Aetna Student Health
Plan Design and Benefits

Open Choice PPO

Occidental College

Policy Year: 2024–2025
Policy Number: 232090
https://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 Occidental College students and their eligible dependents. 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.

EMMONS HEALTH SERVICES

Emmons Wellness Center is committed to providing the students of Occidental College with accessible, culturally sensitive, and high quality medical care, psychological counseling services, and student-driven wellness education. Emmon's staff utilizes a comprehensive approach to wellness services that seeks to enhance the physical and emotional wellbeing of students so they may be fully engaged in all aspects of college life.

Emmons medical providers are available to all students Monday-Friday, 9am – 12pm and 1pm – 4pm via Zoom telehealth consultation. Appointments and walk-ins are available. Students wishing to see a medical provider should call the front desk at (323) 259-2657 to be put on a medical provider's schedule. The Center is closed on holidays and has limited summer hours. Check the Emmons Wellness Center website for update at www.oxy.edu/emmons-wellness-center.

Coverage Dates

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

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

Coverage Period	Coverage Start Date	Coverage End Date
Fall	08/01/2024	12/31/2024
Spring/Summer	01/01/2025	07/31/2025

Rates

	Fall	Spring/Summer
Student	$1,620.50	$1,620.50
Spouse	$1,620.50	$1,620.50
One Child	$1,620.50	$1,620.50
Two or More Children	$3,241.00	$3,241.00

All refund requests should be sent to the University who must confirm the student status with Gallagher Student Health & Special Risk and submit the refund request on behalf of the student. All refunds will be assessed a $35 processing fee.

Student Coverage

Eligibility

All students who are registered in a degree program are automatically enrolled in this insurance plan at registration, unless proof of comparable coverage is furnished. International Students are automatically enrolled in this insurance plan at registration.

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.

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.

Enrollment

Eligible students will be automatically enrolled in this Plan, unless you submit a completed waiver by visiting www.jcbins.com and selecting your school from the dropdown and registering by the deadline dates listed on the previous page.

Dependent Coverage

Eligibility

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

Enrollment

To enroll your dependents, please opt into the plan and create your student account at www.jcbins.com.

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

Your newborn child is covered on your health plan for the first 31-days from the moment of birth. To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31-day period. You must still enroll the child within 31-days of birth even when coverage does not require payment of an additional premium contribution for the newborn. If you miss this deadline, your newborn will not have health benefits after the first 31-days. If your coverage ends during this 31-day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 31-day period has not ended.

A child that you, or that you and your spouse, civil union partner or domestic partner adopts or is placed with you for adoption, is covered on your plan for the first 31-days after the adoption or the placement is complete. To keep your child covered, we must receive your completed enrollment information within 31-days after the adoption or placement for adoption. You must still enroll the child within 31-days of the adoption or placement for adoption even when coverage does not require payment of an additional **premium** contribution for the child. If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31-days. If your coverage ends during this 31-day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31-day period has not ended.

If you need information or have general questions on dependent enrollment, call Gallagher Student Health & Special Risk at 323-603-2007.

Medicare Eligibility Notice

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

Termination and Refunds

All refund requests must be sent to the University who will confirm nonstudent status with Gallagher Student Health & Special Risk, 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 Gallagher Student Health & Special Risk account.

In-network Provider Network

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

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

Precertification

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification. Your in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify when required, there will be 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.

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 medical services	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 60 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**
Policy year deductibles		
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$150 per policy year	$300 per policy year
Spouse	$150 per policy year	$300 per policy year
Each Child	$150 per policy year	$300 per policy year
Family	None	None
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network care for Preventive care and wellness, • In-network care for Pediatric Vision Care, • In-network care for Pediatric Dental Type A services, • In-network care for Outpatient Prescription Drugs, • In-network and out-of-network care for Physician, specialist and consultants Office visits, • In-network and out-of-network care Walk-in clinic visits, • In-network and out-of-network care Hospital Emergency room, • In-network and out-of-network care for Chiropractic services, • In-network and out-of-network care for Acupuncture, • In-network and out-of-network care for Mental Health and Substance related disorders Outpatient Office Visits, • In-network and out-of-network care for Abortions, • In-network and out-of-network care for Well Newborn Nursery Care.		
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.		

