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# Aetna Student Health<sup>SM</sup>

## Plan Design and Benefits Summary

### OA Elect Choice EPO

## Harvey Mudd College

Policy Year: 2020 – 2021

Policy Number: 867938

[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)

(877) 480-4161



This is a brief description of the Student Health Plan. The plan is available for Harvey Mudd 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 [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com). If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

## Student Health Services

Student Health Services (SHS) is The Claremont Colleges health facility. All Covered Charges incurred at SHS are paid at 100%. Staffed by doctors, nurse practitioners and medical support staff, it is open

Monday, Tuesday and Friday 8:00 a.m. to 5:00 p.m., Wednesday 8:00 a.m. to 7:00 p.m. and Thursday 9:00 a.m. to 5:00 p.m. during the Fall and Spring semesters.

Hours are subject to change. Please check the SHS webpage: <https://services.claremont.edu/student-health-services/>

## Coverage Dates and Rates

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

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
Annual*	08/30/2020	08/29/2021	09/30/2020
Fall*	08/30/2020	01/03/2021	09/30/2020
Spring/Summer	01/04/2021	08/29/2021	02/04/2021
Summer	05/15/2021	08/29/2021	06/15/2021

\* Early Start students are eligible as of 08/01/2020.

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

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
Annual*	08/30/2020	08/29/2021	09/30/2020
Fall*	08/30/2020	01/03/2021	09/30/2020
Spring/Summer	01/04/2021	08/29/2021	02/04/2021
Summer	05/15/2021	08/29/2021	06/15/2021

\* Early Start students are eligible as of 08/01/2020.

## Rates

The rates below reflect premiums for the Plan underwritten by Aetna Health and Life Insurance Company (Aetna), as well as a **The Claremont Colleges administrative fee**.

Undergraduate Rates				
	Annual	Fall Semester	Spring/Summer Semester	Summer Semester
<b>Student</b>	\$2,655.00	\$930.00	\$1,735.00	\$785.00
<b>Spouse</b>	\$2,655.00	\$930.00	\$1,735.00	\$785.00
<b>One Child</b>	\$2,655.00	\$930.00	\$1,735.00	\$785.00
<b>Two or More Children</b>	\$5,310.00	\$1,860.00	\$3,470.00	\$1,570.00

### Who is eligible?

The following students are eligible for enrollment in the plan:

- All domestic undergraduate students who pay registration fees and are matriculating toward a degree through Harvey Mudd College.
- All international undergraduate students (this includes non-student exchange visitors such as visiting faculty, scholars, and researchers) with a current passport or student visa (F-1, J-1, or M-1 visa) temporarily located outside the home country who have not been granted permanent residency status while engaged in full-time educational activities through Harvey Mudd College.

All continuing and newly matriculated students are required to have health insurance coverage. You will be automatically enrolled in SHIP, unless proof of comparable coverage is provided and a waiver is submitted by the Waiver Deadline Date. If you have other health insurance, such as coverage as a dependent under your parent's or spouse's insurance plan and you do not wish to enroll in SHIP, you may submit a waiver application (domestic students only). You must remain enrolled in school for at least the first 31 days from their effective date of coverage, except in the case of medical withdrawal (as verified and approved by the school) to maintain eligibility.

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

### Enrollment

All domestic undergraduate students — who are required to have health insurance but who are allowed to waive with comparable coverage — who have not waived coverage by the Waiver Deadline Date will be automatically enrolled in the plan. All international undergraduate students will be automatically enrolled in the plan and no waiver will be allowed.

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

**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.

## Dependent Coverage

### Eligibility

Covered students may also enroll their lawful spouse, domestic partner, and their dependent children under age of 26.

Eligible Dependents must be enrolled on the date the student enrolls or within 31 days of birth, adoption, marriage, arrival in the U.S., or termination of other coverage (proof of date may be requested). Students who wish to enroll their eligible Dependents must submit a completed enrollment form (available online on your school webpage at **[www.4studenthealth.com](http://www.4studenthealth.com)**), with proper premium payment, by the Deadline Date listed. Newly acquired Dependents (spouse and/or children) are not subject to the Enrollment Deadline Dates. However, enrollment and full premium payment for all newly acquired Dependents (spouse and/or children) must be submitted within 31 days of the attainment of such Dependents. Otherwise, enrollment cannot be accepted after the Enrollment Deadline Dates listed.

