Aetna Student Health
Plan Design and Benefits Summary
Open Choice PPO

Santa Clara University

Policy Year: 2026–2027
Policy Number: 232093
www.aetnastudenthealth.com
(877) 480-4167

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 Santa Clara University students. The plan is insured by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at https://www.aetnastudenthealth.com. If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

Cowell Center

The Cowell Center is the comprehensive health care provider for the Santa Clara University student community. Staffed by nurse practitioners and registered nurses, it is open weekdays from 8:30 a.m. to 5:00 p.m., during the Fall and Spring semesters. For more information, call the Cowell Center at (408) 554-4501. In the event of an emergency, call 911 or the Campus Police at (408) 554-4444.

Contact Counseling and Psychological Services (CAPS) 24/7 for mental health concerns any hour of day or night at (408) 554-5220. CAPS provides a 24/7 crisis hotline.

CVS Virtual Care®

From everyday illnesses and chronic conditions to mental health support, we've got your back. Once you tell us what you need, we'll connect you with trusted, in-network providers so you can schedule a virtual visit. Most mental health visits are available within two weeks. You can access 24/7 care through our virtual clinic. [General Care: 100% coverage. Behavioral Health**:** See the schedule of benefits for more information.] Go to CVS.com/virtual-care to register and schedule an appointment

Who is eligible?

All domestic undergraduate, graduate, Law, and Jesuit School of Theology students in a degree seeking program who are enrolled at least halftime in their school or college are automatically enrolled unless proof of comparable coverage is provided by completing an online waiver form by the deadline. All F-1 and J-1 Visa students, regardless of number of units, are required to have insurance and are automatically enrolled in the Student Health Insurance Plan. Dependents of insured students are not eligible for the Student Health Insurance Plan.

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective. You cannot meet this eligibility requirement if you are enrolled in a program of study that offers classes only online.

Coverage Dates and Rates

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

The rates below include premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna).

Undergraduates

	Annual 09/15/2026 - 09/14/2027	Winter/Spring/Summer 01/01/2027 - 09/14/2027	Spring/Summer 04/01/2027 - 09/14/2027
Student	$3,361.00	$2,377.00	$1,557.00

Graduates

	Annual 09/15/2026 - 09/14/2027	Winter/Spring/Summer 01/01/2027 - 09/14/2027	Spring/Summer 04/01/2027 - 09/14/2027
Student	$3,901.00	$2,757.00	$1,804.00

Law

	Annual 08/15/2026 - 08/14/2027	Winter/Spring/Summer 01/01/2027 - 08/14/2027
Student	$3,901.00	$2,429.00

Jesuit School of Theology

	Annual 09/01/2026 - 08/31/2027	Spring/Summer 02/01/2027 - 08/31/2027
Student	$3,901.00	$2,281.00

Enrollment

1. Go to gallagherstudent.com/scu
2. Login under "Profile."
3. Once logged into your Gallagher account, select the 2026-2027 student health insurance plan link under "My Coverage Options."
4. Click on the "Enroll" button under "Plan Summary."
5. Complete and submit the form by following the instructions.
6. Enrollment confirmation email will be sent.

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

Withdrawal from Classes – Leave of Absence

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

Withdrawal from Classes – Other than Leave of Absence

- If you withdraw from classes within 31- days after the start date of classes, you will be considered ineligible for coverage. Your coverage will be terminated retroactively, and any premium paid will be refunded.
- If you withdraw from classes more than 31-days after the start date of classes, your coverage will remain in force through the end of the period for which premium payment has been received. No premium will be refunded.
- If you withdraw from classes to enter the armed forces of any country, your coverage will end as of the date of such entry. We will refund your premium, on a pro-rata basis, if you submit a written request within 90 days from the date you withdraw.

