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Aetna Student Health[SM]
Plan Design and Benefits Summary

Open Choice PPO

California State Polytechnic University, Pomona

CAL POLY POMONA

Policy Year: 2020 - 2021
Policy Number: 686133
www.aetnastudenthealth.com
(877) 480-4161

Disclaimer: These rates and benefits are pending approval by the California Department of Insurance and can change. If they change, we will update this information.

This is a brief description of the Student Health Plan. The plan is available for California State Polytechnic University, Pomona students. The plan is insured by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at **www.aetnastudenthealth.com**. If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

STUDENT HEALTH SERVICES

The Student Health Services (SHS) is the California State Polytechnic University, building 46 health facilities. Staffed by doctors, nurse practitioners and medical support staff, it is open Monday–Friday 8:00 a.m. to 5:00 p.m., during the Fall, Winter and Spring quarters and Monday–Thursday 7:00 a.m. to 6:00 p.m., during the Summer quarter.

For more information, call the Health Services at (909) 869-4000. In the event of an emergency, call 911 or the Campus Police at (909) 869-3070.

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.

INTERNATIONAL

Coverage Period	Coverage Start Date	Coverage End Date
Annual	08/20/2020	08/19/2021
Spring/Summer	01/15/2021	08/19/2021

EXCHANGE

Coverage Period	Coverage Start Date	Coverage End Date
Annual	08/20/2020	08/19/2021
Fall	08/20/2020	01/14/2021
Spring/Summer	01/15/2021	08/19/2021
Spring	01/15/2021	05/26/2021
Summer	05/27/2021	08/19/2021

ELI

Coverage Period	Coverage Start Date	Coverage End Date
Annual	08/12/2020	08/11/2021
Fall Full	08/12/2020	01/08/2021
Fall A	08/12/2020	10/17/2020
Fall B	10/18/2020	01/08/2021
Spring Full	01/09/2021	05/25/2021
Spring A	01/09/2021	03/21/2021
Spring B	03/22/2021	05/25/2021
Summer	05/26/2021	08/11/2021

American Semester Program (ASP)

Coverage Period	Coverage Start Date	Coverage End Date
Fall	08/12/2020	01/08/2021
Spring	01/09/2021	05/26/2021
Summer	05/27/2021	08/11/2021

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as a California State Polytechnic University administrative fee.

INTERNATIONAL

	Annual	Spring/Summer
Student	$1,324.00	$795.00

EXCHANGE

	Annual	Fall	Spring/Summer	Spring	Summer
Student	$1,324.00	$549.00	$795.00	$492.00	$323.00

ELI

	Annual	Fall Full	Fall A	Fall B	Spring Full	Spring A	Spring B	Summer
Student	$1,304.00	$536.00	$239.00	$297.00	$489.00	$257.00	$232.00	$279.00

American Semester Program (ASP)

	Fall	Spring	Summer
Student	$536.00	$493.00	$275.00

Student Coverage

Who is eligible?

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) are required to purchase this insurance Plan, Students must actively attend classes for at least the first 45 days after the date for which coverage is purchased.

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.

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.

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.

Enrollment

Eligible students may enroll in the insurance plan online at www.jcbins.com or by calling customer service at (909) 270-4744. Please refer to the Coverage Periods section of this document for coverage dates.

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 Aetna within 90 days of withdrawal from school.

If you withdraw from school within the first 45 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 45 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.)

Medicare Eligibility Notice

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

In-network Provider Network

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

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

Precertification-

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification. Your in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to www.aetnastudenthealth.com.

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.

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.
- Any benefit penalty incurred will not count toward your **policy year deductibles** or **maximum out-of-pocket limits**.

Coordination of Benefits (COB)

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

Description of Benefits

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

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

Open Choice PPO

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	$100 per policy year	$200 per policy year
Individual This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.		
Eligible health services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Eligible health services applied to the in-network policy year deductibles will not be applied to satisfy the out-of-network policy year deductibles.		
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-Network care and Out-of-Network Care for Preventive Care and Wellness, Physician or Specialist Office Visits, Walk-In Clinic Visit, Consultant Office visits, Urgent Care, Outpatient Mental Health & Outpatient Substance Abuse Office Visits, Pediatric Dental Services, Pediatric Vision Care Services and Supplies, First Postnatal Visit, Well Newborn Nursery Care, Hearing Aid Exams, Adult Vision Care Exam, and Outpatient Prescription Drugs		
Maximum out-of-pocket limit per **policy year**		
Student	$2,500 per policy year (Combined)	