For questions regarding enrollment, contact Relation Insurance Services at (800) 537-1777. |

### 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

You can only get care outside of the **service area** (out-of-network) for **emergency services**.

A LISTING OF ALL **IN-NETWORK PROVIDERS** IN YOUR **SERVICE AREA** MAY BE ACCESSED AT ANY TIME IN OUR **DIRECTORY**. YOU CAN SEARCH THE **DIRECTORY** AT [WWW.AETNA.COM](http://WWW.AETNA.COM) UNDER THE DOCFIND® LABEL.

## Service area

Your plan generally pays for eligible health services only within a specific geographic area, called a service area. There are some exceptions, such as for emergency services, urgent care and transplants.

## 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](http://www.aetnastudenthealth.com)**.

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

#### OA Elect Choice EPO

Policy year deductible	In-network coverage	Out-of-network coverage
You have to meet your policy year deductible before this plan pays for benefits.		
Student	\$500 per policy year	N/A
Spouse	\$500 per policy year	N/A
Each Child	\$500 per policy year	N/A
Family	None	N/A
<b>Policy year deductible waiver</b>		
The policy year deductible is waived for all of the following eligible health services: <ul style="list-style-type: none"><li>• In-Network Care for Preventive care and wellness, Pediatric Vision and Dental Care, Outpatient Prescription Drugs, and services performed at the Student health Center and for services referred by the student health center</li></ul>		
<b>Maximum out-of-pocket limit per policy year</b>		
Student	\$7,350 per policy year	N/A
Spouse	\$7,350 per policy year	N/A
Each Child	\$7,350 per policy year	N/A
Family	\$14,700 per policy year	N/A
<b>Referral Requirements</b>		
<b>**Referrals are NOT required for the 20/21 policy year (08/30/2020 through 08/29/2021).</b>		
A Student Health Services (SHS) referral is required for non-emergency care within a 25-mile radius from campus, unless SHS is closed. The Preferred care deductible is waived for services performed at the Student health Center and for Preferred Care referred by the student health center.		
<b>Exceptions</b>		
<ul style="list-style-type: none"><li>• Treatment is for an Emergency Medical Condition. A referral is required for follow-up care.</li><li>• Obstetric and Gynecological Treatment</li><li>• Pediatric Care</li><li>• Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness)</li><li>• Prescribed Medicine Expenses</li><li>• Mental and Nervous Disorders Expenses</li><li>• Substance Abuse Disorders Expenses</li><li>• The Student Health Center is closed</li><li>• For medical care rendered at another facility when classes are not in session, such as for official school breaks and holidays</li><li>• Medical care received when the student is more than 25 miles from campus</li><li>• Medical care received when a student is no longer able to use the SHC due to a change in student status</li></ul>		
Your <b>covered dependents</b> do not use the <b>school health services</b> for care so they don't need to get <b>referrals</b> .		
Eligible health services	In-network coverage	Out-of-network coverage
<b>Routine physical exams</b>		

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.	
Maximum visits per policy year age 22 and over	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit.  No copayment or policy year deductible applies	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 Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	Not Covered
Eligible health services	In-network coverage	Out-of-network coverage
Genetic risk counseling for breast and ovarian cancer counseling office visits  This insurance Plan provides coverage for the screening, diagnosis, and treatment of breast cancer.	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	Not Covered

Obesity/Healthy Diet maximum per policy year (Applies to covered persons age 22 and older)	26 visits (10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)	
Misuse of Alcohol maximum per policy year	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</li> <li>The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul>	
Tobacco Products Counseling maximum per policy year		
Depression screening maximum per policy year		
STI maximum per policy year		
Routine cancer screenings	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	Not Covered
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</li> <li>The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul>	
Lung cancer screening maximums	1 screenings every 12 months	
Stress Management	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	Not Covered
<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Chronic Conditions	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	Not Covered
Stress Management and Chronic Conditions maximum	1 visit	



Prenatal care services (Preventive care services only)  (includes participation in the California Prenatal Screening Program)	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	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
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	Not Covered
Female contraceptive prescription drugs and devices  Coverage includes up to a 12-month supply of FDA-approved prescription contraceptives.	100% (of the negotiated charge) per item  No copayment or policy year deductible applies	Not Covered
Female voluntary sterilization-Inpatient & Outpatient provider services	100% (of the negotiated charge)  No copayment or policy year deductible applies	Not Covered
<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Physicians and other health professionals</b>		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) (includes telemedicine consultations)	\$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	Not Covered
<b>Allergy testing and treatment</b>		