Termination of coverage

Starting July 1, 2026, if a student graduates, takes a leave of absence, or is no longer enrolled in classes, they may request to terminate their student health insurance coverage during the policy year. The request must be made to Gallagher Student Health at least 30 days before the desired termination date. Upon receipt, coverage will be terminated within the same calendar month if feasible, but no later than the last day of the month in which the 30-day period ends. When a student or dependent chooses to terminate coverage under these circumstances, they are only responsible for premium payments up to the termination date. If a premium was paid in full for an academic term, the member will receive a pro rata refund for any unused coverage. Santa Clara University is responsible for refunding students for any period they are not covered, in accordance with applicable state law.

In-network Provider Network

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

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

Precertification

You need pre-approval from us for some covered services. Pre-approval is also called precertification. Your in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify when required, there will be up to a $500 penalty for each type of covered service that was not precertified. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to www.aetna.com.

Precertification Call

Precertification should be secured within the timeframes specified below. To obtain precertification, call Member Services at the toll-free number on your ID card. You, your physician or the facility must call us within these timelines:

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

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

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

Coordination of Benefits (COB)

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

Description of Benefits

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

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

	In-network coverage	**Out-of-network coverage**
Policy year deductibles		
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$500 per policy year	$1,000 per policy year
Policy year deductible waiver		
The policy year deductible is waived for all of the following covered services: • In-network care for Preventive care and wellness, • In-network care for Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy), • In-network and out-of-network care for Pediatric Dental Type A services, • In-network and out-of-network care for Mental Health and Substance related disorders Outpatient Office Visits, • In-network care for Pediatric Vision Care, • In-network and out-of-network care for Chiropractic, • In-network and out-of-network care for Urgent care, • In-network and out-of-network care for Physician, specialist, consultants and walk-in clinic office visits, • In-network and out-of-network care for Outpatient Prescription Drugs, • In-network and out-of-network care for Well Newborn Nursery Care		
Individual This is the amount you owe for in-network and out-of-network covered services each policy year before the plan begins to pay for covered services. After the amount you pay for covered services reaches the policy year deductible, this plan will begin to pay for covered services for the rest of the policy year.		
Maximum out-of-pocket limits		
	In-network coverage	**Out-of-network coverage**
Student	$8,700 per policy year	$17,400 per policy year

	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per 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	60% (of the recognized charge) per visit
Well woman preventive visits		
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	60% (of the recognized charge) per visit
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Depression, Misuse of alcohol & drugs, Tobacco Products, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Stress management counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Chronic condition counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit

Lung cancer screening maximums	1 screening every 12 months	
	In-network coverage	**Out-of-network coverage**
Prenatal and postpartum care services - Preventive care services only (includes participation in the California Prenatal Screening Program)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation support and counseling services Includes clinically indicated interventions to support lactation consultations, counseling, education and all breast-feeding equipment and supplies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Family planning services – contraceptives		
Contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit For each 30-day supply or 12-month supply	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Voluntary sterilization, including vasectomy services-Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Voluntary sterilization, including vasectomy services-Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Any contraceptive methods that are only "reviewed" by the FDA and not "approved", “granted” or “cleared” by the FDA		

	In-network coverage	Out-of-network coverage
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) (includes telemedicine consultations)	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit No policy year deductible applies
Allergy testing and treatment		
Allergy testing performed at a physician or specialist office	80% (of the negotiated charge) per visit	60% (of the recognized charge)
Allergy injections treatment performed at a physician's, or specialist office when you see the physician	80% (of the negotiated charge) per visit	60% (of the recognized charge)
Allergy sera and extracts administered via injection at a physician's or specialist's office	80% (of the negotiated charge) per visit	60% (of the recognized charge)
Physician and specialist surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Covered 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	60% (of the recognized charge) per visit
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Covered 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		

	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 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit No policy year deductible applies
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
The following are not covered services: • All services and supplies provided in: - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps		
Preadmission testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Home health Care	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	100	

