Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

Aetna Student Health[SM]
Plan Design and Benefits Summary

OA Managed Choice POS

University of San Diego

Policy Year: 2021 - 2022
Policy Number: 474959
www.aetnastudenthealth.com
1-866-746-6590

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

UNIVERSITY OF SAN DIEGO STUDENT HEALTH CENTER

Patient Care Hours Monday, Tuesday, Thursday & Friday
8:30 a.m. to 4:30 p.m.

Patient Care Hours during Fall and Spring semesters:
Wednesday Mornings: 8:30 a.m. to 11:00 a.m.
Wednesday afternoon and evenings: 1:30 p.m. to 6:30 p.m.

Note: Closed from 11:00 a.m. to 1:30 p.m. for Dept. Staff Meeting.

Immunization and Laboratory Clinic Hours
Monday, Tuesday, Thursday, Friday 9:00 a.m. to 3:00 p.m.
Wednesday 9:00 a.m. to 11:00 a.m. and 1:30 p.m. to 5:00 p.m.

Outpatient Medical Care

The Policy Deductible will be waived for a student when treatment is rendered at the Student Health Center (SHC) or Counseling Center or when referred to a Preferred Provider by the SHC or Counseling Center. Waiver provision is not applicable during Winter, Spring, and Summer breaks.

Quality, accessible and convenient outpatient medical care is provided for acute illnesses, minor injuries, preventive care and medical problems. A physician, nurse practitioner, and/or physician assistant and registered nurses are on duty during operating hours.

In order to minimize patient waiting time, students are strongly encouraged to schedule appointments in advance. Patients without appointments will be triaged by the registered nurse, who will determine whether the patient should be seen that day or scheduled for the next day. Please note that patients who arrive more than 10 minutes late for appointments may need to reschedule their appointment for another day.

All currently registered undergraduate, graduate, law and paralegal students who have paid the health fee are eligible for services at the USD Student Health Center. All non-students (i.e. visiting scholars) are not eligible to utilize the services of the Wellness units and are therefore not eligible to waive the Preferred Care Deductible

Most services are provided free of charge, and modest fees to cover costs are required for medications, immunizations and certain physical exams and labs. Payment is due at the time of service at the Student Health Center. Patients may pay with *check, CampusCash*, *AMERICAN EXPRESS* or *VISA/Mastercard*. (Cash is not accepted).

SHC Summer and Intersession: Monday – Friday, 10:00 a.m. to 3:00 p.m.

SHC Location: Maher Hall 140 For additional information regarding services provided at the Student Health Center visit: **https://www.sandiego.edu/health-center/** In case of emergency, call **911** or Public Safety Dispatch at **(619) 260-7777** or go directly to an emergency care facility.

For non-emergency situations please visit or call the University of San Diego Student Health Center at:

5998 Alcalá Park Maher Hall 140 San Diego, CA 92110 **(619) 260-4595**

Coverage Periods New Domestic and all International Students

Students: Coverage for new Domestic and all International students enrolled for the Annual term will become effective at 12:01 AM on August 01, 2021 and will terminate at 11:59 PM on July 31, 2022.

Spring Semester students: Coverage for all insured students enrolled for the Spring Semester, will become effective at 12:01 AM on February 1st, 2022, and will terminate at 11:59 PM on July 31, 2022.

Coverage Periods Returning Domestic Students

Students: Coverage for all returning Domestic students enrolled for the Annual term, will become effective at 12:01 AM on August 15, 2021 and will terminate at 11:59 PM on July 31st, 2022.

Rates

The rates below are inclusive of any fees that may be assessed by Gallagher Student Health.

International Student Plan Cost

	Annual
Student	$3,370

Domestic Student Plan Cost

	Annual
Student	$3,370

Student Coverage

Eligibility

All full-time **Domestic** students are automatically enrolled in the Student Health Insurance Plan at registration. If you are currently insured by a plan that provides comparable coverage, you may waive coverage under the Student Health Insurance Plan.

All **International and English Language Academy** students are automatically enrolled in this insurance plan at registration and the premium for coverage is added to their tuition billing, unless proof of comparable coverage is furnished. In addition, all degree-seeking international students on visas that permit full-time study, degree-seeking international students on F-1 student visas, International exchange students on J-1 student visas, Visiting scholars and researchers on J-1 visas are eligible to enroll in the Student Health Insurance Plan.

