



**Aetna Student Health  
Plan Design and Benefits  
Summary  
OA Managed Choice POS**



**Mount Saint Mary's University**

Policy Year: 2024–2025

Policy Number: 686160

<https://www.aetnastudenthealth.com>

(877) 480-4161



This is a brief description of the Student Health Plan. The plan is available for Mount Saint Mary’s University 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 <https://www.aetnastudenthealth.com>. If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

**Mount Saint Mary’s University Student Health Services**

The Chalon and Doheny Student Health Services are the University's on-campus health facilities. Staffed by nurse practitioners and registered nurses, the Chalon Campus Student Health Services is open Tuesday and Thursday, 9:00am - 7:00pm. The Doheny Campus Student Health Services is open Monday, Wednesday and Friday, 9:00am - 7:00pm and Saturdays, 8:30am - 4:00pm.

For more information, call Chalon Campus Student Health Services at 310-954-4110 or Doheny Campus Student Health Services at 213-477-2685. In the event of an emergency, call 911 or Campus Security at 310-954-4123 (Chalon) or 213-477-2502 (Doheny).

**Coverage Dates and Rates**

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

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Fall	08/15/2024	01/01/2025	09/10/2024
Spring/Summer	01/02/2025	08/14/2025	01/28/2025
Summer (New Nursing Students)	05/06/2025	08/14/2025	05/22/2025

**Rates**

**Undergraduates and Graduate Students**

	Fall Semester	Spring/Summer Semester	Summer Semester (New Nursing Students)
Student	\$1,111	\$1,784	\$802

The rates above include premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna) as well as an administrative fee payable to JCB Insurance Solutions.

## Student Coverage

### Who is eligible?

**Traditional Undergraduate, Accelerated Nursing, Doctorate in Physical Therapy (D.P.T.), and A.D.N. Students:** All Traditional Undergraduate, Accelerated Nursing, & D.P.T. enrolled in 9 units or more, and A.D.N Students enrolled in 7 units or more at MSMU must carry Student Health Insurance. The student will be automatically enrolled in coverage, and MSMU will automatically include charges for the coverage in the school invoice to the student.

**Graduate Nursing Students:** Graduate Nursing Students are eligible for the Student Health Insurance but are not automatically enrolled. Enrollment is voluntary for Graduate Nursing Students. To enroll, visit the MSMU Business Office to enroll.

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

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

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

### Enrollment

Eligible students will be automatically enroll in this Plan, unless you submit a completed waiver by visiting [www.jcbins.com](http://www.jcbins.com) and selecting your school on the home page and registering by the deadline dates listed on the previous page. For questions, please call JCB Insurance Solutions customer service at (310) 734-0742.

**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 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.)

### Termination and Refunds

All refund requests must be sent to the University who will confirm nonstudent status with JCB and submit the refund request on behalf of the student. Only refunds submitted by the University before the refund deadline will be considered. Credit card refunds must be requested within 120 days of the date of purchase and before the refund deadline. No refunds will be considered after the refund deadline. All refunds will be processed back to the original form of payment only, no exceptions. All refunds will be assessed a \$35 processing fee. Please allow 30 business days for us to receive and process the refund request, then an additional 3-5 business days to receive the refund from your financial institution. Pro-rated/partial refunds are not allowed.

NOTE: You can check to see if your return has been processed by [logging in to your JCB account](#).

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

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

### 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. If you do not precertify when required, up to a \$500 penalty for each type of eligible health service that was not precertified. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to [www.aetnastudenthealth.com](http://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. You, your physician or the facility must call us within these timelines:

Non-emergency admissions:	Call at least 14 days before the date you are scheduled to be admitted.
Emergency admission:	Call within 48 hours or as soon as reasonably possible after you have been admitted.
Urgent admission:	Call before you are scheduled to be admitted.
Outpatient non-emergency:	Call at least 14 days before the care is provided, or the treatment is scheduled

An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.