Eligible health services	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit No copayment or policy year deductible applies
Maximum age and visit limits per policy year through age 21	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.	
Maximum visits per policy year age 22 and over	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	70% (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 Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	
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	70% (of the recognized charge) per visit No copayment or policy year deductible applies
Maximum visits per policy year	1 visit	
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	70% (of the recognized charge) per visit No copayment or policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
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	70% (of the recognized charge) per visit No copayment or policy year deductible applies
Obesity/Healthy Diet maximum per policy year (Applies to covered persons age 22 and older)	26 visits (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 maximum per policy year Tobacco Products Counseling maximum per policy year Depression screening maximum per policy year STI maximum 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.	
Routine cancer screenings	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	70% (of the recognized charge) per visit No copayment or policy year deductible applies
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.	
Lung cancer screening maximums	1 screenings every 12 months	
Stress Management	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	70% (of the recognized charge) per visit No copayment or policy year deductible applies
Chronic Conditions	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	70% (of the recognized charge) per visit No copayment or policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Stress Management and Chronic Conditions maximum	1 visit	
Prenatal care services (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	70% (of the recognized charge) per visit No copayment or policy year deductible applies
Lactation support and counseling services	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	70% (of the recognized charge) per visit No copayment or policy year deductible applies
Breast pump supplies and accessories	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	70% (of the recognized charge) per visit No copayment or policy year deductible applies
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	70% (of the recognized charge) per visit No copayment or policy year deductible applies
Female contraceptive prescription drugs and devices Coverage includes up to a 12-month supply of FDA-approved prescription contraceptives.	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	70% (of the recognized charge) per visit No copayment or policy year deductible applies
Female voluntary sterilization-Inpatient & Outpatient provider services	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	70% (of the recognized charge) per visit No copayment or policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) includes telemedicine consultations)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Allergy testing and treatment		
Allergy testing & Allergy injections treatment, including Allergy sera and extracts administered via injection 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.
Physician and specialist - surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	100% (of the negotiated charge)	70% (of the recognized charge)
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per admission	$100 copayment then the plan pays 70% (of the balance of the recognized charge) per admission
In-hospital non-surgical physician services	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Home health Care	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Maximum visits per policy year	Unlimited	
Hospice-Inpatient	100% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
Hospice-Outpatient	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Skilled nursing facility-Inpatient	$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per admission	$100 copayment then the plan pays 70% (of the balance of the recognized charge) per admission
Maximum days of confinement per policy year	Unlimited	

Eligible health services	In-network coverage	Out-of-network coverage
Hospital emergency room	$100 copayment then the plan pays 100% (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/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 the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • A separate hospital emergency room copayment/coinsurance 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/coinsurance will be waived and your inpatient copayment/coinsurance will apply. • Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance. • Separate copayment/coinsurance 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/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. 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/coinsurance amounts.		
Urgent Care	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Non-urgent use of urgent care provider	Not covered	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19.		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	70% (of the recognized charge) per visit No copayment or deductible applies
Type B services	70% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit No copayment or deductible applies
Type C services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit No copayment or deductible applies
Orthodontic services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit No copayment or deductible applies
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		
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	100% (of the negotiated charge)	100% (of the recognized charge)
Adult dental care for dental injuries	100% (of the negotiated charge) per visit	100% (of the recognized charge) per visit
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.
First Postnatal Visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit No copayment or policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Well newborn nursery care in a hospital or birthing center	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Family planning services – other		
Voluntary sterilization for males-surgical services	100% (of the negotiated charge)	70% (of the recognized charge)
Reversal of voluntary sterilization	100% (of the negotiated charge)	70% (of the recognized charge)
Abortion physician or specialist surgical services	100% (of the negotiated charge)	70% (of the recognized charge)
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
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Mental Health & Substance Abuse Treatment		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per admission	$100 copayment then the plan pays 70% (of the balance of the recognized charge) per admission
Outpatient office visits (includes telemedicine consultations)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit

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 facility services	Covered according to the type of benefit and the place where the service is received.		
Transplant services Inpatient and outpatient 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 Travel and Lodging Expenses for any one transplant	$10,000	$10,000	$10,000
Maximum Lodging Expenses per **IOE** patient	$50 per night	$50 per night	$50 per night
Maximum Lodging Expenses per companion	$50 per night	$50 per night	$50 per night