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.	Not Covered
<b>Physician and specialist - surgical services</b>		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge)	Not Covered
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	Not Covered
<b>Alternatives to physician office visits</b>		
Walk-in clinic visits (non-emergency visit)	\$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	Not Covered
<b>Hospital and other facility care</b>		
Inpatient hospital (room and board) and other miscellaneous services and supplies)  Includes birthing center facility charges	80% (of the negotiated charge) per admission	Not Covered
<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	Not Covered
<b>Alternatives to hospital stays</b>		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge)	Not Covered
Home health Care	80% (of the negotiated charge) per visit	Not Covered

Maximum visits per policy year	Unlimited	
Hospice-Inpatient	80% (of the negotiated charge) per admission	Not Covered
Hospice-Outpatient	80% (of the negotiated charge) per visit	Not Covered
Skilled nursing facility-Inpatient	80% (of the negotiated charge) per admission	Not Covered
Maximum days of confinement per policy year	Unlimited	
Hospital emergency room	\$100 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered

**Important note:**

- As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply.
- Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance.
- Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you.
- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts.

Urgent Care	\$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	Not covered
Non-urgent use of urgent care provider	Not covered	Not covered
<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Pediatric dental care</b> (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	Not covered
Type B services	100% (of the negotiated charge) per visit No copayment or deductible applies	Not covered
Type C services	100% (of the negotiated charge) per visit	Not covered

	No copayment or deductible applies	
Orthodontic services	100% (of the negotiated charge) per visit	Not covered
	No copayment or deductible applies	
Dental emergency treatment	Covered according to the type of benefit and the place where the service is received.	Not covered
<b>Specific Conditions</b>		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.	Not covered
Impacted wisdom teeth	80% (of the negotiated charge)	Not covered
Adult dental care for dental injuries	80% (of the negotiated charge)	Not covered
<b>Maternity care</b>		
Maternity care (includes delivery and postpartum Care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Not covered
First Postnatal Visit	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	Not covered
Well newborn nursery care In a hospital or birthing center	80% (of the negotiated charge)  No policy year deductible applies	Not covered
<b>Family planning services – other</b>		
Voluntary sterilization for males-surgical services	80% (of the negotiated charge)	Not covered
Abortion physician or specialist surgical services	80% (of the negotiated charge)	Not covered
Reversal of voluntary sterilization - physician or specialist surgical services	80% (of the negotiated charge)	Not covered
<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Gender reassignment (sex change) treatment</b>		
Inpatient hospital (room and board) and other miscellaneous services and supplies)	Follows the In-network cost-share for Mental Health Inpatient	Not Covered
Inpatient physician or specialist surgical services	Follows the In-network cost-share for Mental Health Inpatient services	Not Covered
Outpatient physician or specialist surgical services	Follows the In-network cost-share for Mental Health Other Outpatient services	Not Covered

Outpatient gender reassignment surgery specialist office visits (includes telemedicine)	Follows the In-network cost-share for Mental Health office visits	Not Covered	
Outpatient gender dysphoria mental health office visits (includes telemedicine)	Follows the In-network cost-share for Mental Health office visits	Not Covered	
Hormone therapy	Follows the In-network cost-share for Mental Health Other Outpatient services	Not Covered	
Speech therapy	Follows the In-network cost-share for Mental Health Other Outpatient services	Not Covered	
Autism spectrum disorder			
Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis	Covered according to the type of benefit and the place where the service is received.	Not Covered	
Mental Health & Substance Abuse Treatment			
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	100% (of the negotiated charge) per admission	Not Covered	
Outpatient office visits (includes telemedicine consultations)	\$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	Not Covered	
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	100% (of the negotiated charge) per visit	Not Covered	
Eligible health services	In-network coverage Network (IOE facility)	In-network coverage Network (Non-IOE facility)	Out-of-network coverage
Transplant services Inpatient and outpatient facility services	Covered according to the type of benefit and the place where the service is received.		
Transplant services Inpatient and outpatient physician and specialist services	Covered according to the type of benefit and the place where the service is received.		
Transplant services-travel and lodging	Covered	Covered	Not Covered
Lifetime Maximum Travel and Lodging Expenses for any one	\$10,000	\$10,000	Not Covered