Maximum out-of-pocket limits		
	In-network coverage	**Out-of-network coverage**
Student	$6,850 per policy year	Unlimited
Spouse	$6,850 per policy year	Unlimited
Each Child	$6,850 per policy year	Unlimited
Family	$13,700 per policy year	Unlimited

	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	Not Covered
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	Not Covered
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	Not Covered
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	Not Covered

	In-network coverage	Out-of-network coverage
Stress management counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Chronic condition counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Maximum:	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration.	
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	Not Covered
Lactation support and counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	Not Covered
Family planning services – contraceptives		
Contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered

	In-network coverage	Out-of-network coverage
Contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit For each 30 day supply or 12 month supply	100% (of the negotiated charge) per item No copayment or policy year deductible applies	Not Covered
Voluntary sterilization, including vasectomy services-Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	60% (of the recognized charge)
Voluntary sterilization, including vasectomy services-Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	60% (of the recognized charge)
The following are not covered under this benefit: • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA		
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 No policy year deductible applies	60% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing performed at a physician or specialist office	80% (of the negotiated charge)	60% (of the recognized charge)
Allergy injections treatment performed at a physician or specialist office	80% (of the negotiated charge)	60% (of the recognized charge)
Allergy sera and extracts administered via injection at a physician or specialist office	80% (of the negotiated charge)	60% (of the recognized charge)
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)	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic		

	In-network coverage	Out-of-network coverage
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
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 No policy year deductible applies	$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit No policy year deductible applies
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per admission	60% (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	60% (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	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Home health Care	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • 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

	In-network coverage	**Out-of-network coverage**
Hospice-Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospice-Outpatient	80% (of the negotiated charge) per visit	60% (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		
Skilled nursing facility-Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospital emergency room	$150 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	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

	In-network coverage	Out-of-network coverage
Urgent care	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	60% (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)

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	100% (of the recognized charge) per visit
Type B services	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit
Type C services	50% (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

Accidental injury to sound natural teeth	100% (of the negotiated charge)	100% (of the recognized charge)

The following are not covered under this benefit:

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

	In-network coverage	Out-of-network coverage
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.
The following are not covered under this benefit: • Dental implants		
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.
The following are not covered under this benefit: • 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		
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.
The following are not covered under this benefit: • 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)		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Cosmetic treatment and procedures		
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.
Obesity surgery-travel and lodging		
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

	In-network coverage	Out-of-network coverage
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
The following are not covered under this benefit: • 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 *Eligible health services and exclusions – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are: - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications - Hypnosis or other forms of therapy - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement		
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.
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Abortion services (including pre abortion and follow-up abortion related services)	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
The following are not covered under this benefit: • Reversal of voluntary sterilization procedures, including related follow-up care		
Gender affirming treatment		
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
Behavioral health 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.		
Mental Health Conditions & Substance Use Disorder Treatment		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission

	In-network coverage	Out-of-network coverage
Outpatient office visits (includes telemedicine consultations)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit No policy year deductible applies
Other outpatient treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive outpatient program	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
	In-network coverage (IOE facility)*	**Out-of-network coverage** (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Transplant services		
Inpatient and outpatient transplant facility services	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		
Infertility services		
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.
Fertility preservation services		
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

	In-network coverage	**Out-of-network coverage**
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	60% (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.

The following are not covered under this benefit:

- Enteral nutrition
- Blood transfusions and blood products

	In-network coverage	Out-of-network coverage
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Acupuncture therapy	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit No policy year deductible applies
The following are not covered under this benefit: • Acupressure		
Chiropractic services	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit No policy year deductible applies
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Other services and supplies		
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	$150 copayment then the plan pays 100% (of the balance of the negotiated charge) per trip	Paid the same in-network coverage
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient care		
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician		

	In-network coverage	Out-of-network coverage
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.
The following are not covered under this benefit: • 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		
Prosthetic devices including contact lenses for aniridia & Orthotics	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: • Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss or misuse • Communication aids		
Hearing Aid Exams		
Hearing exam	100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit No policy year deductible applies
The following are not covered under this benefit: • Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay		
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations)	100% (of the negotiated charge) per visit No policy year deductible applies	100% (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 No policy year deductible applies	100% (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	
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.