Eligible health services	In-network coverage	Out-of-network coverage
Basic 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.
Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	100% (of the negotiated charge) per visit	70% (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	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Outpatient Chemotherapy, Radiation & Respiratory Therapy	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Acupuncture 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.
Chiropractic services	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Maximum visits per policy year	50	

Eligible health services	In-network coverage	Out-of-network coverage
Other services and supplies		
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	100% (of the negotiated charge) per trip	Paid the same in-network coverage
Durable medical and surgical equipment	100% (of the negotiated charge) per item	70% (of the recognized charge) per item
Enteral formulas and nutritional supplements	100% (of the negotiated charge) per item	70% (of the recognized charge) per item
Prosthetic Devices & Orthotics	100% (of the negotiated charge) per item	70% (of the recognized charge) per item
Hearing aid exams	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Hearing aid exam maximum	One hearing exam every policy year	
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams (including refraction)- Performed by a legally qualified ophthalmologist or optometrist Includes comprehensive low vision evaluations Includes visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: 1 year supply Extended wear disposable: 1 year supply Non-disposable lenses: 1 year supply	
***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.		
Vision Care-Limited to covered persons age 19 and over		
Adult routine vision exams (including refraction) Performed by a legally qualified ophthalmologist or optometrist Includes fitting of prescription contact lenses	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs		
Copayment/coinsurance waiver for risk reducing breast cancer		
The per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
Copayment waiver for tobacco cessation prescription and over-the-counter drugs		
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 pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your prescription drug copayment will apply after those two regimens per policy year have been exhausted.		
Copayment waiver for contraceptives		
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 prescription drug copayment continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at a in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
Generic prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	Coinsurance is 70% (of the negotiated charge) but will be no more than $250 per supply No policy year deductible applies	Coinsurance is 70% (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)		
For each fill up to a 30 day supply filled at a retail pharmacy	Coinsurance is 70% (of the negotiated charge) but will be no more than $250 per supply No policy year deductible applies	Coinsurance is 70% (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)		
For each fill up to a 30 day supply filled at a retail pharmacy	Coinsurance is 70% (of the negotiated charge) but will be no more than $250 per supply No policy year deductible applies	Coinsurance is 70% (of the recognized charge) but will be no more than $250 per supply No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Orally administered anti-cancer prescription drugs- For each fill up to a 30 day supply filled at a retail or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Preventive care drugs and supplements filled at a retail or mail order pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
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.	
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 is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	

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

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 in the certificate
- Refer to the *When you disagree - claim decisions and appeals procedures* section in the certificate 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 in the certificate.
- Any **medically necessary** treatment due to complications from cosmetic procedures.

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

- Acne 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 in the certificate.

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**

Educational services

- 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 in the ertificate. 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.

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 in the certificate

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 in the certificate.

Refer to the *When you disagree - claim decisions and appeals procedures* section in the certificate 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)
- 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.

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, referral and precertification requirements* section in the certificate.

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 in the certificate.

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 in the certificate*

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 in the certificate, 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

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- **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 vestibuloplasty, 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 in the certificate. Facings on molar crowns and pontics will always be considered **cosmetic**.
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material or
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces(that are determined not to be **medically necessary** mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including **temporomandibular joint dysfunction** disorder (TMJ) and **craniomandibular joint dysfunction** disorder (CMJ) treatment, orthognathic **surgery**, and

treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services under your plan – Specific conditions* section in the certificate.
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another **eligible health service**
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in the *Eligible health services under your plan – Pediatric dental care* section in the certificate.
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Eligible health services under your plan —Pediatric dental care* section in the certificate.
- 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
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- 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
- 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 in the certificate.*
- 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 in the certificate*, 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 in the Certificate.

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, 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

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 in the certificate. 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), storage or thawing of eggs, embryos or sperm, unless due to iatrogenic **infertility**.
  - 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 in the certificate.

- 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

- See *Educational services* within this section

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: Medi-Cal 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**.

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

Sanctioned Countries

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 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)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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.

English	**To access language services at no cost to you, call the number on your ID card.**
Albanian	Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit.
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ፡ ፡
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հեռախոսահամարով
Bantu-Kirundi	Kugira uronke serivisi z'indimi ata kiguzi, hamagara inomero iri ku karangamuntu kawe
Bengali	আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন।
Burmese	သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပတ်အား ခေါ်ဆိုပါ။
Catalan	Per accedir a serveis lingüístics sense cap cost per a vostè, telefoni al número indicat a la seva targeta d'identificació.
Cebuano	Aron maakses ang mga serbisyo sa lengguwahe nga wala kay bayran, tawagi ang numero nga anaa sa imong kard sa ID.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Cherokee	ᏩᎩᏍᏗ ᏕᏫᏂᎯᏍᏗ ᎢᏳᎾᏓᎵᏁᎯᏗ Ꮭ ᎠᏁᏍᏗ ᏗᏣᎬᏩᏁᏗ ᏱᎩ, ᎾᏥᎯᏓᏔᏅᏏ ᎾᏍᎩ ᏗᏎᏍᏗ ᏥᏌᎪᏥᏊ ᎤᎾᏙ ID ᏆᏂᏲᏍᏗ ᏣᏤᏈᎢ.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Choctaw	Anumpa tosholi i toksvli ya peh pilla ho ish i payahinla kvt chi holisso kallo iskitini holhtena takanli ma i payah
Chuukese	Ren omw kopwe angei aninisin eman chon awewei (ese kamé), kopwe kééri ewe nampa mei mak won noum ena katen ID
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
Dutch	Voor gratis taaldiensten, bel het nummer op uw ziekteverzekeringskaart.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.

Hawaiian	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obụla, kpọọ nọmba nọ na kaadi njirimara gị
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢတၢ်ကမၤနှဲ်ကျိာ်တၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ် လၢတအိဉ်ဒီးအပှၤလၢနကဘဉ်ဟ့ဉ်အီၤအဂီၤ.ကိးဘဉ်လီတဲစိနိဉ်ဂ့ၢ်လၢအအိဉ်လၢနခိဉ်ဂီၤ (ID) အလိၤန္ဉ်တက့ၢ်.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی(ID) کارتی خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डावरील क्रमांकावर फोन करा.
Marshallese	Ṇan bōk jipañ kōn kajin ilo an ejjeḷọk wōṇean ñan kwe, kwōn kallok nōṃba eo ilo kaat in ID eo aṃ.
Micronesian-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílı̨́go nanitinígíí bee néého’dólzinígíí béésh bee hane’í biká’ígíí áajį’ hólne’.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të kɔɔr yïn ran de wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke yïn cɔl ran ye kɔc kuɔny në namba de abac tɔ̈ në ID kard duɔ̈n de tïït de nyin de panakim kɔ̈u.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.

Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian	Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul de membru.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Sudanic Fulfulde	Heeɓa a naasta nder ekkitol jaangirde woldeji walla yoɓugo, ewnu lamba je ɗon windi ha do ɗerowol maaɗa.
Swahili	Kupata huduma za lugha bila malipo kwako, piga nambari iliyo kwenye kadi yako ya kitambulisho.
Syriac-Assyrian	ܟܝ ܡܨܝܬܘܢ ܬܠܒܘܢ ܥܠ ܫܡܫܬܐ ܕܡܬܪܓܡܢܐ ܡܓܢܐܝܬ، ܩܪܘܢ ܠܡܢܝܢܐ ܥܠ ܦܬܩܐ ܕܗܝܡܢܘܬܐ ܕܝܠܟܘܢ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Telugu	భాష సేవలను మీకు ఖర్చు లేకుండా అందుకునేందుకు, మీ ఐడి కార్డుపై ఉన్న నంబరుకు కాల్ చేయండి.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Tongan	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he fika 'oku hā atu 'i ho'o ID kaati.
Turkish	Dil hizmetlerine ücretsiz olarak erişmek için kimlik kartınızdaki numarayı arayın.
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Urdu	لسانی خدمات تک مُفت رسائی کے لیے، اپنے بیمہ کے ID کارڈ پر درج نمبر پر کال کریں۔
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Yiddish	צו באקומען שפראך סערוויסעס פריי פון אפצאל, רופט דעם נומער אויף אייער ID קארטל.
Yoruba	Láti ráyèsí àwọn iṣẹ́ èdè fún ọ lọ́fẹ̀ẹ́, pe nọ́mbà tó wà lórí káàdì ìdánimọ̀ rẹ.