We will provide a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 30 days as long as you remain enrolled in the plan.



## Coordination of Benefits (COB)

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

## Description of Benefits

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

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

	In-network coverage	Out-of-network coverage
<b>Policy year deductibles</b>		
<b>Student</b>	None	None
<b>Maximum out-of-pocket limits</b>		
	In-network coverage	Out-of-network coverage
<b>Student</b>	\$7,350 per policy year	\$15,000 per policy year

	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	50% (of the recognized charge) per visit
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.	
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	50% (of the recognized charge) per visit
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	
The following is not covered under this benefit: <ul style="list-style-type: none"><li>Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel</li></ul>		

	In-network coverage	Out-of-network coverage
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	50% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
Preventive screening and counseling services		
Preventive screening and counseling services for Misuse of alcohol & drugs, Tobacco Products, sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Stress management counseling office visits	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Chronic condition counseling office visits	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Routine cancer screenings	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Maximum:	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"><li>• 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</li><li>• The comprehensive guidelines supported by the Health Resources and Services Administration.</li></ul>	
Lung cancer screening maximums	1 screening every 12 months*	
Prenatal and postpartum 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	50% (of the recognized charge) per visit

	In-network coverage	Out-of-network coverage
Lactation support and counseling services	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	50% (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	50% (of the recognized charge) per item
<b>Physicians and other health professionals</b>		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) (includes telemedicine consultations)	\$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	\$30 copayment then the plan pays 100% (of the balance of the recognized charge) per visit
<b>Allergy testing and treatment</b>		
Allergy testing performed at a physician or specialist office	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Allergy injections treatment performed at a physician or specialist office	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Allergy sera and extracts administered via injection at a physician or specialist office	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
<b>Physician and specialist surgical services</b>		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge)	50% (of the recognized charge)
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"> <li>A stay in a hospital (Hospital stays are covered in the <i>Eligible health services and exclusions – Hospital and other facility care</i> section)</li> <li>Services of another physician for the administration of a local anesthetic</li> </ul>		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"> <li>A stay in a hospital (Hospital stays are covered in the <i>Eligible health services and exclusions – Hospital and other facility care</i> section)</li> </ul>		

<ul style="list-style-type: none"> <li>• A separate facility charge for surgery performed in a physician's office</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>		
	In-network coverage	Out-of-network coverage
<b>Alternatives to physician office visits</b>		
Walk-in clinic visits (non-emergency visit)	\$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	\$30 copayment then the plan pays 100% (of the balance of the recognized charge) per visit
<b>Hospital and other facility care</b>		
Inpatient hospital (room and board) and other miscellaneous services and supplies)  Includes birthing center facility charges	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Preadmission testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
<b>Alternatives to hospital stays</b>		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"> <li>• The services of any other physician who helps the operating physician</li> <li>• A stay in a hospital (See the <i>Hospital care – facility charges</i> benefit in this section)</li> <li>• A separate facility charge for surgery performed in a physician's office</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>		
Home health Care	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"> <li>• 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)</li> <li>• Transportation</li> <li>• Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present</li> <li>• Homemaker or housekeeper services</li> <li>• Food or home delivered services</li> <li>• Maintenance therapy</li> </ul>		
Hospice-Inpatient	80% (of the negotiated charge) per admission	80% (of the recognized charge) per admission
Hospice-Outpatient	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit



**The following are not covered under this benefit:**

- Funeral arrangements
- 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

	In-network coverage	Out-of-network coverage
Skilled nursing facility- Inpatient	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Maximum days of confinement per policy year	100	
Hospital emergency room	\$100 copayment then the plan pays 80% (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.

