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

## California College of the Arts

Policy Year: 2026–2027
Policy Number: 686151
www.aetnastudenthealth.com
(877) 480-4161

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

### ⌈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. Go to CVS.com/virtual-care to register and schedule an appointment

### Coverage Periods

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

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

| Coverage Period | Coverage Start Date | Coverage End Date | Enrollment/Waiver Deadline |
|---|---|---|---|
| **Fall** | 08/01/2026 | 12/31/2026 | 09/15/2026 |
| **Spring/Summer** | 01/01/2027 | 07/31/2027 | 02/01/2027 |

### Student Coverage

### Eligibility

All undergraduate and graduate students and dependents, who are enrolled at California College of the Arts, and who actively attend classes for at least the first 31 days, after the date when coverage becomes effective.

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

### Enrollment

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

## Dependent Coverage

### Eligibility

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

### Enrollment

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

**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.

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

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

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

If you need information or have general questions on dependent enrollment, call Gallagher Student Health & Special Risk at 510-542-5306.

### Medicare Eligibility Notice

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

### Termination and Refunds

All refund requests must be sent to the University who will confirm nonstudent status with Gallagher Student Health & Special Risk and submit the refund request on behalf of the student. Only refunds submitted by the University **before** the refund deadline will be considered. Credit card **refunds** must be requested within **120 days** of the date of purchase and before the refund deadline. No refunds will be considered after the refund

deadline. All refunds will be processed back to the original form of payment only, no exceptions. All refunds will be assessed a $35 processing fee. Please allow 30 business days for us to receive and process the refund request, then an additional 3-5 business days to receive the refund from your financial institution. Pro-rated/partial refunds are not allowed.

**NOTE:** You can check to see if your return has been processed by logging in to your Gallagher Student Health & Special Risk account.

### 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 & Special Risk 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. California College of the Arts 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.

### Service area

Your plan generally pays for covered 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 **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** | $100 per policy year | N/A |
| **Spouse** | $100 per policy year | N/A |
| **Each Child** | $100 per policy year | N/A |
| **Family** | None | N/A |
| **Policy year deductible waiver** | | |
| The policy year deductible is waived for all of the following covered services:<br>• In-Network Care for Preventive care and wellness, Pediatric Vision and Dental Care, Physician or Specialist Office Visit Expense, Walk-In Clinic Visit Expense, Consultant Expense, Urgent Care Expense, Acupuncture Expense, Outpatient Mental Health Office Visit Expense, Outpatient Substance Abuse Treatment Office Visit Expense, and Outpatient Prescription Drugs<br>• In-Network care for Well newborn nursery care and Outpatient prescription drugs | | |
| **Individual**<br>This is the amount you owe for in-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** | $6,000 per policy year | N/A |
| **Spouse** | $6,000 per policy year | N/A |
| **Each Child** | $6,000 per policy year | N/A |
| **Family** | $12,000 per policy year | N/A |

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Routine physical exams** | | |
| Performed at a physician's office | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | Not Covered |
| **Preventive care immunizations** | | |
| Performed in a facility or at a physician's office | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | Not Covered |
| **Well woman preventive visit** | | |
| Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | Not Covered |
| **Preventive screening and counseling services** | | |
| Preventive screening and counseling services for Obesity and/or healthy diet counseling, Depression, 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<br><br>No copayment or policy year deductible applies | Not Covered |
| Stress management counseling office visits | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | Not Covered |
| Chronic condition counseling office visits | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | Not Covered |

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| Routine cancer screenings | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | Not Covered |
| Lung cancer screening maximums | 1 screening every 12 months* | |
| Prenatal and postpartum care services -Preventive care services only (includes participation in the California Prenatal Screening Program) | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | Not Covered |
| Lactation support and counseling services<br><br>Includes clinically indicated interventions to support lactation consultations, counseling, education and all breast-feeding equipment and supplies | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | Not Covered |
| Breast pump supplies and accessories | 100% (of the negotiated charge) per item<br><br>No copayment or policy year deductible applies | Not Covered |
| **Family planning services – contraceptives** | | |
| Contraceptive counseling services<br>office visit | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | Not Covered |
| Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit<br><br>For each 30 day supply or 12 month supply | 100% (of the negotiated charge) per item<br><br>No copayment or policy year deductible applies | Not Covered |

