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Aetna Student Health
Plan Design and Benefits Summary
OA Elect Choice EPO

Pomona College

Policy Year: 2021–2022
Policy Number: 686131
www.aetnastudenthealth.com
(877) 480-4161

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

This is a brief description of the Student Health Plan. The plan is available for Pomona 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.** 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			
Returning Students	08/30/2021	07/31/2022	09/03/2021
New Students	08/01/2021	07/31/2022	09/03/2021
Fall			
Returning Students	08/30/2021	01/03/2022	09/03/2021
New Students	08/01/2021	01/03/2022	09/03/2021
Spring (New & Returning)	01/04/2022	07/31/2022	01/17/2022

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			
Returning Students	08/30/2021	07/31/2022	09/03/2021
New Students	08/01/2021	07/31/2022	09/03/2021
Fall			
Returning Students	08/30/2021	01/03/2022	09/03/2021
New Students	08/01/2021	01/03/2022	09/03/2021
Spring (New & Returning)	01/04/2022	07/31/2022	01/17/2022

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.**

Coverage Period	Student Rate	Spouse/Domestic Partner Rate	One Child Rate	Two or More Children Rate
Annual				
Returning Students	$2,570.00	$2,560.00	$2,560.00	$5,120.00
New Students	$2,782.00	$2,772.00	$2,772.00	$5,544.00
Fall				
Returning Students	$982.00	$978.00	$978.00	$1,956.00
New Students	$1,194.00	$1,190.00	$1,190.00	$2,380.00
Spring (New & Returning)	$1,598.00	$1,592.00	$1,592.00	$3,184.00

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 Pomona 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 Pomona 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 https://www.gallagherstudent.com/cuc.Pomona), 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 Gallagher Student Health at 833-882-3588.

Medicare Eligibility Notice

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

Termination and Refunds

1) Voluntary Withdrawal or Approved Leave of Absence

If you voluntarily withdraw from the College or are approved for a leave of absence, your coverage will remain in force through the end of the period for which you have paid for coverage and the premium amount will not be refunded unless:

- you submit a written request for termination of the policy within 7 (seven) days of your leaving the College; and
- you have made no claims against the policy within the policy effective date; and
- your leave date is not later than 31 (thirty-one days) past the official first day of classes in a given semester.

Should these requirements be met, the policy amount will be refunded on a pro-rata basis.

2) Separation from the College

Should you be involuntarily separated from the College at any time during the coverage period, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded unless:

- your separation is more than 31 days after the policy effective date; or
- you have made a claim against the policy during the coverage period.

In the latter two instances, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded.

3) Service in Armed Forces

If you withdraw from classes to enter the armed forces of any country, coverage will terminate as of the effective date of such entry and a pro rata refund of premiums will be made.

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.

Precertification

You do not need to obtain pre-certification for any services. However, your provider is required to obtain pre-certification for certain Preferred Care services. Refer to the Precertification provisions in the Coverage section of the Certificate of Coverage for a complete description of the precertification programs including the types of services, treatments, procedures, visits or supplies that require precertification. No penalty will be applied to you for a Preferred Care service that was not pre-certified.

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		
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
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-Network Care for Preventive care and wellness, 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		
Maximum out-of-pocket limits		
	In-network coverage	**Out-of-network coverage**
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
Referral Requirements		
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. **Exceptions** • Treatment is for an Emergency Medical Condition. A referral is required for follow-up care. • Obstetric and Gynecological Treatment • Pediatric Care • Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness) • Prescribed Medicine Expenses • Mental and Nervous Disorders Expenses • Substance Abuse Disorders Expenses • The Student Health Center is closed • For medical care rendered at another facility when classes are not in session, such as for official school breaks and holidays • Medical care received when the student is more than 25 miles from campus • Medical care received when a student is no longer able to use the SHC due to a change in student status Your **covered dependents** do not use the **school health services** for care so they don't need to get **referrals**.		

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	Not Covered
Maximum age and visit limits per policy year through age 21	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents.	
Covered persons age 22 and over: Maximum visits per policy year	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention	
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Maximum visits per policy year	1 visit	
Preventive screening and counseling services		
Preventive screening and counseling services for 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	Not Covered
Stress management counseling office visits	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
Chronic condition counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Maximum:	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration.	
Lung cancer screening maximums	1 screening every 12 months*	
Prenatal care services -Preventive care services only (includes participation in the California Prenatal Screening Program)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Lactation support and counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	Not Covered
Family planning services – female contraceptives		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Female contraceptive generic prescription drugs and devices provided, administered, or removed, by a provider during an office visit For each 30 day supply or 12 month supply	100% (of the negotiated charge) per item No copayment or policy year deductible applies	Not Covered

Eligible health services	In-network coverage	Out-of-network coverage
Female Voluntary sterilization- Inpatient & Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	Not Covered
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 80% (of the balance of the negotiated charge) per visit	Not Covered
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.	Not Covered
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)	Not Covered
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	Not Covered
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		

Eligible health services	In-network coverage	Out-of-network coverage
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	Not Covered
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	Not Covered
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	Not Covered
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	Not Covered
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	Not Covered
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	Not Covered
Hospice-Outpatient	80% (of the negotiated charge) per visit	Not Covered

