		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit Coverage includes up to a 12 month supply of FDA-approved prescription contraceptives.	100% (of the negotiated charge) per item No copayment or policy year deductible applies	75% (of the recognized charge) per item
Female voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	75% (of the recognized charge)

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit
Physicians and other health professionals		
Physician and specialist services		
Office hours visits (non-surgical and non-preventive care by a physician and specialist)	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 75% (of the balance of the recognized charge) per visit thereafter
Telemedicine consultation By a physician or specialist	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.
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Allergy injections treatment performed at a physician's, or specialist office when you see the physician	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.
Allergy sera and extracts administered via injection at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physician and specialist - inpatient surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon	90% (of the negotiated charge)	75% (of the recognized charge)
Anesthetist	90% (of the negotiated charge)	75% (of the recognized charge)
Surgical assistant	90% (of the negotiated charge)	75% (of the recognized charge)
Physician and specialist - outpatient surgical services		
Outpatient surgery Performed in the outpatient department of a hospital or ambulatory surgical facility	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Anesthetist	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Surgical assistant	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
In-hospital non-surgical physician services		
In-hospital non-surgical physician services	90% (of the negotiated charge)	75% (of the recognized charge)
Consultant services (non-surgical and non-preventive)		
Office hours visits (non-surgical and non-preventive care)	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 75% (of the balance of the recognized charge) per visit thereafter
Telemedicine consultation by a consultant or specialist	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.
Second opinion 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.
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 75% (of the balance of the recognized charge) per visit thereafter
Hospital and other facility care		
Inpatient hospital (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 For physician charges, refer to the *Physician and specialist – inpatient surgical services* benefit	90% (of the negotiated charge) per admission	75% (of the recognized charge) per admission
Preadmission testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Alternatives to hospital stays		
Outpatient surgery (facility charges)		
Facility charges for surgery performed in the outpatient department of a hospital or surgery center For physician charges, refer to the *Physician and specialist - outpatient surgical services* benefit	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Home health care		
Outpatient	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Maximum visits per policy year	Unlimited	
Hospice care		
Inpatient facility (room and board and other miscellaneous services and supplies)	90% (of the negotiated charge) per admission	75% (of the recognized charge) per admission
Outpatient	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Skilled nursing facility		
Inpatient facility (room and board and miscellaneous inpatient care services and supplies) Subject to semi-private room rate unless intensive care unit is required Room and board includes intensive care	90% (of the negotiated charge) per admission	75% (of the recognized charge) per admission
Maximum days of confinement per policy year	100	

Eligible health services	In-network coverage	Out-of-network coverage
Emergency services and urgent care		
Emergency services		
Hospital emergency room	$175 copayment then the plan pays 90% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered
Important note: • As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment and coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, or call Member Services for an address at 1-877-480-4161 and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • A separate hospital emergency room copayment will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment will be waived and your inpatient copayment will apply. • Covered benefits that are applied to the hospital emergency room copayment cannot be applied to any other copayment under the plan. Likewise, a copayment that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment. • Separate copayment amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment amounts may be different from the hospital emergency room copayment. They are based on the specific service given to you. • Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment amounts that are different from the hospital emergency room copayment amounts.		
Urgent care		
Urgent medical care provided by an urgent care provider	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 75% (of the balance of the recognized charge) per visit thereafter
Non-urgent use of urgent care provider	Not covered	Not covered
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19.		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	75% (of the recognized charge) per visit
Type B services	70% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Orthodontic services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency 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.
Specific conditions		
Birthing center (facility charges)		
Inpatient (room and board and other miscellaneous services and supplies)	Paid at the same cost-sharing as hospital care.	Paid at the same cost-sharing as hospital care.
Diabetic services and supplies (including equipment and training)		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Impacted wisdom teeth		
Impacted wisdom teeth	90% (of the negotiated charge)	75% (of the recognized charge)
Adult dental care for cancer treatments and dental injuries		
Adult dental care for cancer treatments	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.
Adult dental care for dental injuries	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Anesthesia and hospital charges for dental care		
Anesthesia and hospital charges for dental care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Blood and body fluid exposure		
Blood and body fluid exposure	90% (of the negotiated charge)	75% (of the recognized charge)
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment		
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Dermatological treatment		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maternity care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
First Postnatal Visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	75% (of the recognized charge) per visit No policy year deductible applies
Well newborn nursery care in a hospital or birthing center	90% (of the negotiated charge) No policy year deductible applies	75% (of the recognized charge) No policy year deductible applies
Note: *The per admission copayment amount and/or policy year deductible 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.*		
Pregnancy complications		
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	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.
Family planning services – other		
Voluntary sterilization for males Inpatient physician or specialist surgical services	90% (of the negotiated charge)	75% (of the recognized charge)
Voluntary sterilization for males Outpatient physician or specialist surgical services	90% (of the negotiated charge)	75% (of the recognized charge)
Reversal of voluntary sterilization Outpatient physician or specialist surgical services	90% (of the negotiated charge)	75% (of the recognized charge)
Reversal of voluntary sterilization Inpatient physician or specialist surgical services	90% (of the negotiated charge)	75% (of the recognized charge)
Abortion Inpatient physician or specialist surgical services	90% (of the negotiated charge)	75% (of the recognized charge)
Abortion Outpatient physician or specialist surgical services	90% (of the negotiated charge)	75% (of the recognized charge)