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| Voluntary sterilization, including vasectomy services-Inpatient provider services | 100% (of the negotiated charge)<br><br>No copayment or policy year deductible applies | Not Covered |
| Voluntary sterilization, including vasectomy services-Outpatient provider services | 100% (of the negotiated charge)<br><br>No copayment or policy year deductible applies | Not Covered |
| The following are not preventative covered services:<br>Any contraceptive methods that are only "reviewed" by the FDA and not "approved", “granted” or “cleared” by the FDA<br>• | | |
| **Physicians and other health professionals** | | |
| Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) (includes telemedicine consultations) | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | Not Covered |
| **Allergy testing and treatment** | | |
| Allergy testing performed at a physician or specialist office | 90% (of the negotiated charge) | Not Covered |
| Allergy injections treatment performed at a physician, or specialist office when you see the physician | 90% (of the negotiated charge) | Not Covered |
| Allergy sera and extracts administered via injection at a physician’s or specialist’s office | 90% (of the negotiated charge) | 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) | 90% (of the negotiated charge) | Not Covered |
| **The following are not covered under this benefit:**<br>• A stay in a hospital (Hospital stays are covered in the *Covered services and exclusions – Hospital and other facility care* section)<br>• Services of another physician for the administration of a local anesthetic | | |

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses) | 90% (of the negotiated charge) per visit | Not Covered |
| **The following are not covered under this benefit:**<br>• A stay in a hospital (Hospital stays are covered in the *Covered services and exclusions – Hospital and other facility care* section)<br>• A separate facility charge for surgery performed in a physician's office<br>• Services of another physician for the administration of a local anesthetic | | |
| **Alternatives to physician office visits** | | |
| Walk-in clinic visits (non-emergency visit) | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | Not Covered |
| **Hospital and other facility care** | | |
| Inpatient hospital (room and board) and other miscellaneous services and supplies)<br><br>Includes birthing center facility charges | 90% (of the negotiated charge) per admission | Not Covered |
| The following are not covered services:<br>• All services and supplies provided in:<br>- Rest homes<br>- Any place considered a person's main residence or providing mainly custodial or rest care<br>- Health resorts<br>- Spas<br>- Schools or camps | | |
| Preadmission testing | Covered according to the type of benefit and the place where the service is received | Not Covered |
| In-hospital non-surgical physician services | 90% (of the negotiated charge) per visit | Not Covered |

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Alternatives to hospital stays** | | |
| Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center | 90% (of the negotiated charge) per visit | Not Covered |
| **The following are not covered under this benefit:**<br>• A stay in a hospital (See the *Hospital care – facility charges* benefit in this section)<br>• A separate facility charge for surgery performed in a physician's office<br>• Services of another physician for the administration of a local anesthetic | | |
| Home health Care | 90% (of the negotiated charge) per visit | Not Covered |
| **The following are not covered under this benefit:**<br>• 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)<br>• Transportation<br>• Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present<br>• Homemaker or housekeeper services<br>• Food or home delivered services<br>• Maintenance therapy | | |
| Hospice-Inpatient | 90% (of the negotiated charge) per admission | Not Covered |
| Hospice-Outpatient | 90% (of the negotiated charge) per visit | Not Covered |
| **The following are not covered under this benefit:**<br>• Funeral arrangements<br>• Financial or legal counseling which includes estate planning and the drafting of a will<br>• Homemaker or caretaker services that are services which are not solely related to your care and may include:<br>- Sitter or companion services for either you or other family members<br>- Transportation<br>- Maintenance of the house | | |
| Skilled nursing facility-Inpatient | 90% (of the negotiated charge) per admission | Not Covered |
| Emergency room | $150 copayment then the plan pays 90% (of the balance of the negotiated charge) per visit | Paid the same as in-network coverage |
| Non-emergency care in an emergency room | Not covered | Not covered |