Eligible health services	In-network coverage	Out-of-network coverage
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	Not Covered
Hospital emergency room	$100 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered
Important note: • As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply. • Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance. • Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you. • Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts.		
The following are not covered under this benefit: • Non-emergency services in a hospital emergency room facility, freestanding emergency medical care facility or comparable emergency facility		
Urgent care	$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	Not covered
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)		

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19.		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	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 No copayment or deductible applies	Not covered
Orthodontic services	100% (of the negotiated charge) per visit No copayment or deductible applies	Not covered
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.	Not covered
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.	Not covered

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)	Not covered
Accidental injury to sound natural teeth	80% (of the negotiated charge)	Not covered

The following are not covered under this benefit:

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

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.	Not covered
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.	Not covered
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.	Not covered
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.	Not covered
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.	Not covered
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	Not covered
Maximum benefit payable for travel expenses per companion for each round trip – two round trips covered (the surgery and one follow-up visit)	$130	Not covered
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	Not covered
Maximum benefit payable for lodging expenses per companion for surgery stay	$100 per day up to four days	Not covered
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

Eligible health services	In-network coverage	Out-of-network coverage
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.	Not covered
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	Not covered
Family planning services – other		
Voluntary sterilization for males-surgical services	80% (of the negotiated charge)	Not covered
Reversal of voluntary sterilization	80% (of the negotiated charge)	Not covered
Abortion	80% (of the negotiated charge)	Not covered
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the Behavioral health section	Not covered

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)	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	Not covered
Other outpatient treatment (includes skilled behavioral health services in the home)	100% (of the negotiated charge) per visit	Not covered
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.	Not Covered

Eligible health services	In-network coverage	Out-of-network coverage
Fertility preservation services		
Fertility preservation	Covered according to the type of benefit and the place where the service is received.	Not Covered
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	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
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.	Not Covered
The following are not covered under this benefit: • Enteral nutrition • Blood transfusions and blood products		

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	Not Covered
Acupuncture therapy	80% (of the negotiated charge) per visit	Not Covered
The following are not covered under this benefit: • Acupressure		
Chiropractic services	80% (of the negotiated charge) per visit	Not Covered
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.	Not Covered
Other services and supplies		
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	$200 copayment then the plan pays 100% (of the balance of the negotiated charge) per trip	Paid the same in-network coverage
Durable medical and surgical equipment	80% (of the negotiated charge) per item	Not Covered
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		
Nutritional support	Covered according to the type of benefit or the place where the service is received.	Not Covered
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		

Eligible health services	In-network coverage	Out-of-network coverage
Prosthetic devices including contact lenses for aniridia & Orthotics	80% (of the negotiated charge) per item	Not Covered
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 Exams		
Hearing exam	$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	Not Covered
Hearing 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	Not Covered
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	Not Covered
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.	Not Covered
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	$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	

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		
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 prescription drug copayment will not apply to female contraceptive methods when obtained at a in-network pharmacy. This means that such contraceptive methods are paid at 100% for: • Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. • If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%.		

The prescription drug copayment continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at a in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Preferred Generic prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Preferred Brand-Name prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$80 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year 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	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$120 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year 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	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$120 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered

Eligible health services	In-network coverage	Out-of-network coverage
Orally administered anti-cancer prescription drugs- For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge)	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.	
Sexual enhancement or dysfunction prescription drugs-Up to 8 pills for each 30 day supply filled at a retail pharmacy	Paid according to the tier of drug in the schedule of benefits above	Not Covered
Sexual enhancement or dysfunction prescription drugs	Paid according to the tier of drug in the schedule of benefits above	Not Covered
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 In-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

Cornea or cartilage transplants

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

Cosmetic services and plastic surgery

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

Court-ordered services and supplies

- This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding, unless they are a covered benefit under your plan

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.

Judgment or settlement

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

Medical supplies – outpatient disposable

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

Non-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*

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

Students in mental health field

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

Telemedicine

- Services given when you are not present at the same time as the **provider**
- Services including:
  - **Telemedicine** kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

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

Treatment in a federal, state, or governmental entity

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

Wilderness treatment programs

See *Educational services* within this section

The Pomona College 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 Wùɖù/Bassa

Dè dɛ nìà kɛ dyɛ̀dɛ̀ gbo: Ɔ jǔ kɛ̀ m̀ dyí Ɓàsɔ́ɔ̀-wùdù-po-nyɔ̀ jǔ nɪ̀, nìì à wudu kà kò dò po-poɔ̀ ɓɛ́ m̀ gbo kpáa. Đá **1-877-480-4161**(TTY: **711**).

中文/Chinese

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

Farsi/فارسی

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**).

Gujarati/ગુજરાતી

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

Kreyòl Ayisyen/Haitian Creole

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

Igbo

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

한국어/Korean

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

Português/Portuguese

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

Русский/Russian

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

Tagalog

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

Urdu/اردو

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

Tiếng Việt/Vietnamese

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

Yorùbá/Yoruba

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

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