**The following are not covered under this benefit:**

- Non-emergency services in a hospital emergency room facility, freestanding emergency medical care facility or comparable emergency facility

Urgent care	\$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	\$30 copayment then the plan pays 100% (of the balance of the recognized charge) per visit
Non-urgent use of an urgent care provider	Not covered	Not covered

**The following is not covered under this benefit:**

- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

	In-network coverage	Out-of-network coverage
<b>Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19.)</b>		
Type A services	100% (of the negotiated charge) per visit  No copayment or deductible applies	50% (of the recognized charge) per visit
Type B services	100% (of the negotiated charge) per visit  No copayment or deductible applies	50% (of the recognized charge) per visit
Type C services	100% (of the negotiated charge) per visit  No copayment or deductible applies	50% (of the recognized charge) per visit
Orthodontic services	100% (of the negotiated charge) per visit  No copayment or deductible applies	50% (of the recognized charge) per visit
Dental emergency services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.

## Pediatric dental care exclusions

The following are not covered under this benefit:

- 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, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth
- Crown, inlays and onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - 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
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - 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 and exclusions – Specific conditions* section
- 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 this section
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs
- 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
- 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

	In-network coverage	Out-of-network coverage
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
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.

The following are not covered under this benefit:

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking,

running, working or wearing shoes - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet		
Impacted wisdom teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Accidental injury to sound natural teeth	80% (of the negotiated charge)	80% (of the recognized charge)
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"> <li>• The care, filling, removal or replacement of teeth and treatment of diseases of the teeth</li> <li>• Dental services related to the gums</li> <li>• Apicoectomy (dental root resection)</li> <li>• Orthodontics</li> <li>• Root canal treatment</li> <li>• Soft tissue impactions</li> <li>• Bony impacted teeth</li> <li>• Alveolectomy</li> <li>• Augmentation and vestibuloplasty treatment of periodontal disease</li> <li>• False teeth</li> <li>• Prosthetic restoration of dental implants</li> <li>• Dental implants</li> </ul>		
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.
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"> <li>• Dental implants</li> </ul>		
Blood and body fluid exposure	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.
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"> <li>• Services and supplies provided for the treatment of an illness that results from your clinical related injury as these are covered elsewhere in the student policy</li> </ul>		
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.
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"> <li>• Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)</li> <li>• Services and supplies provided by the trial sponsor without charge to you</li> <li>• 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)</li> </ul>		
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.



<b>The following are not covered under this benefit:</b>		
<ul style="list-style-type: none"> <li>Cosmetic treatment and procedures</li> </ul>		
	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Obesity bariatric Surgery and 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.
<b>Obesity surgery-travel and lodging</b>		
Maximum benefit payable for travel expenses for each round trip – three 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 – two 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 two days	\$100 per day up to two days
Maximum benefit payable for lodging expenses per companion for surgery stay	\$100 per day up to four days	\$100 per day up to four days
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"> <li>Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described above and in the <i>Eligible health services and exclusions – Preventive care and wellness</i> 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: <ul style="list-style-type: none"> <li>Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications</li> <li>Hypnosis or other forms of therapy</li> <li>Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement</li> </ul> </li> </ul>		
Maternity care that is not considered preventive 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.
<b>The following are not covered under this benefit:</b>		
<ul style="list-style-type: none"> <li>Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries</li> </ul>		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge)	50% (of the recognized charge)

	In-network coverage	Out-of-network coverage
<b>Gender affirming treatment</b>		
Gender affirming treatment, including surgical, hormone replacement therapy, and counseling treatment	Covered according to the Behavioral health section	Covered according to the Behavioral health section
<b>Behavioral health</b> Medically necessary treatment of mental health conditions and substance use disorders are covered under the same terms and conditions applied to other medical conditions and in accordance with the federal Mental Health Parity and Addiction Equity Act.		
<b>Mental Health Conditions &amp; Substance Use Disorder Treatment</b>		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Outpatient office visits (includes telemedicine consultations)	\$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	\$30 copayment then the plan pays 100% (of the balance of the recognized charge) per visit
Other outpatient treatment (includes skilled behavioral health services in the home)	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Partial hospitalization treatment		
Intensive outpatient program		
	<b>In-network coverage (IOE facility)*</b>	<b>Out-of-network coverage</b> (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
<b>Transplant services</b>		
Inpatient and outpatient transplant facility 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.
Inpatient and outpatient transplant physician and specialist 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.
Transplant services-travel and lodging	Covered	Covered
Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	\$10,000	\$10,000
Maximum payable for Lodging Expenses per IOE patient	\$50 per night	\$50 per night
Maximum payable for Lodging Expenses per companion	\$50 per night	\$50 per night