<table>
<tr><th></th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td colspan="3">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
Homemaker or housekeeper services
Food or home delivered services
Maintenance therapy</td></tr>
<tr><td>Hospice-Inpatient</td><td>80% (of the negotiated charge) per admission</td><td>60% (of the recognized charge) per admission</td></tr>
<tr><td>Hospice-Outpatient</td><td>80% (of the negotiated charge) per visit</td><td>60% (of the recognized charge) per visit</td></tr>
<tr><td colspan="3">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</td></tr>
<tr><td>Skilled nursing facility-Inpatient</td><td>80% (of the negotiated charge) per admission</td><td>60% (of the recognized charge) per admission</td></tr>
<tr><td>Emergency room</td><td>$150 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</td><td>Paid the same as in-network coverage</td></tr>
<tr><td>Non-emergency care in an emergency room</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td colspan="3">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 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 services that are applied to the emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered services under the plan cannot be applied to the l emergency room copayment/coinsurance.
Separate copayment/coinsurance amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These copayment/coinsurance</td></tr>
</table>

amounts may be different from the emergency room copayment/coinsurance. They are based on the specific service given to you.
- Services given to you in the emergency room that are not part of the emergency room benefit may be subject to copayment/coinsurance amounts that are different from the emergency room copayment/coinsurance amounts.

The following are not covered under this benefit:
- Non-emergency services in a hospital emergency room facility.

	In-network coverage	**Out-of-network coverage**
Urgent care	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit No policy year deductible applies
Non-urgent use of an urgent care provider	Not covered	Not covered

The following is not covered under this benefit:
- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19.		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	100% (of the recognized charge) No copayment or policy year deductible applies
Type B services	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.

Pediatric dental care exclusions

The following are not covered under this benefit:
- Asynchronous dental treatment
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth
- Crown, inlays and onlays, and veneers unless:

- It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
- The tooth is an abutment to a covered partial denture or fixed bridge

- Mouth guards, and other devices to protect, replace or reposition teeth
- Dental implants except when part of an approved treatment plan for a **covered service** described in *Covered services and exclusions - Reconstructive surgery and supplies*
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Covered services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another covered service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in this section
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider

	In-network coverage	**Out-of-network coverage**
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Podiatric (foot care) treatment Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

	In-network coverage	Out-of-network coverage
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)	60% (of the recognized charge)
Accidental injury to sound natural teeth	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants		
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Dental implants		
Blood and body fluid exposure	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Services and supplies provided for the treatment of an illness that results from your clinical related injury as these are covered elsewhere in the student policy		

	In-network coverage	Out-of-network coverage
Clinical trials		
Routine patient costs	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered services: • Services and supplies related to data collection and record-keeping needed only for the clinical trial • Services and supplies provided by the trial sponsor for free • The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies or those that qualify for and are determined to be covered by the Independent Medical Review (IMR) as described in the *Claims procedures, Complaints, claim decisions, and appeal procedures s*ection)		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Cosmetic treatment and procedures		
Obesity bariatric Surgery and services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Obesity surgery-travel and lodging		
Maximum benefit payable for travel expenses for each round trip – three round trips covered (one pre-surgical visit, the surgery and one follow-up visit)	$130	$130
Maximum benefit payable for travel expenses per companion for each round trip – two round trips covered (the surgery and one follow-up visit)	$130	$130
Maximum benefit payable for lodging expenses per patient and companion for the pre-surgical and follow-up visits	$100 per day up to two days	$100 per day up to two days
Maximum benefit payable for lodging expenses per companion for surgery stay	$100 per day up to four days	$100 per day up to four days
The following are not covered under this benefit: • Weight management treatment. • Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate. • Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:		

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications - Hypnosis, or other forms of therapy - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement		
Maternity care that is not considered preventive care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Gender affirming treatment		
Gender affirming treatment, including surgical, hormone replacement therapy, and counseling treatment	Covered according to the Behavioral health section	Covered according to the Behavioral health section
Behavioral health Medically necessary treatment of mental health conditions and substance use disorders are covered under the same terms and conditions applied to other medical conditions and in accordance with the federal Mental Health Parity and Addiction Equity Act.		
Mental Health Conditions & Substance Use Disorder Treatment		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Outpatient office visits (includes telemedicine consultations)	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit No policy year deductible applies
Other outpatient treatment (includes skilled behavioral health services in the home)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Covered 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