Eligible health services	In-network coverage	Out-of-network coverage
Gender reassignment (sex change) treatment		
Inpatient hospital (room and board) and other miscellaneous services and supplies)	Follows the In-network cost-share for Mental Health Inpatient	Follows the Out-of-network cost-share for Mental Health Inpatient
Inpatient physician or specialist surgical services	Follows the In-network cost-share for Mental Health Inpatient services	Follows the Out-of-network cost-share for Mental Health Inpatient services
Outpatient physician or specialist surgical services	Follows the In-network cost-share for Mental Health Other Outpatient services	Follows the Out-of-network cost-share for Mental Health Other Outpatient services
Outpatient gender reassignment surgery specialist office visits (includes telemedicine)	Follows the In-network cost-share for Mental Health office visits	Follows the Out-of-network cost-share for Mental Health office visits
Outpatient gender dysphoria mental health office visits (includes telemedicine)	Follows the In-network cost-share for Mental Health office visits	Follows the Out-of-network cost-share for Mental Health office visits
Hormone therapy	Follows the In-network cost-share for Mental Health Other Outpatient services	Follows the Out-of-network cost-share for Mental Health Other Outpatient services
Speech therapy	Follows the In-network cost-share for Mental Health Other Outpatient services	Follows the Out-of-network cost-share for Mental Health Other Outpatient services
Mental health treatment		
Mental health treatment – inpatient		
Inpatient hospital mental disorders treatment (room and board and other miscellaneous hospital services and supplies) Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Mental disorder room and board intensive care	90% (of the negotiated charge) per admission	75% (of the recognized charge) per admission

Eligible health services	In-network coverage	Out-of-network coverage
Mental health treatment - outpatient		
Outpatient mental disorders treatment office visits to a physician or behavioral health provider	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 75% (of the balance of the recognized charge) per visit thereafter
Outpatient mental disorders telemedicine cognitive behavioral therapy consultations	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Other outpatient mental disorders treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive Outpatient Program The cost share doesn't apply to in-network peer counseling support services	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Substance abuse related disorders treatment-inpatient		
Inpatient hospital substance abuse detoxification (room and board and other miscellaneous hospital services and supplies) Inpatient hospital substance abuse rehabilitation (room and board and other miscellaneous hospital services and supplies) Inpatient residential treatment substance abuse (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Substance abuse room and board intensive care	90% (of the negotiated charge) per admission	75% (of the recognized charge) per admission

Eligible health services	In-network coverage	Out-of-network coverage
Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation		
Outpatient substance abuse office visits to a physician or behavioral health provider	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 75% (of the balance of the recognized charge) per visit thereafter
Outpatient substance abuse telemedicine cognitive behavioral therapy consultations	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Other outpatient substance abuse services Partial hospitalization treatment Intensive Outpatient Program The cost share doesn't apply to in-network peer counseling support services	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Obesity (bariatric) Surgery		
Inpatient and outpatient facility and physician services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Obesity surgery-travel and lodging		
Maximum Benefit payable for Travel Expenses for each round trip – 3 round trips covered (one pre-surgical visit, the surgery, and one follow-up visit)	$130	$130
Maximum Benefit payable for Travel Expenses per companion for each round trip – 2 round trips covered (the surgery, and one follow-up visit)	$130	$130
Maximum Benefit payable for Lodging Expenses per patient and companion for the pre-surgical and follow-up visits	$100 per day, up to 2 days	$100 per day, up to 2 days
Maximum Benefit payable for Lodging Expenses per companion for surgery stay	$100 per day, up to 4 days	$100 per day, up to 4 days