**The following are not covered under this benefit:**

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

	In-network coverage	Out-of-network coverage
<b>Infertility services</b>		
Treatment of 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.
<b>Fertility preservation services</b>		
Fertility preservation	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

**The following are not covered under the infertility treatment benefit:**

- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the 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
  - Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue
  - 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

<b>Specific therapies and tests</b>		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	50% (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	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit

	In-network coverage	Out-of-network coverage
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
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.
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"> <li>• Enteral nutrition</li> <li>• Blood transfusions and blood products</li> </ul>		
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Combined for short-term rehabilitation services and habilitation therapy services		
Acupuncture therapy	\$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	\$30 copayment then the plan pays 100% (of the balance of the recognized charge) per visit
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"> <li>• Acupressure</li> </ul>		
Chiropractic services	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
<b>Other services and supplies</b>		
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	Paid the same in-network coverage
Durable medical and surgical equipment	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"> <li>• Whirlpools</li> <li>• Portable whirlpool pumps</li> <li>• Sauna baths</li> <li>• Massage devices</li> <li>• Over bed tables</li> <li>• Elevators</li> <li>• Communication aids</li> <li>• Vision aids</li> <li>• Telephone alert systems</li> <li>• Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise</li> </ul>		



equipment even if they are prescribed by a physician		
	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Nutritional support	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.
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"><li>Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition</li></ul>		
Prosthetic devices including contact lenses for aniridia & Orthotics	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"><li>Services covered under any other benefit</li><li>Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace</li><li>Trusses, corsets, and other support items</li><li>Repair and replacement due to loss or misuse</li><li>Communication aids</li></ul>		
<b>Hearing Aid Exams</b>		
Hearing exam	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"><li>Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay</li></ul>		
Hearing Aids	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
Hearing aids maximum per ear	One hearing aid per ear every 24 month consecutive period	
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"><li>A replacement of:<ul style="list-style-type: none"><li>A hearing aid that is lost, stolen or broken</li><li>A hearing aid installed within the prior 60 month period</li></ul></li><li>Replacement parts or repairs for a hearing aid</li><li>Batteries or cords</li><li>Cochlear implants</li><li>A hearing aid that does not meet the specifications prescribed for correction of hearing loss</li><li>Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist</li></ul>		
<b>Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)</b>		
Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations)	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Low vision Maximum Fitting of contact Maximum	One comprehensive low vision evaluation every five years 1 visit	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item	50% (of the recognized charge) per item

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: up to 1 year supply Extended wear disposable: up to 1 year supply Non-disposable lenses: 1 year supply	
	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per policy year	One optical device	
<b>*Important note:</b> 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.		
<b>The following are not covered under this benefit:</b> <ul style="list-style-type: none"><li>Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes</li></ul>		
<b>Adult vision care Limited to covered persons age 19 and over</b>		
Adult routine vision exams (including refraction) Performed by a legally qualified ophthalmologist or therapeutic optometrist, or any other providers acting within the scope of their license Includes fitting of prescription contact lenses	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
<b>The following are not covered under this benefit:</b> Adult vision care <ul style="list-style-type: none"><li>Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses</li><li>Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes</li></ul> Adult vision care services and supplies <ul style="list-style-type: none"><li>Special supplies such as non-prescription sunglasses</li><li>Special vision procedures, such as orthoptics or vision therapy</li><li>Eye exams during your stay in a hospital or other facility for health care</li><li>Eye exams for contact lenses or their fitting</li><li>Eyeglasses or duplicate or spare eyeglasses or lenses or frames</li><li>Replacement of lenses or frames that are lost or stolen or broken</li><li>Acuity tests</li><li>Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures</li><li>Services to treat errors of refraction</li></ul>		