<table>
<tr><th></th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td>Maximum number of optical devices per policy year</td><td colspan="2">One optical device</td></tr>
<tr><td colspan="3">*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.</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes</td></tr>
<tr><td colspan="3">Adult vision care Limited to covered persons age 19 and over</td></tr>
<tr><td>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</td><td>$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit

No policy year deductible applies</td><td>50% (of the recognized charge) per visit</td></tr>
<tr><td>Maximum visits per policy year</td><td colspan="2">1 visit</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
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
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</td></tr>
</table>

Outpatient prescription drugs		
Policy year deductible and copayment/coinsurance waiver for risk reducing breast cancer		
The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
Outpatient prescription drug policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs		
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%.		
Outpatient prescription drug copayment waiver for contraceptives		
The outpatient prescription drug prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy. This means that such contraceptive methods are paid at 100% for: • All FDA approved contraceptive prescription drugs and devices, including over-the-counter (OTC) contraceptive prescription drugs and devices. Related services and supplies needed to administer covered devices will also be paid at 100%. • A therapeutic equivalent prescription drug or device when a prescription drug or device is not available or is deemed medically inadvisable by your provider when you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
Generic prescription drugs (including specialty drugs) 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	$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Preferred brand-name prescription drugs (including specialty drugs) 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	$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered

	In-network coverage	Out-of-network coverage
Non-preferred brand-name prescription drugs (including specialty drugs) 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	$65 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$162.50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Contraceptives (birth control)		
For each fill up to a 12 month supply of generic and OTC drugs and devices filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	Not Covered
For each fill up to a 12 month supply of brand name prescription drugs and devices filled at a retail pharmacy	Paid according to the type of drug per the schedule of benefits, above A brand name contraceptive is 100% (of the negotiated charge), No policy year deductible if there are no generic therapeutic equivalents.	Not Covered
Contraceptive important note: The prescription drug cost share will not apply to contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes over-the-counter (OTC) contraceptive prescription drugs and devices for each of the methods identified by the FDA. If a prescription drug is not available or inadvisable by your provider, the therapeutic equivalent prescription drug for that method will be paid at 100%. The prescription drug cost share will apply to prescription drugs that have a generic equivalent or therapeutic equivalent obtained at a network pharmacy unless you receive a medical exception. A therapeutic equivalent is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury. You can fill up to a 12 month supply at one time.		
Anti-cancer drugs taken by mouth- For each fill up to a 30 day supply	100% (of the negotiated charge) No policy year deductible applies	Not Covered
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	Not Covered

	In-network coverage	Out-of-network coverage
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	Not Covered
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 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	Not Covered
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

Generic prescription drug substitution

If you or your prescriber requests a covered brand-name prescription drug when a covered generic prescription drug equivalent is available, you will be responsible for the cost difference between the generic prescription drug and the brand-name prescription drug, plus the cost sharing that applies to the brand-name prescription drug.

The cost difference is not applied towards your policy year deductible or maximum out-of-pocket limit.

Dispense as written (DAW)

If a prescriber prescribes a covered brand-name prescription drug where a generic prescription drug equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost sharing for the brand-name prescription drug. If a prescriber does not specify DAW and you request a covered brand-name prescription drug where a generic prescription drug equivalent is available, you will be responsible for the cost difference between the brand-name prescription drug and the generic prescription drug, plus the cost sharing that applies to the brand-name prescription drug.

The cost difference related to a prescription drug that is not specified as "DAW" is not applied towards your policy year deductible or maximum out-of-pocket limit.

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 disorders 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

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)

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 service 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. (Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.)
- Coverage that may be provided under the Eligible health services and exclusions - Gender affirming treatment section.

Court-ordered services and supplies

- 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:

- 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* 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

Hearing aids

Any tests, appliances and devices to:

- Improve your hearing
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech

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:
  - **I**mplants, 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 given when you are not present at the same time as the **provider**
- 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 Occidental College Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health[SM] 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: CRCoordinator@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 ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-877-480-4161** (መስማት ለተሳናቸው: **711**).

العربية**/Arabic**

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

Bàsɔ̀ɔ̀ Wùɖù/Bassa

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

中文/Chinese

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

فارسی**/Farsi**

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

Français/French

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

ગુજરાતી**/Gujarati**

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

Kreyòl Ayisyen/Haitian Creole

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

Igbo

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

한국어/Korean

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

Português/Portuguese

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

Русский/Russian

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

Tagalog

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

Urdu/اردو

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

Tiếng Việt/Vietnamese

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

Yorùbá/Yoruba

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