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

Enrollment

Any student who wants to be enrolled in the Student Health Insurance Plan can elect to actively enroll in the plan by completing and submitting an enrollment form and are encouraged to do so by the deadline. Immediately upon submitting the Enrollment Form, you will receive a reference number indicating the form has been successfully submitted

Enrollment Process/Procedure

- Go to www.gallagherstudent.com/USD.
- Login using your MySanDiego account and password
- Click the green 'Enroll' button under 'Plan Summary'.
- Follow the instructions to complete the form.
- Save a copy of your reference number.

Waiver Process/Procedure

Any student who is currently enrolled in a health insurance plan that meets the University's waiver requirements and that will be in effect until **July 31st, 2022** can elect to waive the University of San Diego Student Health Insurance Plan. Recognizing a student's health insurance coverage may change, at the beginning of each academic year students will be asked to provide proof of comparable coverage in order to waive the Student Health Insurance Plan. To document proof of comparable coverage, an online waiver form must be completed and submitted by the deadline.

Waiver Process & Criteria

Waive

- Go to www.gallagherstudent.com/USD.
- Login using your MySanDiego account and password
- Click the yellow 'Waive' button under 'Plan Summary'.
- Follow the instructions to complete the form.
- Save a copy of your reference number. This number only confirms submission, not approval of your form.

Immediately upon submitting the Waiver Form, you will receive a reference number indicating that the form has been successfully submitted. The online process is the only accepted process for waiving coverage. The University of San Diego reserves the right to audit and subsequently reject a waiver request. If it is determined that a student waived coverage with a health insurance plan that was not comparable coverage, the student will be automatically enrolled in the Student Health Insurance Plan, effective the date that the determination was made and there will be no pro-rata of premium.

Students can only waive the Student Health Insurance Plan if they are enrolled in an insurance plan that meets the University's waiver requirements. This means the policy must:

- Be in effect throughout the semester and renewable for continuous coverage
- Have an unlimited policy maximum
- Include outpatient care (doctor visits, outpatient surgery, etc.)
- Include inpatient and outpatient hospital services
- Have **$25,000** Repatriation and **$50,000** Medical Evacuation coverage (required for International Students)
- Services should include but are not limited to:
    - Preventive and non-urgent care
    - Emergency care
    - Surgical care
    - Lab work & Diagnostic Testing, X-Rays
    - Physical therapy
    - Chiropractic care
    - Prescription drugs
    - Mental health and substance abuse treatment

In the event students waive the Student Health Insurance Plan and then loses current coverage due to a qualifying event, (i.e. parent loss of coverage or the maximum age limit available is attained), students have the right to petition to add coverage within **31 days** of the qualifying event. If the petition is received within **31 days** of the qualifying event, there will be no break in coverage. For petitions received after the **31 days**, the effective date of coverage will be the date that the petition is received at Gallagher Student Health. If approved, the premium will not be prorated.

Enrollment & Waiver Deadline

Enrollment & Waiver Deadline

Annual	Spring
September 13, 2021	February 04, 2022

If premium is received after the effective date, coverage will be made effective the date the correct premium is received by Gallagher Student Health & Special Risk. Enrollment forms will be accepted up until 30 days of the requested coverage period. Premium is not prorated. **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, upon written request received by Aetna within 90 days of withdrawal from school.

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 pre-certify when required, up to a $500 penalty for each type of eligible health service that was not pre-certified. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to www.aetnastudenthealth.com.

Precertification Call

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

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

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 **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	$300 per policy year	$600 per policy year
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-Network Care for Preventive Care Expense benefits, Physician and specialist services office visits, Consultant services office visits, Walk-in clinic visits, Urgent care, Pediatric Dental Benefits, Outpatient mental disorders treatment office visits, Outpatient substance abuse office visits, and Outpatient prescription drugs, Services for which a referral for the condition is provided by the Student Health Center, and all services rendered by the Student Health Center • In-Network and Out-of-Network care for Pediatric Vision Benefits and Well newborn nursery care		
Maximum out-of-pocket limits		
	In-network coverage	**Out-of-network coverage**
Student	$7,900 per policy year	$12,700 per policy year

Eligible health services	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (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	65% (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	

Eligible health services	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	65% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (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	65% (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	65% (of the recognized charge) per visit
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit
Maximum:	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration.	
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	65% (of the recognized charge) per visit