Eligible health services	In-network coverage	Out-of-network coverage
Reconstructive surgery and supplies		
Reconstructive surgery and supplies (includes reconstructive breast surgery)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage Network (IOE facility)	In-network coverage Network (Non-IOE facility)	Out-of-network coverage
Transplant services			
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received.		
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received.		
Transplant services-travel and lodging	Covered	Covered	Covered
Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	$10,000	$10,000	$10,000
Maximum payable for Lodging Expenses per **IOE** patient	$50 per night	$50 per night	$50 per night
Maximum payable for Lodging Expenses per companion	$50 per night	$50 per night	$50 per night

Eligible health services	In-network coverage	Out-of-network coverage
Treatment of infertility		
Basic infertility services Inpatient and outpatient care - basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Chemotherapy		
Chemotherapy	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Outpatient infusion therapy		
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient radiation therapy		
Outpatient radiation therapy	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Outpatient respiratory therapy		
Respiratory therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Transfusion or kidney dialysis of blood		
Transfusion or kidney dialysis of blood	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Pulmonary rehabilitation	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Rehabilitation and habilitation therapy services		
Outpatient physical, occupational, speech, and cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Acupuncture		
Acupuncture	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 75% (of the balance of the recognized charge) per visit thereafter
Chiropractic services		
Chiropractic services	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Maximum visits per policy year	50	

Eligible health services	In-network coverage	Out-of-network coverage
Diagnostic testing for learning disabilities		
Diagnostic testing for learning disabilities	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Other services and supplies		
Emergency ground, air, and water ambulance	90% (of the negotiated charge) per trip	Paid the same as in-network coverage
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Durable medical equipment	90% (of the negotiated charge) per item	75% (of the recognized charge) per item
Enteral and parenteral nutritional supplements	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.
Osteoporosis (non-preventive care)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Prosthetic and orthotic devices		
Prosthetic and orthotic devices	90% (of the negotiated charge) per item	75% (of the recognized charge) per item
Hearing exams		
Hearing aid exams	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 75% (of the balance of the recognized charge) per visit thereafter
Hearing aid exam maximum	One hearing exam every policy year	
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.
Genetic Testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Diethylstilbestrol (DES) Treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Vision care		
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the negotiated charge) per visit No policy year deductible applies	75% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year	1 visit	
Pediatric comprehensive low vision evaluations		
Performed by a legally qualified ophthalmologist or optometrist	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum	One comprehensive low vision evaluation every **policy year**	
Pediatric vision care services and supplies		
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	75% (of the recognized charge) per visit No policy year deductible applies
Maximum number of eyeglass frames per policy year	One set of eyeglass frames	
Maximum number of prescription lenses per policy year	One pair of prescription lenses	
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	75% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year	1 visit	
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Maximum number of optical devices per policy year	One optical device	
*__Important note__: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both. Coverage does not include the office visit for the fitting of prescription contact lenses.		
Adult vision care Limited to covered persons age 19 and over		
Adult routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist or optometrist	90% (of the negotiated charge) per visit	75% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
Aniridia		
Aniridia	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient prescription drugs		
Policy year deductible and copayment waiver for risk reducing breast cancer		
The **policy year deductible** and the **prescription copayment** will not apply to risk reducing breast cancer **prescription drugs** when obtained at a in-network or out-of-network **pharmacy**. This means that such risk reducing breast cancer **prescription drugs** are paid at 100%.		
Policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs		
The **policy year deductible** and the **prescription** drug **copayment** will not apply to the first two 90-day treatment regimens per **policy year** for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **in-network or out-of-network pharmacy**. This means that such **prescription drugs** and OTC drugs are paid at 100%. Your **policy year deductible** and any **prescription drug copayment** will apply after those two regimens per **policy year** have been exhausted.		
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 a 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 outpatient prescription drug 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 a select care pharmacy or in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
Generic prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	Coinsurance is 50% (of the negotiated charge) but will be no more than $250 per supply No policy year deductible applies	Coinsurance is 50% (of the recognized charge) but will be no more than $250 per supply No policy year deductible applies
Preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	Coinsurance is 50% (of the negotiated charge) but will be no more than $250 per supply No policy year deductible applies	Coinsurance is 50% (of the recognized charge) but will be no more than $250 per supply No policy year deductible applies
Non-Preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	Coinsurance is 50% (of the negotiated charge) but will be no more than $250 per supply No policy year deductible applies	Coinsurance is 50% (of the recognized charge) but will be no more than $250 per supply No policy year deductible applies
Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a retail pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	

Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, contact Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card 1-877-480-4161.	
Preventative Care Tobacco cessation prescription and over-the-counter drugs		
Preventive care tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	

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

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

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

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

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

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

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

General exceptions and exclusions

Alternative health care

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

Armed forces

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

Artificial organs

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

This exclusion does not apply to the use of non-human material to repair, replace, or restore function of an organ if it is **medically necessary** and not experimental.

Breasts

- Services and supplies given by a provider for breast reduction or gynecomastia, except as **medically necessary**.

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

  Refer to the *When you disagree - claim decisions and appeals procedures* section for information on how to request an independent medical review from the California Department of Insurance for experimental or investigational treatment

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

This exclusion does not apply to medically necessary cornea or cartilage 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 or as described in the *Eligible health services under your plan – Reconstructive surgery and supplies* section.
- Coverage that may be provided under the *Eligible health services under your plan - Gender reassignment (sex change) treatment* section.
- Any **medically necessary** treatment due to complications from cosmetic procedures.

Counseling

- Religious, career, pastoral, or financial counseling

Custodial care

Except for services provided under hospice care, skilled nursing care, or inpatient hospital benefits, assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

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.

This exclusion does not apply to the **covered benefits** provided in the *Eligible health services under your plan –Adult dental care for cancer treatments and dental injuries* benefit.

Durable medical equipment (DME)

- 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

- Certain early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time and similar programs) and other intensive educational interventions

Educational services

- 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, including infant formulas, 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 that are not medically necessary and 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
- Because a law requires it
- 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.

  Refer to the *When you disagree - claim decisions and appeals procedures* section for information on how to request an independent medical review from the California Department of Insurance for experimental or investigational treatment

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

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

This exclusion does not apply to diabetic shoes and inserts covered in the Eligible health services under your plan – Prosthetics and orthotic devices benefit.

Gender reassignment (sex change) treatment

- Cosmetic services and supplies such as:
  - Rhinoplasty
  - Face-lifting
  - Lip enhancement
  - Facial bone reduction
  - Lepharoplasty
  - Breast augmentation
  - 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

  Any services that would be otherwise available to a **covered person** will be covered for those undergoing gender reassignment treatment.

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

This exclusion does not apply to **medically necessary** growth/height care

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 24 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist
- Hearing exams 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

The maintenance therapy exclusion above does not apply to habilitative services that maintain or prevent deterioration or regression of function

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

This exclusion does not apply to **hospice care** services authorized by applicable state law.

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.

Maternity and related newborn care

- Any services and supplies related to planned home births or in any other place not licensed to perform deliveries unless the birth occurs in an emergency situation and the mother is unable to reach a place licensed to perform deliveries

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. 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

This exclusion does not apply to any disposable supplies that are **covered benefits** in the *Eligible health services under your plan –Durable medical equipment, Home health care, Hospice care, Diabetic services and supplies (*including *equipment and training)* and *Outpatient prescription drug* benefits.

Motor vehicle accidents

- Services and supplies given by a provider for injuries sustained from a motor vehicle accident but only when benefits have been paid under other automobile medical payment insurance.

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, except as covered in the *Eligible health services under your plan – Emergency services and urgent care section*

Obesity

- 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 selling the organ

Other primary payer

- Payment for a portion of the charge that has been paid by Medicare or another party as the primary payer

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions

This exclusion does not apply to **medically necessary** infusion therapy services in an outpatient setting.