Infertility services		
Treatment of basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Fertility preservation services		
Fertility preservation	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Infertility services exclusions

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

	In-network coverage	**Out-of-network coverage**
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan • Enteral nutrition • Blood transfusions and blood products • Dialysis		
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	60% (of the recognized charge) per visit
Acupuncture therapy	80% (of the negotiated charge) per visit	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit
The following are not covered under this benefit: • Acupressure		

	In-network coverage	Out-of-network coverage
Chiropractic services	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit No policy year deductible applies
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Other services and supplies		
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	$150 copayment then the plan pays 80% (of the balance of the negotiated charge) per trip	Paid the same in-network coverage
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient care		
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician		
Nutritional support	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition		
Cochlear implants	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Prosthetic devices - Cranial prosthetics (Medical wigs)	80% (of the negotiated charge) per item	80% (of the actual charge) per item
All other Prosthetic devices including contact lenses for aniridia & Orthotics	80% (of the negotiated charge) per item	60% (of the recognized charge) per item

	In-network coverage	Out-of-network coverage
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	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay		
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit No copayment or policy year deductible applies
Low vision Maximum Fitting of contact Maximum	One comprehensive low vision evaluation every five years 1 visit	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No copayment or policy year deductible applies	100% (of the recognized charge) per item No copayment or policy year deductible applies
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 1 year supply Extended wear disposable: up to 1 year supply Non-disposable lenses: 1 year supply	
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per policy year	One optical device	

	In-network coverage	Out-of-network coverage
*__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 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year	1 visit	
The following are not covered under this benefit: Adult vision care • 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 • 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		

Outpatient prescription drugs		
Policy year deductible and copayment/coinsurance waiver for risk reducing breast cancer		
The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
Outpatient prescription drug policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs		
The prescription drug copayment will not apply to treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.		
Outpatient prescription drug copayment waiver for contraceptives		
The outpatient prescription drug prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy. This means that such contraceptive methods are paid at 100% for: • All FDA approved contraceptive prescription drugs and devices, including over the counter (OTC) contraceptive prescription drugs and devices. Related services and supplies needed to administer covered devices will also be paid at 100%. • A therapeutic equivalent prescription drug or device when a prescription drug or device is not available or is deemed medically inadvisable by your provider when you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
	In-network coverage	**Out-of-network coverage**
Generic prescription drugs Your cost-share may not exceed $250 for each 30-day supply of an individual prescription. This does not include any policy year deductible.		
For each fill up to a 30-day supply filled at a retail pharmacy	$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$15 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$37.50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered

	In-network coverage	Out-of-network coverage
Preferred brand-name prescription drugs Your cost-share may not exceed $250 for each 30-day supply of an individual prescription. This does not include any policy year deductible		
For each fill up to a 30-day supply filled at a retail pharmacy	$45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$45 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$112.50 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 Your cost-share may not exceed $250 for each 30-day supply of an individual prescription. This does not include any policy year deductible		
For each fill up to a 30-day supply filled at a retail pharmacy	$80 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$80 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$200 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Specialty prescription drugs Your cost-share may not exceed $250 for each 30-day supply of an individual prescription. This does not include any policy year deductible		
For each fill up to a 30-day supply filled at a specialty pharmacy or a retail pharmacy	$200 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$200 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
Diabetic insulin important note: Your cost share will not exceed $25 per 30-day supply of a covered preferred prescription insulin drug filled at an in-network pharmacy.		
Contraceptives (birth control) Brand-name prescription drugs and devices are covered at 100% at an in-network pharmacy when a generic is not available. See the important note below and your Certificate of Coverage - preventive contraceptives important note regarding therapeutic equivalents.		
For each fill up to a 12-month supply of generic and OTC drugs and devices filled at a retail or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above

	In-network coverage	Out-of-network coverage
For each fill up to a 12-month supply of brand name prescription drugs and devices filled at a retail or mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above A brand name contraceptive is 100% (of the negotiated charge), No policy year deductible if there are no generic therapeutic equivalents.	Paid according to the type of drug per the schedule of benefits, above
Preventive contraceptive important note: The prescription drug cost share will not apply to contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes over the counter (OTC) contraceptive prescription drugs and devices for each of the methods identified by the FDA. If a prescription drug is not available or deemed inadvisable by your provider, the therapeutic equivalent prescription drug for that method will be paid at 100%. The prescription drug cost share will apply to prescription drugs that have a therapeutic equivalent obtained at a network pharmacy unless you receive a medical exception. You can fill up to a 12-month supply at one time.		
Anti-cancer drugs taken by mouth- For each fill up to a 30-day supply	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Preventive care drugs and supplements filled at a retail pharmacy For each 30-day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30-day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	
Tobacco cessation prescription and over-the-counter drugs (Preventive care)-Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30-day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above

	In-network coverage	Out-of-network coverage
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	

Outpatient prescription drug exclusions

Important note:

Please refer to your Covered services and exclusions section for medical benefits in the Certificate of Coverage for additional information

The following are not covered services:

- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes, except as medically necessary for gender affirming treatment
- Dietary supplements, except as described in the Covered services and exclusions -Nutritional Support section
- Drugs or medications:
    - Administered or entirely consumed at the time and place they are prescribed or provided
    - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception or unless it is for the coverage of an FDA approved, FDA granted or FDA cleared OTC contraceptive drug, device or other product.
    - Not approved by the FDA and not proven safe or effective for your diagnosis or health condition. Refer to the Other services-Clinical trials section and/or Independent medical review (IMR) managed by the California Department of Insurance section for experimental, investigational, or unproven information.
    - Provided under your medical plan while inpatient at a healthcare facility
    - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
    - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
    - That are drugs or growth hormones used to stimulate growth and prescribed only to treat idiopathic short stature except as provided under the *Covered services and exclusions - Gender affirming treatment* section
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
    - Any provider administered treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes except as described in the covered service or the pharmacy drug guide. Refer to the Other services-Clinical trials section and/or Independent medical review (IMR) managed by the California Department of Insurance section for experimental, investigational, or unproven information.
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Provider administered implantable drugs and associated devices except for:

- Implantable drugs and associated devices used to treat mental health conditions or substance use disorders or as specifically stated in the schedule of benefits or the certificate
- Implantable infusion pumps
- Contraceptive implants

- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
  - That are used for the purpose of improving visual acuity or field of vision except when medically necessary or an over-the-counter alternative is not available.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card based on misuse, waste, or abuse utilization review by us.
  - See Utilization Review in the Outpatient Prescription Drug coverage
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents or at home test kits for sexually transmitted diseases.
- A manufacturer's product when a therapeutic equivalent drug, supply or equipment as defined by the FDA, is on the plan's drug guide, except when medically necessary
- Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide, except for FDA approved contraceptive drugs, devices and products. or when a different dosage or form is medically necessary.

Outpatient prescription drugs important note:

If a provider prescribes a covered brand-name prescription drug when a generic equivalent is available and not covered by the plan, you will pay the generic price for the brand name drug. If a provider prescribes a covered brand-name prescription drug when a generic prescription drug equivalent is available and covered by the plan, you will pay the cost share for the generic drug if the brand is medically necessary. If the brand-name prescription drug is not medically necessary, you will be responsible for the cost share that applies to the brand-name drug.

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

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

Out of Country claims

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

General Exclusions

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, including cosmetic drugs, medications, and preparations used for cosmetic purposes, except where described in the *Covered services and exclusions* section

Court-ordered services and supplies

- This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a covered service under your plan**.** This does not include services required or recommended by the Community Assistance, Recovery, and Empowerment (CARE) court or plan. CARE Court evaluation and treatment services will be covered regardless of whether the service is provided by an in-network or out-of-network provider.

Custodial care

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

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

This exclusion does not apply to:

- Medically necessary treatment of mental health disorders and substance use disorders
- Assistance with activities of daily living that are provided as part of covered services under Hospice care when given as part of a home health care program, hospice care program, inpatient skilled nursing facility care or inpatient hospital care

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 except when part of an approved treatment plan for an covered service described in the *Covered services and exclusions – Reconstructive surgery and supplies* section.

This dental care exclusion for adults does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts as these are covered services.

Educational services

Services that are non-medical and are not medically necessary to treat mental health conditions or substance use disorders are:

- Any service or supply for education, training or retraining services or testing, except where described in the *Covered services and exclusions – Diabetic services and supplies (including equipment and training)* or *Preventive care and wellness* sections.
  Excluded education and training or retraining services or testing are:
  - Special education
  - Remedial education
  - Job training
  - Job hardening programs
- Educational services, any services, schooling related or similar, including therapeutic programs, within a school setting.

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples include, examinations to get or keep a job and examinations required under a labor agreement or other contract
- 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, investigational, or unproven

- Experimental, investigational, or unproven drugs, devices, treatments or procedures unless otherwise covered under clinical trials. You can request an independent medical review from the California Department of Insurance if you receive an adverse benefit determination for an experimental or investigational service. Refer to the Claims procedures, Complaints, claim decisions, and appeal procedures section

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

The following are not covered 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 and precertification requirements* section

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

This exclusion does not apply to gender affirming treatment or bone growth stimulation devices.

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

This exclusion does not apply to:

- Hearing screenings or exams
- Bone anchored hearing aid
- Cochlear implants

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

This exclusion does not apply to disposable supplies that must be covered as or in connection with durable medical equipment, hospice care, ostomy and urological supplies, and outpatient prescription drugs

Other primary payer

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

Personal care, comfort or convenience items

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

Prescription drugs and medicines

- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones, unless we have approved a medical exception
- Drugs or medications recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception

Private duty nursing

School health services

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

- Services and supplies provided by health professionals who the policyholder:
  - Employs
  - Is affiliated with
  - Has an agreement or arrangement with
  - Otherwise designates

Services not permitted by law

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

Services provided by a family member

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

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or 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
- This exclusion does not apply to services to treat a mental health condition or substance use disorder

Therapies and tests

- Full Body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy treatment
- Sensory or hearing and sound integration therapy

The Santa Clara University University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health℠ 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.

Discrimination is Against the Law

Aetna complies with applicable California and Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ethnic group, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, medical condition, genetic information, or sex (consistent with 45 CFR § 92.101(a)(2) and California 2 CCR § 14025). Aetna does not exclude people or treat them less favorably because of race, color, national origin, ethnic group, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, medical condition, genetic information, or disability.

Aetna:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:
  - Qualified sign language interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 1-800-872-3862 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnic group, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, medical condition, genetic information, or disability, by action or inaction, you can file a grievance with:

Civil Rights Coordinator
Attn: 1557 Coordinator
CVS Pharmacy, Inc.

1 CVS Drive, MC 2332, (HMO customers: P.O. Box 14032 Lexington, KY 40512-4032)
Woonsocket, RI 02895
Phone: 1-800-648-7817, TTY: 711
Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

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

You can also file a 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/smartscreen/main.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 https://www.hhs.gov/ocr/complaints/index.html.

This notice is available at Aetna's website: https://www.aetna.com/.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of companies offering and administering health and dental plans and other products such as life, disability, and long-term care insurance. In California, this includes Aetna's wholly-owned subsidiaries Aetna Life Insurance Company, Aetna Health of California Inc., Aetna Better Health of California Inc., Aetna Dental of California Inc., and Health and Human Resource Center Inc., and its other affiliates licensed in California. Aetna's ultimate parent is CVS Health Corporation ("CVS Health").