Eligible health services	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	65% (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	65% (of the recognized charge) per item
Family planning services – female contraceptives		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit
Female 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	65% (of the recognized charge) per item
Female Voluntary sterilization-Inpatient & Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	65% (of the recognized charge)
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Male contraceptive methods, sterilization procedures or devices		
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) (includes telemedicine consultations)	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	65% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing & Allergy injections treatment including Allergy sera and extracts administered via injection performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
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)	65% (of the recognized charge)
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic		
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	65% (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 (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)	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	65% (of the recognized charge) per visit
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	65% (of the recognized charge) per admission
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	65% (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	65% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
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	65% (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		
Hospice-Inpatient	80% (of the negotiated charge) per admission	65% (of the recognized charge) per admission
Hospice-Outpatient	80% (of the negotiated charge) per visit	65% (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	65% (of the recognized charge) per admission
Hospital emergency room	$150 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

Eligible health services	In-network coverage	Out-of-network coverage
Urgent care	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	65% (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	70% (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, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered **cosmetic**.

- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material or
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants (that are determined not to be **medically necessary** mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including **temporomandibular joint dysfunction** disorder (TMJ) and **craniomandibular joint dysfunction** disorder (CMJ) treatment, orthognathic **surgery**, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services 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 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, except as **medically necessary**
- Treatment by other than a **dental provider**

Eligible health services	**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)

Eligible health services	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.
Coverage is limited to routine patient services from in-network providers.		
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 four days	$100 per day up to four days

Eligible health services	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.
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	65% (of the recognized charge) No policy year deductible applies
Family planning services – other		
Voluntary sterilization for males-surgical services	80% (of the negotiated charge)	65% (of the recognized charge)
Reversal of voluntary sterilization	80% (of the negotiated charge)	65% (of the recognized charge)
Abortion	80% (of the negotiated charge)	65% (of the recognized charge)
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the Behavioral health section	Covered according to the Behavioral health section
All other cosmetic services and supplies not listed under eligible health services above are not covered under this benefit. This includes, but is not limited to the following: - Rhinoplasty - Face-lifting - Lip enhancement - Facial bone reduction - Blepharoplasty - Liposuction of the waist (body contouring) - Hair removal (including electrolysis of face and neck) - Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which are used in feminization - Voice and communication therapy - Chest binders - Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered **cosmetic**		

Eligible health services	In-network coverage	Out-of-network coverage
Mental Health & Substance Abuse Treatment Coverage provided under the same terms, conditions as any other **illness**.		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission	65% (of the recognized charge) per admission
Outpatient office visits (includes telemedicine consultations)	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	65% (of the recognized charge) per visit
Other outpatient treatment (includes skilled behavioral health services in the home)	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Eligible health services	**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		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Treatment of infertility		

Basic infertility services Inpatient and outpatient care - basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
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 services 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, embryos or sperm
- The care of the donor in a donor egg cycle which includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers
- The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which the person is not genetically related
- Obtaining sperm from a person not covered under this plan for ART services
  - Home ovulation prediction kits or home pregnancy tests
  - The purchase of donor embryos, donor oocytes, or donor sperm
  - Reversal of voluntary sterilizations, including follow-up care
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)
- ART services are not provided for out-of-network care

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	65% (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	65% (of the recognized charge) per visit
Eligible health services	**In-network coverage**	**Out-of-network coverage**

Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	65% (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		
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	65% (of the recognized charge) per visit
Acupuncture therapy	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
The following are not covered under this benefit: • Acupressure		
Chiropractic services	80% (of the negotiated charge) per visit	65% (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.
Other services and supplies		
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	65% (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		
Eligible health services	**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	65% (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	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Hearing aid exam maximum	One hearing exam every policy year	
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	70% (of the recognized charge) per visit No policy year deductible applies
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	70% (of the recognized charge) per item No policy year deductible applies
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.
Maximum number of optical devices per policy year	One optical device	

*__Important note__: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.		
The following are not covered under this benefit: • Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes		
Adult vision care Limited to covered persons age 19 and over		
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	65% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
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		

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs		
You have to meet your prescription drug policy year deductible below before this plan pays for outpatient prescription drug benefits.		
Student	$100 per policy year	N/A
**Note: When the plan includes both a medical policy year deductible and a separate outpatient prescription drug policy year deductible, the combined policy year deductible amounts for in-network coverage will not be more than $7,350 per person per policy year.		
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 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.		
Preferred Generic prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	$15 copayment per supply $100 Prescription Drug Deductible Applies	Not Covered
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$37.50 copayment per supply $100 Prescription Drug Deductible Applies	Not Covered
Preferred Brand-Name prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	$40 copayment per supply $100 Prescription Drug Deductible Applies	Not Covered