transplant			
Maximum Lodging Expenses per <b>IOE</b> patient	\$50 per night	\$50 per night	Not Covered
Maximum Lodging Expenses per companion	\$50 per night	\$50 per night	Not Covered
<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>	
Basic infertility services	Covered according to the type of benefit and the place where the service is received.	Not Covered	
<b>Specific therapies and tests</b>			
<b>Outpatient diagnostic testing</b>			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	Not Covered	
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	Not Covered	
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	Not Covered	
<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>	
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)	80% (of the negotiated charge) per visit	Not Covered	
Combined for short-term rehabilitation services and habilitation therapy services			
Acupuncture therapy	Covered according to the type of benefit and the place where the service is received.	Not Covered	
Chiropractic services	80% (of the negotiated charge) per visit	Not Covered	
Maximum visits per policy	Unlimited		

year		
Other services and supplies		
Emergency ground, air, and water ambulance  (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
Durable medical and surgical equipment	80% (of the negotiated charge) per item	Not Covered
Enteral formulas and nutritional supplements	Covered according to the type of benefit and the place where the service is received.	Not Covered
Prosthetic Devices & Orthotics	80% (of the negotiated charge) per item	Not Covered
Hearing aid exams	\$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	Not Covered
Hearing aid exam maximum	One hearing exam every policy year	
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams (including refraction)- Performed by a legally qualified ophthalmologist or optometrist  Includes comprehensive low vision evaluations  Includes visit for fitting of contact lenses	100% (of the negotiated charge) per visit  No policy year deductible applies	Not Covered
Maximum visits per policy year	1 visit	
Low vision Maximum	One comprehensive low vision evaluation every policy year	
Fitting of contact Maximum	1 visit	
Eligible health services	In-network coverage	Out-of-network coverage
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit  No policy year deductible applies	Not Covered
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-	One set of eyeglass frames One pair of prescription lenses Daily disposables: 1 year supply	

conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	Extended wear disposable: 1 year supply Non-disposable lenses: 1 year supply	
<b>*Important note:</b> Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both. Coverage does not include the office visit for the fitting of prescription contact lenses.		
<b>Vision Care-Limited to covered persons age 19 and over</b>		
Adult routine vision exams (including refraction) Performed by a legally qualified ophthalmologist or optometrist  Includes fitting of prescription contact lenses	\$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	Not Covered
Maximum visits per policy year	1 visit	
<b>Outpatient prescription drugs</b>		
<b>The copayment/coinsurance waiver for risk reducing breast cancer</b>		
The per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
<b>Copayment waiver for tobacco cessation prescription and over-the-counter drugs</b>		
The outpatient prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.		
Your outpatient prescription drug copayment will apply after those two regimens per policy year have been exhausted.		
<b>Copayment waiver for contraceptives</b>		
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:		
<ul style="list-style-type: none"><li>Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%.</li></ul>		



- If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%.

The outpatient prescription drug copayment continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at a in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

Eligible health services	In-network coverage	Out-of-network coverage
<b>Generic prescription drugs (including specialty drugs)</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	\$20 copayment per supply 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.	\$40 copayment per supply No policy year deductible applies	Not Covered
<b>Preferred brand-name prescription drugs (including specialty drugs)</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	\$40 copayment per supply 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.	\$80 copayment per supply No policy year deductible applies	Not Covered
<b>Non-preferred brand-name prescription drugs (including specialty drugs)</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	\$60 copayment per supply 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.	\$120 copayment per supply No policy year 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) 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 drugs and OTC drugs filled at a pharmacy  For each 30 day supply	100% (of the negotiated charge per prescription or refill)	Not Covered

	No copayment or policy year deductible applies	
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug. The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:

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

## Exclusions

### Alternative health care

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

### Armed forces

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

### Artificial organs

- Any device that would perform the function of a body organ
- This exclusion does not apply to the use of non-human material to repair, replace, or restore function of an organ if it is medically necessary and not experimental.

### Breasts

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

### **Clinical trial therapies (experimental or investigational)**

- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the *Eligible health services under your plan - Clinical trial therapies (experimental or investigational)* section in the Certificate.

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

### **Clinical trial therapies (routine patient costs)**

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies)

### **Cornea or cartilage transplants**

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

This exclusion does not apply to **medically necessary** cornea or cartilage transplants.

### **Cosmetic services and plastic surgery**

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

This exclusion does not apply to:

- **Surgery** after an accidental **injury** when performed as soon as medically feasible or as described in the *Eligible health services under your plan – Reconstructive surgery and supplies* section in the certificate.
- Coverage that may be provided under the *Eligible health services under your plan - Gender reassignment (sex change) treatment* section in the certificate.
- Any **medically necessary** treatment due to complications from cosmetic procedures.

### **Custodial care**

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

### **Dermatological treatment**

- **Cosmetic** treatment and procedures

### **Dental care for adults**

- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of **injuries** to or diseases of

- the teeth
- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

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

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

#### **Durable medical equipment (DME)**

- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems
- Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a **physician**

#### **Educational services**

- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services under your plan – Diabetic services and supplies (including equipment and training)* section in the certificate. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

#### **Elective treatment or elective surgery**

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

### Enteral formulas and nutritional supplements

- Any food item, including infant formulas, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible health services under your plan – Enteral formulas and nutritional supplements* section in the certificate.

### Examinations

Any health or dental examinations that are not **medically necessary** and needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract
- Because a law requires it
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

### Experimental or investigational

- **Experimental or investigational** drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (**experimental or investigational**) or covered under clinical trials (routine patient costs). See the *Eligible health services under your plan – Other services* section in the Certificate.

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

### Emergency services and urgent care

- Non-**emergency services** in a **hospital** emergency room facility
- Non-urgent care in an **urgent care facility**(at a non-hospital freestanding facility)

### Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

### Felony

- Services and supplies that you receive as a result of an **injury** due to your commission of a felony

### Foot care

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts,

- ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
- Routine pedicure services, such as cutting of nails, corns and calluses when there is no **illness** or **injury** of the feet

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

#### **Gender reassignment (sex change) treatment**

- **Cosmetic** services and supplies such as:
  - Rhinoplasty
  - Face-lifting
  - Lip enhancement
  - Facial bone reduction
  - Lefharoplasty
  - Breast augmentation
  - Liposuction of the waist (body contouring)
  - Hair removal (including electrolysis of face and neck)
  - Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which are used in feminization
  - Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered **cosmetic**

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

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

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

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the *Medical necessity precertification requirements* section in the Certificate.

#### **Genetic care**

- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects

#### **Growth/Height care**

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- **Surgical procedures**, devices and growth hormones to stimulate growth

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

#### **Hearing aids and exams**

The following services or supplies:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 24 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist
- Hearing exams given during a stay in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries, amplifiers, and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

#### **Home health care**

- Nursing and **home health aide** services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Homemaker or housekeeper services
- Food or home delivered services
- Maintenance therapy

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

#### **Hospice care**

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling which includes estate planning and the drafting of a will
- Homemaker or caretaker services that are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

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

#### **Incidental surgeries**

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

#### **Maternity and related newborn care**

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

### Medical supplies – outpatient disposable

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

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

### Motor vehicle accidents

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

### Non-medically necessary services and supplies

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

### Non-U.S .citizen

- Services and supplies received by a **covered person** (who is not a United States citizen) within the **covered person's** home country but only if the home country has a socialized medicine program, except as covered in the *Eligible health services under your plan – Emergency services and urgent care* section in the certificate.

### Obesity

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Eligible health services under your plan – Preventive care and wellness* section in the certificate, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs,



recreational therapy or other forms of activity or activity enhancement

#### Organ removal

- Services and supplies given by a **provider** to remove an organ from your body for the purpose of selling the organ

#### Other primary payer

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

#### Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions

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

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

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

#### Pediatric dental care

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- **Cosmetic** services and supplies including plastic surgery, reconstructive surgery, **cosmetic surgery**, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *Eligible health services under your plan* section in the certificate. Facings on molar crowns and pontics will always be considered **cosmetic**.
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material or
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces(that are determined not to be **medically necessary** mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including **temporomandibular joint dysfunction** disorder (TMJ) and **craniomandibular joint dysfunction** disorder (CMJ) treatment, orthognathic **surgery**, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services under your plan – Specific conditions* section in the certificate.
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another **eligible health service**

- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in the *Eligible health services under your plan – Pediatric dental care* section in the certificate.
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Eligible health services under your plan —Pediatric dental care* section in the certificate.
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a **dental provider**

#### **Personal care, comfort or convenience items**

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

#### **Preventive care and wellness**

- Services for diagnosis or treatment of a suspected or identified **illness or injury**
- Non-preventive care exams given during your **stay** for medical care
- Psychiatric, psychological, personality or emotional testing or exams
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods or devices, except as covered in the *Eligible health services under your plan – Family planning services - other* section in the certificate.
- The reversal of voluntary sterilization procedures, including any related follow-up care

#### **Private duty nursing (outpatient only)**

#### **Prosthetic devices**

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless covered under the *Eligible health services under your plan – Prosthetic and orthotic devices* in the certificate, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss or misuse

#### **School health services**

- Services and supplies normally provided without charge by the **policyholder's**:
  - **School health services**
  - Infirmary
  - **Hospital**
  - **Pharmacy** or
- by **health professionals** who
  - Are employed by

- Are Affiliated with
- Have an agreement or arrangement with, or
- Are otherwise designated by

the **policyholder**.

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

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

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

- Any treatment, **prescription drug**, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - **Surgery, prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

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

#### **Sinus surgery**

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

#### **Strength and performance**

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

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

- Dental implants

#### **Therapies and tests**

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

#### **Transplant services**

- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing **illness**
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from

- harvesting, for an existing **illness**
- Travel and lodging expenses

#### **Treatment in a federal, state, or governmental entity**

- Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

#### **Treatment of infertility**

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

- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate, except for otherwise-**covered benefits** provided to a **covered person** who is a surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - Cryopreservation (freezing), storage or thawing of eggs, embryos or sperm, unless due to iatrogenic **infertility**.
  - The care of the donor in a donor egg cycle which includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which the person is not genetically related.
  - Obtaining sperm from a person not covered under this plan for ART services.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor oocytes, or donor sperm.
- Reversal of voluntary sterilizations, including follow-up care.
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures.
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery).
- ART services are not provided for out-of-network care.

#### **Vision Care**

Pediatric vision care services and supplies

- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Adult vision care

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Adult vision care services and supplies

Your plan does not cover adult vision care services and supplies, except as described in the *Eligible health services under your plan – Other services* section in the certificate.

- Special supplies such as non-**prescription** sunglasses

- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a **hospital** or other facility for health care
- Eye exams for contact lenses or their fitting
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures
  - Services to treat errors of refraction

**Wilderness treatment programs**

- See *Educational services* within this section

## **Exceptions and exclusions that apply to outpatient prescription drugs**

### **Compounded prescriptions**

- Compound prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones

### **Cosmetic drugs**

- Medications or preparations used for cosmetic purposes

**Devices, products and appliances**, unless medically necessary for the administration of a covered outpatient **prescription drug**.

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

### **Drugs or medications**

- Which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), unless recommended by the United States Preventive Services Task Force. This exception does not apply to FDA approved OTC female contraceptive methods prescribed by a provider
- That is therapeutically equivalent or therapeutically alternative to a covered **prescription drug** including biosimilar (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved). Even if one drug or medication becomes available OTC, the prescription strengths of these drugs are still covered. The entire class of the **prescription drugs** will not be excluded in this case
- Not approved by the FDA
- For which the cost is covered by a federal, state, or government agency (for example: Medi-Cal or Veterans Administration)
- That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications

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

### **Immunizations related to travel or work**

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

### **Infertility**

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

### **Prescription drugs:**

- Filled prior to the effective date or after the termination date of coverage under this plan.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not **medically**

**necessary**, or otherwise improper, and drugs obtained for use by anyone other than the person identified on the ID card.

#### **Refills**

- Refills dispensed more than one year from the date the latest **prescription** order was written

#### **Replacement of lost or stolen prescriptions**

##### **We reserve the right to exclude:**

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

The Harvey Mudd College Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health<sup>SM</sup> is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

#### **Sanctioned Countries**

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

#### **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call the number listed on your ID card at no cost.

#### **Smartphone or Tablet**

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

#### **Non-Discrimination**

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters

- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

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

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





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