Outpatient prescription or non-prescription drugs and medicines

- Outpatient **prescription drugs** or non-prescription drugs and medicines provided free of charge to you by the **policyholder**

Pediatric dental care

- Braces (orthodontics), mouth guards, and other devices to protect, replace or reposition teeth that are not **medically necessary**
- **Cosmetic** services and supplies including :
- plastic surgery, reconstructive surgery, **cosmetic surgery**, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance
- Augmentation and other substances to protect, clean, whiten bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Eligible health services under your plan* section

- Veneers on molar crowns and pontics will always be considered cosmetic

- Procedures, appliances, or restorations (other than those for replacement of structure loss from caries) which alter, restore or maintain occlusion
- Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for **cosmetic** purposes
- TMJ dysfunction procedures solely for the treatment of bruxism. **Eligible health services** are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation.
- General anesthesia and intravenous sedation, unless **medically necessary** and only when done in connection with another **eligible health service**
- Orthodontic treatment, except as covered in the *Eligible health services under your plan – Pediatric dental care* section, such as:
  - Lingually placed direct bonded appliances and arch wires (invisible braces)
  - Removable acrylic aligners (invisible aligners)
- Pontics, crowns, cast or processed restorations made with high noble metals (gold foil)
- Replacement of third molars (wisdom teeth) and teeth beyond the normal complement of 32
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
    - Rendered before the effective date or after the termination of coverage
- Surgical removal of impacted third molars (wisdom teeth) only for orthodontic reasons, except as **medically necessary** and unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests
- Treatment by other than a **dental provider**

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
- Non-preventive care 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
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods or devices, except as covered in the *Eligible health services under your plan – Family planning services - other section*
- The reversal of voluntary sterilization procedures, including any related follow-up care

Private duty nursing (outpatient only)

Prosthetic devices

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless covered under the *Eligible health services under your plan – Prosthetic and orthotic devices*, 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 or misuse

School health services

- Services and supplies normally provided without charge 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, civil union 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

This exclusion does not apply to **prescription drugs** prescribed for the treatment of sexual dysfunction/enhancement as covered under the *Outpatient prescription drugs – Other services* section.

Sinus surgery

- Any services or supplies given by providers for non-medically necessary sinus surgery except for acute purulent sinusitis

Strength and performance

- Services , devices and supplies that are not medically necessary such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

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

- Dental implants

Therapies and tests

- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

Transplant services

- 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

Treatment of infertility

All charges associated with the treatment of infertility, except as described under the *Eligible health services under your plan – Treatment of infertility – Basic infertility* section. This includes:

- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate, except for otherwise - covered benefits provided to a covered person who is a surrogate. 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 (frozen) eggs, embryos or sperm
  - The care of the donor in a donor egg cycle which includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which the person is not genetically related
  - Obtaining sperm from a person not covered under this plan for ART services
- 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
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)
- ART services are not provided for out-of-network care

Vision Care

Pediatric vision care services and supplies

- 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 licensed **residential treatment facility** or otherwise licensed institution)
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

Exceptions and exclusions that apply to outpatient prescription drugs

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, unless medically necessary for the administration of a covered outpatient prescription drug.

Dietary supplements including medical foods. This does not apply to enteral and parenteral nutrition or FDA approved OTC drugs required by the USPSTF A and B recommendations list (e.g. aspirin, vitamin D, folic acid, and iron supplements) when prescribed by a physician

Drugs or medications

- Which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), unless recommended by the United States Preventive Services Task Force. This exception does not apply to FDA approved OTC female contraceptive methods prescribed by a provider
- That is therapeutically equivalent or therapeutically alternative to a covered prescription drug including biosimilar (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved). Even if one drug or medication becomes available OTC, the prescription strengths of these drugs are still covered. The entire class of the prescription drugs will not be excluded in this case
- Not approved by the FDA
- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
- 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

Duplicative drug therapy (e.g. two antihistamine drugs)

Immunizations related to travel or work

- Immunizations related to travel or work unless recommended by the United States Preventive Services Task Force (USPSTF)

Infertility

- Injectable prescription drugs used primarily for the treatment of infertility.

Prescription drugs:

- Filled prior to the effective date or after the termination date of coverage under this plan.
- 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

We reserve the right to exclude:

- A manufacturer's product when a same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the preferred drug guide.
- Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our preferred drug guide.

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If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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如欲使用免費語言服務，請致電 (877) 480-4161。(Chinese)
Afin d'accéder aux services langagiers sans frais, composez le (877) 480-4161. (French)
Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa (877) 480-4161. (Tagalog)
Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie (877) 480-4161 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 480-4161 (877). (Arabic)
Pou jwenn sèvis lang gratis, rele (877) 480-4161. (French Creole-Haitian)
Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero (877) 480-4161 (Italian)

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