Eligible health services	In-network coverage	Out-of-network coverage
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$100 copayment per supply $100 Prescription Drug Deductible Applies	Not Covered
Non-Preferred Generic prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	$65 copayment per supply $100 Prescription Drug 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 $100 Prescription Drug Deductible Applies	Not Covered
Non-Preferred Brand-Name prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	$65 copayment per supply $100 Prescription Drug 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 $100 Prescription Drug Deductible Applies	Not Covered
Orally administered anti-cancer prescription drugs- For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge per prescription or refill No copayment or 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
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.	

The following are not covered under the outpatient prescription drugs benefit:

- Biological sera
- Compounded prescriptions containing bulk chemicals not approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones
- Cosmetic drugs including medications and preparations used for cosmetic purposes
- Devices, products and appliances, except those that are specially covered
- Dietary supplements
- Drugs or medications
  - Which do not, by federal or state law, require a **prescription** order i.e. over-the-counter (OTC) drugs), even if a **prescription** is written except as specifically provided above
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while an inpatient of a healthcare facility
  - Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been 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)
  - For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
  - That are used to treat increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the **covered person** meets one or more clinical criteria detailed in our **precertification** and clinical policies
- Duplicative drug therapy (e.g. two antihistamine drugs)
- Immunizations related to travel or work
- **Infertility**
  - **Injectable prescription drugs** used primarily for the treatment of **infertility**
- Injectables
  - Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by us.
  - Needles and syringes, except for those used for self-administration of an injectable drug.
  - Any drug which, due to its characteristics, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription drugs**:
  - Filled prior to the effective date or after the termination date of coverage under this plan.
  - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **preferred drug guide**.
  - That are not **medically necessary** or otherwise improper, and drugs obtained for use by anyone other than the person identified on the ID card.
- Refills dispensed more than one year from the date the latest **prescription** order was written
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- A manufacturer's product when the same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the **preferred drug guide**
- Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our **preferred drug guide**

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:
- **Stay** in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
- Education service including wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders except as described in the *Eligible health services and exclusions – Preventive care and wellness* section
- Pathological gambling, kleptomania, pyromania

Breasts

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

Clinical trial therapies (experimental or investigational)

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

Cosmetic services and plastic surgery

- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body. Whether or not for psychological or emotional reasons. Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.

This exclusion does not apply to:

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

Custodial care
Examples are:

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

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 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
  - Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program

Elective treatment or elective surgery

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

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

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.

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-medically necessary services and supplies

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

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 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

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

Wilderness treatment programs

See *Educational services* within this section

The University of San Diego Student Health Insurance Plan is underwritten by Aetna Life Insurance Company Aetna Health and Life Insurance Company (Aetna). Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company Aetna Health and 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.

Non-Discrimination

Aetna is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

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, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.

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 Wùdù/Bassa

Dè dɛ nìà kɛ dyɛ́dɛ́ gbo: Ɔ jǔ kɛ́ m̀ dyi Bàsɔ̀ɔ̀-wùdù-po-nyɔ̀ jǔ nɨ́, nɨ̀ɨ à wudu kà kò dò po-poɔ̀ ɓɛ́ m̀ gbo kpáa. Ɓá **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**).

اردو/Urdu

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

2021/2022 Plan Design & Benefits Summary Update

The following changes have been made to the original plan design and benefits summary describing your plan.

Unless otherwise indicated, all changes listed below are retroactive to your plan's effective date.

Issue Date of this Update: 10/25/2021
Page Number: see below

Restated the Gender affirming treatment benefit on page 15 as follows:

Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the Behavioral health section	Covered according to the Behavioral health section

Restated the Family planning services – female contraceptives benefit on page 9 as follows:

Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit
Female 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	65% (of the recognized charge) per item
Female Voluntary sterilization-Inpatient & Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	65% (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		

Restated the following plan exclusions on pages 25 and 26

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)

Educational services

Examples of these services that are non-medical and are not medically necessary to treat mental health disorders 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
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution). This exclusion does not include therapy by a licensed provider for behavioral health services if provided on an outpatient basis as part of a wilderness treatment program.
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program