<table>
<tr><th></th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td colspan="3">Important note:<ul><li>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.</li><li>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.</li><li>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.</li><li>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 amounts may be different from the emergency room copayment/coinsurance. They are based on the specific service given to you.</li><li>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.</li></ul></td></tr>
<tr><td colspan="3">The following are not covered under this benefit:<ul><li>Non-emergency services in a hospital emergency room or an independent freestanding emergency department</li></ul></td></tr>
<tr><td>Urgent care</td><td>$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies</td><td>Not Covered</td></tr>
<tr><td>Non-urgent use of an urgent care provider</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td colspan="3">The following is not covered under this benefit:<ul><li>Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)</li></ul></td></tr>
</table>

| | 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<br><br>No copayment or deductible applies | Not Covered |
| Type B services | 100% (of the negotiated charge) per visit<br><br>No copayment or deductible applies | Not Covered |
| Type C services | 100% (of the negotiated charge) per visit<br><br>No copayment or deductible applies | Not Covered |
| Orthodontic services | 100% (of the negotiated charge) per visit<br><br>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, 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. | 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:**<br>• Services and supplies for:<br>- The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches<br>- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes<br>- Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies<br>- Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet | | |
| Impacted wisdom teeth | 90% (of the negotiated charge) | Not Covered |
| Accidental injury to sound natural teeth | 90% (of the negotiated charge) | Not Covered |

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| **The following are not covered under this benefit:**<br>• The care, filling, removal or replacement of teeth and treatment of diseases of the teeth<br>• Dental services related to the gums<br>• Apicoectomy (dental root resection)<br>• Orthodontics<br>• Root canal treatment<br>• Soft tissue impactions<br>• Bony impacted teeth<br>• Alveolectomy<br>• Augmentation and vestibuloplasty treatment of periodontal disease<br>• False teeth<br>• Prosthetic restoration of dental implants<br>• 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. | Not Covered |
| **The following are not covered under this benefit:**<br>• 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:**<br>• 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 trials** | | |
| Routine patient costs | Covered according to the type of benefit and the place where the service is received. | Not Covered |
| The following are not covered services:<br>• Services and supplies related to data collection and record-keeping needed only for the clinical trial<br>• Services and supplies provided by the trial sponsor for free<br>• 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. | Not Covered |

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| **The following are not covered under this benefit:**<br>• 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 two 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:<br>• Weight management treatment.<br>• Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate.<br>• Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:<br>- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications<br>- Hypnosis, or other forms of therapy<br>- 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. | Not Covered |
| **The following are not covered under this benefit:**<br>• Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries | | |

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| Well newborn nursery care in a hospital or birthing center | 90% (of the negotiated charge)<br><br>No policy year deductible applies | Not Covered |
| Abortion services (including pre abortion and follow-up abortion related services) | 100% (of the negotiated charge)<br><br>No policy year deductible applies | Not Covered |
| **Gender affirming treatment** | | |
| Gender affirming treatment, including surgical, hormone replacement therapy, and counseling treatment | Covered according to the Behavioral health section | Not Covered |
| **Behavioral health**<br>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) | 90% (of the negotiated charge) per admission | Not Covered |
| Outpatient office visits (includes telemedicine consultations) | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | Not Covered |
| Other outpatient treatment (includes skilled behavioral health services in the home)<br><br>Partial hospitalization treatment<br><br>Intensive outpatient program | 90% (of the negotiated charge) per visit | Not Covered |
| **Covered services** | **In-network coverage (IOE facility)** | **Out-of-network coverage**<br>(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 |
| | **In-network coverage** | **Out-of-network coverage** |
| **The following are not covered under this benefit:**<br>• Services and supplies furnished to a donor when the recipient is not a covered person<br>• Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness<br>• 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. | Not Covered |
| **Fertility preservation services** | | |
| Fertility preservation | Covered according to the type of benefit and the place where the service is received. | Not Covered |

### Infertility services exclusions

The following are not covered under the **infertility** services benefit except as described as an covered service for fertility preservation:

- All infertility services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Intrauterine (IUI)/intracervical insemination (ICI) services.
- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- Infertility medication not injected by your provider, including but not limited to menotropins, hCG, and GnRH agonists. See the *Covered services and exclusions-Outpatient prescription drugs* section for information on coverage of infertility prescription drugs.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being

raised by someone else, including the biological father.

- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period [or other abnormal testing results as outlined in Aetna's infertility clinical policy

| | **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 | 90% (of the negotiated charge) per visit | Not Covered |
| Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility | 90% (of the negotiated charge) per visit | Not Covered |
| Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility | 90% (of the negotiated charge) per visit | Not Covered |
| Outpatient Chemotherapy, Radiation & Respiratory Therapy | 90% (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:

- 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

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)<br><br>Combined for short-term rehabilitation services and habilitation therapy services | 90% (of the negotiated charge) per visit | Not Covered |
| Acupuncture | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | Not Covered |
| **The following are not covered under this benefit:**<br>• Acupressure | | |
| Chiropractic services | 90% (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) | 90% (of the negotiated charge) per trip | Paid the same in-network coverage |
| Durable medical and surgical equipment | 90% (of the negotiated charge) per item | Not Covered |
| **The following are not covered under this benefit:**<br>• Whirlpools<br>• Portable whirlpool pumps<br>• Sauna baths<br>• Massage devices<br>• Over bed tables<br>• Elevators<br>• Communication aids<br>• Vision aids<br>• Telephone alert systems<br>• 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 |

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| **The following are not covered under this benefit:**<br>• 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 | 90% (of the negotiated charge) per item | Not Covered |
| Prosthetic devices - Cranial prosthetics (Medical wigs) | 90% (of the negotiated charge) per item | Not Covered |
| All other Prosthetic devices including contact lenses for aniridia & Orthotics | 90% (of the negotiated charge) per item | Not Covered |
| **The following are not covered under this benefit:**<br>• Services covered under any other benefit<br>• 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<br>• Trusses, corsets, and other support items<br>• Repair and replacement due to loss or misuse<br>• Communication aids | | |
| **Hearing Aid Exams** | | |
| Hearing exam | 100% (of the negotiated charge) per visit<br><br>No policy year deductible applies | Not Covered |
| The following are not covered under this benefit:<br>• 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<br><br>No policy year deductible applies | Not Covered |
| Low vision Maximum<br>Fitting of contact Maximum | One comprehensive low vision evaluation every five years<br>1 visit | |
| Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses | 100% (of the negotiated charge) per item<br><br>No policy year deductible applies | Not Covered |

<table>
<tr><th></th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td>Maximum number Per year:<br>Eyeglass frames<br>Prescription lenses<br>Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)</td><td colspan="2">One set of eyeglass frames<br>One pair of prescription lenses<br>Daily disposables: up to 1 year supply<br>Extended wear disposable: up to 1 year supply<br>Non-disposable lenses: 1 year supply</td></tr>
<tr><td>Optical devices</td><td>Covered according to the type of benefit and the place where the service is received.</td><td>Not Covered</td></tr>
<tr><td>Maximum number of optical devices per policy year</td><td colspan="2">One optical device</td></tr>
<tr><td colspan="3">*Important note: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:<ul><li>Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes</li></ul></td></tr>
<tr><td colspan="3">Adult vision care Limited to covered persons age 19-27 and over</td></tr>
<tr><td>Adult routine vision exams (including refraction) Performed by a legally qualified ophthalmologist or therapeutic optometrist, or any other providers acting within the scope of their license<br><br>Includes fitting of prescription contact lenses</td><td>90% (of the negotiated charge) per visit</td><td>Not Covered</td></tr>
<tr><td>Maximum visits per policy year</td><td colspan="2">1 visit</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:<br>Adult vision care<ul><li>Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses</li><li>Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes</li></ul>Adult vision care services and supplies<ul><li>Special supplies such as non-prescription sunglasses</li><li>Special vision procedures, such as orthoptics or vision therapy</li><li>Eye exams during your stay in a hospital or other facility for health care</li><li>Eye exams for contact lenses or their fitting</li></ul></td></tr>
</table>