<b>Outpatient prescription drugs</b>		
<b>Policy year deductible and copayment/coinsurance waiver for risk reducing breast cancer</b>		
The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
<b>Outpatient prescription drug policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs</b>		
The prescription drug copayment will not apply to 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%.		
	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Preferred and non-preferred generic prescription drugs (including specialty drugs)</b>		
Your cost-share may not exceed \$250 for each 30 day supply of an individual prescription. This does not include any [policy year] deductible.		
For each fill up to a 30 day supply filled at a retail pharmacy	\$10 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Copayment is 50% (of the recognized charge) but will be no more than \$250 per supply then the plan pays 100% (of the balance of the recognized charge)
<b>Preferred brand-name prescription drugs (including specialty drugs)</b>		
Your cost-share may not exceed \$250 for each 30 day supply of an individual prescription. This does not include any [policy year] deductible		
For each fill up to a 30 day supply filled at a retail pharmacy	\$45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Copayment is 50% (of the recognized charge) but will be no more than \$250 per supply then the plan pays 100% (of the balance of the recognized charge)
<b>Non-preferred brand-name prescription drugs (including specialty drugs)</b>		
Your cost-share may not exceed \$250 for each 30 day supply of an individual prescription. This does not include any [policy year] deductible		
For each fill up to a 30 day supply filled at a retail pharmacy	\$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Copayment is 50% (of the recognized charge) but will be no more than \$250 per supply then the plan pays 100% (of the balance of the recognized charge)
Anti-cancer drugs taken by mouth- For each fill up to a 30 day supply	100% (of the negotiated charge)	100% (of the recognized charge)
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
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.	
	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
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.	

### Outpatient prescription drug exclusions

The following are not eligible health services:

- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as an eligible health service
- Dietary supplements, except as described in the *Eligible health services and exclusions -Nutritional Support* section
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as an eligible health service
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as an eligible health service
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate



- Implantable drugs and associated devices except for medically necessary implantable drugs and associated devices used to treat behavioral health conditions or as specifically stated in the schedule of benefits or the certificate
- Infertility:
  - Prescription drugs used primarily for the treatment of infertility
- Injectables including:
  - Any charges for the administration or injection of prescription drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting [with the exception of Depo Provera and other injectable drugs for contraception]
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide
- Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

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

### Out of Country claims

Out of Country claims should be submitted with appropriate medical service and payment information from the provider of service. Covered services received outside the United States will be considered at the Out-of-network level of benefits.

## General 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.

### Behavioral health treatment

- Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:
  - Remedial education services that are non-medical and are not medically necessary to treat mental health conditions or substance use disorders
  - Services provided in conjunction with school, vocation, work or recreational activities that are not medically necessary to treat mental health disorders or substance use disorders
  - Sexual deviations and disorders except mental health disorders or substance use disorders listed in the most recent edition of the DSM and International Classification of Diseases (ICD)

### Beyond legal authority

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

### Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of donated blood to the hospital, other than blood derived clotting factors
- [Any related services for donated blood including processing, storage or replacement expenses]
- The services of blood donors, including yourself, apheresis or plasmapheresis
- The blood you donate for your own use, excluding administration and processing expenses and except where described in the *Eligible health services and exclusions – Transplant services* section

### Clinical trial therapies (experimental or investigational)

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

### Cornea or cartilage transplants

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

### Cosmetic services and plastic surgery

- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body.

This exclusion does not apply to:

- Surgery after an accidental injury when performed as soon as medically feasible
- Coverage that may be provided under the Eligible health services under your plan - Gender reassignment (sex change) treatment section.

#### **Court-ordered testing**

- Court-ordered testing or care unless medically necessary

#### **Custodial care**

Services and supplies meant to help you with activities of daily living or other personal needs.

Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care [except in connection with hospice care], adult (or child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

This exclusion does not apply to medically necessary treatment of mental health disorders and substance use disorders

#### **Dental care for adults**

- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolectomy
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth
  - Prosthetic restoration of dental implants
  - Dental implants

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

#### **Educational services**

Examples of these services that are non-medical and are not medically necessary to treat mental health conditions or substance use disorders are:

- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services and exclusions – Diabetic services and supplies (including equipment and training)* section. This includes:
  - Special education
  - Remedial education
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program

### **Examinations**

Any health or dental examinations needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract
- 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 and exclusions – Other services* section in the certificate.

### **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

### **Gene-based, cellular and other innovative therapies (GCIT)**

The following are not eligible health services unless you receive prior written approval from us:

- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the *Medical necessity* section.

### **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, service or supply to increase or decrease height or alter the rate of growth
- **Surgical procedures** and devices to stimulate growth



### Incidental surgeries

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

### Judgment or settlement

- Services and supplies for the treatment of an injury or illness to the extent that payment is made as a judgment or settlement by any person deemed responsible for the injury or illness (or their insurers)

### Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

### 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*

### Other primary payer

- Payment for a portion of the charge that **Medicare** or another party pays for as the primary payer

### Outpatient prescription or non-prescription drugs and medicines

- Outpatient **prescription drugs** or non-prescription drugs and medicines provided by the **policyholder**

### Personal care, comfort or convenience items

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

### Private duty nursing

### 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 not permitted by law**

- Some laws restrict the range of health care services a **provider** may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

#### **Services provided by a family member**

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

#### **Sexual dysfunction and enhancement**

- Any treatment, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Implants, devices or preparations to correct or enhance erectile function or sensitivity
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

#### **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

#### **Students in mental health field**

- Any services and supplies provided to a covered student who is specializing in the mental health care field and who receives treatment from a provider as part of their training in that field

#### **Telemedicine**

- Services including:
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

#### **Therapies and tests**

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

#### **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

The Mount Saint Mary's University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health<sup>SM</sup> 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 1-877-480-4161.

### **Smartphone or Tablet**

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

### **Nondiscrimination Notice**

Aetna does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

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

These aids and services include:

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

If you need these services, have questions about our non-discrimination policy, or have a discrimination-related concern that you would like to discuss, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: P.O. Box 14462, Lexington, KY 40512 (HMO customers: P.O. Box 24030 Fresno, CA 93779)
- Email: [CRCordinator@aetna.com](mailto:CRCordinator@aetna.com)

Please visit <https://www.aetna.com/individuals-families/member-rights-resources/complaints-grievances-appeals.html#california> for information about how to file a complaint or grievance with the California Department of Insurance or California Department of Managed Health Care (for HMO enrollees).

You can also file a discrimination complaint with the United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex by following the instructions on the Department's website: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

### Language accessibility statement

*Interpreter services are available for free.*

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

### Español/Spanish

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

### አማርኛ/Amharic

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

### العربية/Arabic

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

### Bàsòò Wùdù/Bassa

Dè dè nìà kè dyédè gbo: ɔ jũ ké n̄ dyi Bàsòò-wùdù-po-nyò jũ n̄, n̄i à wudu kà kò dò po-poò b̄é n̄ gbo kpáa. Đá **1-877-480-4161** (TTY: 711).

### 中文/Chinese

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

### فارسی/Farsi

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

### Français/French

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

### ગુજરાતી/Gujarati



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

#### **Kreyòl Ayisyen/Haitian Creole**

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

#### **Igbo**

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

#### **한국어/Korean**

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

#### **Português/Portuguese**

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

#### **Русский/Russian**

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

#### **Tagalog**

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

#### **اردو/Urdu**

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

#### **Tiếng Việt/Vietnamese**

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

#### **Yorùbá/Yoruba**

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