- 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.<br><br>This means that such contraceptive methods are paid at 100% for:<br>• 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%.<br>• 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.<br><br>The certificate of coverage explains how to get a medical exception. | | |
| | **In-network coverage** | **Out-of-network coverage** |
| **Preferred and non-preferred generic prescription drugs (including specialty drugs)**<br>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 | $10 copayment per supply<br><br>No policy year deductible applies | Not Covered |
| **Preferred brand-name prescription drugs (including specialty drugs)**<br>Your cost-share may not exceed $250 for each 30 day supply of an individual prescription. This does not include any policy year deductible | | |
| For each fill up to a 30 day supply filled at a retail pharmacy | $40 copayment per supply<br><br>No policy year deductible applies | Not Covered |

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Non-preferred brand-name prescription drugs (including specialty drugs)**<br>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 | $70 copayment per supply<br><br>No policy year deductible applies | Not Covered |
| **Diabetic insulin important note:**<br>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)**<br>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 pharmacy | 100% (of the negotiated charge)<br><br>No policy year deductible applies | Not Covered |
| For each fill up to a 12 month supply of brand name prescription drugs and devices filled at a retail pharmacy | Paid according to the type of drug per the schedule of benefits, above<br><br>A brand name contraceptive is 100% (of the negotiated charge), No policy year deductible if there are no generic therapeutic equivalents. | Not Covered |
| **Preventive contraceptive important note:**<br>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%.<br><br>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.<br><br>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)<br><br>No policy year deductible applies | Not Covered |

| | | |
|---|---|---|
| Preventive care drugs and supplements filled at a retail pharmacy<br><br>For each 30 day supply | 100% (of the negotiated charge per prescription or refill<br><br>No copayment or policy year deductible applies | Not Covered |
| Risk reducing breast cancer prescription drugs filled at a pharmacy<br><br>For each 30 day supply | 100% (of the negotiated charge) per prescription or refill<br><br>No copayment or policy year deductible applies | Not Covered |
| Maximums: | Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. | |
| Tobacco cessation prescription and over-the-counter drugs (Preventive care)-Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy<br><br>For each 30 day supply | 100% (of the negotiated charge per prescription or refill<br><br>No copayment or policy year deductible applies | Not Covered |
| Maximums: | Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. | |

### Outpatient prescription drug exclusions

**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.

**Coverage in your home country**

- 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 *Covered services under your plan – Emergency services and urgent care section*

**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.

**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

**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

**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

- 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

**Telemedicine**

- Services given by providers that are not contracted with Aetna to provide telemedicine services

**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 California College of the Arts 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 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 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/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. This notice is available at Aetna's website: https://www.aetna.com/

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**Language accessibility statement**

TTY: 711

To access language services at no cost to you, call 1-877-480-4161.

Para acceder a los servicios de idiomas sin costo, llame al 1-877-480-4161. (Spanish)
如欲使用免費語言服務，請致電 1-877-480-4161 (Chinese)
Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-480-4161. (Vietnamese)
Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-480-4161 (Tagalog)

무료 언어 서비스를 이용하려면 1-877-480-4161 번으로 전화해 주십시오. (Korean)
Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք հեռախոսահամարով: 1-877-480-4161 (Armenian)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-480-4161 تماس بگیرید. (Persian-Farsi)
Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-480-4161. (Russian)

言語サービスを無料でご利用いただくには1-877-480-4161までお電話ください。
(Japanese)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم1-877-480-4161. (Arabic)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-877-480-4161 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
(Punjabi)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-877-480-4161។ (Mon-Khmer, Cambodian)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-877-480-4161. (Hmong)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-877-480-4161 पर कॉल करें। (Hindi)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-877-480-4161(Thai)

## Notice of Language Assistance

**HMO and DMO-based plans:**

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117. Planes basados en DMO y HMO –

IMPORTANTE: ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

**Traditional Plans:**

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-287-0117. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish