Aetna Student Health
Plan Design and Benefits
Summary
Open Access Elect Choice
EPO

Stanford University – Hopkins Marine--Monterey

Policy Year: 2023–2024
Policy Number: 198839
https://www.aetnastudenthealth.com
(888) 834-4708

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 the Stanford 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 available 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.

Vaden Health Center

Vaden Health Center is a multidisciplinary outpatient clinic serving registered Stanford students. The staff of over 100 professionals offers primary care medical services, psychiatric and counseling services, confidential support for those impacted by sexual/relationship abuse, wellness promotion, and health insurance and referral services. Additional clinical services include radiography, laboratory, injection and immunization, travel medicine, nutrition counseling, pharmacy, physical therapy, and some specialty care.

For Vaden Health Center's hours of operation see the website at vaden.stanford.edu.

Students enrolled in Cardinal Care and studying at Hopkins Marine Station can access Tier 1 benefits through in network Aetna providers in Monterey and Santa Cruz Counties. Students can identify in network providers through Docfind: www.aetnastudenthealth.com/en/school/198839/members/find-doctor.html

Who is eligible for Cardinal Care and Dependent Care?

Students, while attending Stanford University, must be covered by health insurance that meets specific parameters. Cardinal Care, the student health insurance plan, is one such option. Students are automatically enrolled in Cardinal Care at the start of their entry quarter each year and have until the waiver deadline of their entry quarter to choose to remain enrolled or waive. Students entering Stanford for the first time who need health insurance coverage for dependents can enroll them only during a defined period of open enrollment that coincides with their student's initial matriculation unless a qualifying life event occurs at a later date.

Coverage Dates and Rates

Coverage for all enrolled students and 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 Cardinal Care underwritten by Aetna Life Insurance Company (Aetna).

	Annual 09/01/2023-08/31/2024 Waiver Deadline: 09/15/2023	Winter 01/01/2024-08/31/2024 Waiver Deadline: 12/15/2023	Spring 04/01/2024-08/31/2024 Waiver Deadline: 03/15/2024	Summer 06/01/2024-08/31/2024 Waiver Deadline: 06/15/2024
Student	$7,128	$4,752	$2,970	$1,782

Dependent Care Eligibility

Students enrolled in Cardinal Care can enroll their spouse, registered domestic partner, and dependent children up to the age of 26. Students can enroll a dependent in Dependent Care only during a defined period of open enrollment that coincides with their student's first 30 days of matriculation unless a qualifying life event occurs at a later date. A qualifying life event will open a 31-day enrollment period.

Dependent Care Dates and Rates

Coverage for enrolled dependents will become effective at 12:00 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 Certificate.

The rates below include premiums for Dependent Care underwritten by Aetna Life Insurance Company (Aetna).

	Autumn 09/01/2023- 08/31/2024 Enrollment Deadline: 09/30/2023	Winter 01/01/2024- 08/31/2024 Enrollment Deadline: 1/30/2024	Spring 04/01/2024- 08/31/2024 Enrollment Deadline: 04/30/2024	Summer 06/01/2024- 08/31/2024 Enrollment Deadline: 06/30/2024

	Monthly Rate
Spouse	$578.00
Child	$300.56
Two or More Children	$541.02
Spouse + Child	$878.56
Spouse + Children	$1119.02

Certificate

Your certificate describes the benefits covered by your Aetna plan. The schedule of benefits in your certificate tells you how we share expenses for eligible health services and tells you about limits and gives you a summary of how your plan works.

Request to Waive

Students are automatically enrolled in Cardinal Care, at the start of their entry quarter each year. The plan year begins on September 1st and ends on August 31st. If you opt to use alternative health insurance coverage, you must formally request to waive Cardinal Care by the end of the applicable deadline below, or you will remain enrolled from your quarter of entry until the end of the plan year (August 31) and will be responsible for paying the corresponding costs which can be significant.

Review your policy carefully before deciding to request a waiver from Cardinal Care coverage. If you are approved for a waiver, you will not be eligible for Cardinal Care for the remainder of the plan year unless you have a pre-defined qualifying life event.

Students who initially opt to waive Cardinal Care, who then lose health insurance coverage or age out of a parent's health insurance plan at age 26, and who wish to have coverage through Cardinal Care, have **31 days** to apply at stanford.mycare26.com/cardinalcare. In most instances, coverage will commence at the start of the next month.

Similarly, students whose dependents lose health insurance coverage and who wish to enroll their dependent(s) in the Stanford Dependent Health Insurance Plan, Dependent Care, have **31 days** to apply at stanford.mycare26.com/cardinalcare. Note that students must be enrolled in Cardinal Care to enroll dependents in the Stanford Dependent Care Plan.

YOU MUST MAKE YOUR HEALTH INSURANCE DECISION EVERY YEAR

If you choose not to have health insurance coverage through Cardinal Care, you will need to waive *EACH* academic year by the applicable deadline. A decision made in one plan year does not carry over to the next.

Quarter entering Stanford	Deadline to Convey Your Health Insurance Decision (Stay Enrolled in Cardinal Care or Waive Coverage)
Autumn Quarter	September 15
Winter Quarter	December 15
Spring Quarter	March 15
Summer Quarter	June 15

Your Alternative Health Care Plan Must Have Comparable Benefits

In order to be approved for a waiver from Cardinal Care coverage, you must have health insurance coverage that meets or exceeds Stanford's minimum standards. These requirements ensure that your health care needs will be adequately covered while you are at Stanford.

Your alternative health insurance policy must meet or exceed the following minimum standards:

- Covers the entire academic year (September 1 through August 31). Gaps in coverage are not allowed.
- Covers inpatient and outpatient medical care in the San Francisco Bay Area (with strong preference for access to providers at Stanford University Medical Center and/or the Sutter Health Providers).
- Coverage for inpatient and outpatient mental health care in the San Francisco Bay Area (with strong preference for access to providers at Stanford University Medical Center and/or the Sutter Health Providers).
- Has an annual deductible $1,000 USD or less (some employer plans may be exempted from this requirement).
- Has an annual out of pocket maximum of $9,100 USD or less (some employer plans may be exempted from this requirement).
- Provides the Essential Minimum Benefits require by the Patient Protection and Affordable Care Act (PPACA) with no annual or lifetime maximums.
- Covers 100% of Preventative Care as defined by the PPACA.
- Contains no exclusions for pre-existing conditions.
- Offers prescription drug coverage.
- Offers coverage for non-emergency as well as emergency care.
- Has lifetime aggregate maximum benefit of at least $2,000,000 USD OR a maximum per condition/per lifetime benefit of $500,000 USD.

Dependent Care Enrollment

To enroll the dependent(s) of a Cardinal Care student, please log on to stanford.mycare26.com/cardinalcare. Dependent Care online applications will not be accepted after the enrollment period deadline, unless there is a qualifying life event that directly affects their insurance coverage. (Examples of a qualifying life event would be loss of health coverage under another health plan, marriage, birth of a child.)

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

- A newborn child - Your newborn child is covered on your Cardinal Care health insurance plan for the first 31 days from the moment of birth.
  - 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 coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.
- An adopted child or a child legally placed with you for adoption - 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.
  - 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, please call our enrollment partner Academic Health Plans at 855-343-8387.

Cardinal Care and Leaves of Absence

If you are covered by Cardinal Care and contemplate taking a leave of absence at any point in your academic career, be sure to contact Vaden Health Center's Insurance and Referral Office for guidance about coverage, in advance, if possible. As you'll see below, timing can be a driver as to whether coverage will be preserved.

A student who is granted a Leave of Absence in Autumn Quarter for which the effective date of the leave is prior to the first day of class will not be charged tuition or any associated fees for the quarter. Upon reversal of the tuition, the student's eligibility for enrollment in Cardinal Care will be canceled retroactive to September 1. (The student's eligibility for enrollment in Cardinal Care will resume upon return to the university and reinstatement of tuition.)

A student who is granted a Leave of Absence in Autumn Quarter for which the effective date of the leave is on or after the first day of class but before the term withdrawal deadline will be charged (prorated) tuition and associated fees for the quarter after confirmation of attendance in classes or participation in units by the Office of the University Registrar. If enrolled in Cardinal Care, the student will remain enrolled through the end of the plan year (August 31) and applicable fees will apply.

A student who is enrolled in Cardinal Care as of Autumn Quarter, and who is granted a Leave of Absence for a subsequent quarter (i.e., Winter Quarter, Spring Quarter, or Summer Quarter) will remain enrolled in and covered by Cardinal Care through the end of the plan year (August 31) and applicable fees will apply.

A student who returns to the university in Winter Quarter or Spring Quarter, and who is subsequently granted a Leave of Absence, i.e., if the effective date of the leave is prior to the first day of class, tuition and any associate fees for the quarter will be reversed. Upon reversal of the tuition, the student's eligibility for enrollment in Cardinal Care will be cancelled retroactively to the start of the applicable coverage period (January 1 for Winter Quarter entry student and April 1 for Spring Quarter entry students) the effective date of the leave is on or after the first day of class but before the respective term withdrawal deadline, the student will be charged (prorated) tuition and associated fees for the quarter after confirmation of attendance in classes, or participation in units, by the Office of the University Registrar. If enrolled in Cardinal Care, the student will remain enrolled through the end of the plan year (August 31) and applicable fees will apply.

Service area

Your plan generally pays for eligible health services only within a specific geographic area, called a service area. There are some exceptions, such as for Tier 2, emergency services, urgent care and transplants.

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.

Precertification (Prior Authorization)

You do not need to obtain precertification for any services. However, your provider is required to obtain precertification for certain Preferred Care services. Refer to the Precertification provisions in the Coverage section of the Certificate 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 available to you.

Plan Design and Benefits Summary

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 available to you, go to **https//:www.aetnastudenthealth.com.**

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

	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna 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	$500 per policy year	Not Applicable
Spouse	$100 per policy year	$500 per policy year	Not Applicable
Each child	$100 per policy year	$500 per policy year	Not Applicable
Family	$300 per policy year	$1,500 per policy year	Not Applicable
Policy year deductible waiver			
The **policy year deductible** is waived for all of the following **eligible health services**: • Tier 2 in-network care for Preventive care and wellness, • Tier 2 in-network care for Pediatric Dental Care type A services, • Tier 2 in-network care for Pediatric Vision Care Services and Supplies, • Tier 2 in-network care for Physicians, Specialists and consults office visits, • Tier 2 in-network care for first postnatal visit, • Tier 2 in-network care for Well Newborn Nursery Care, • Tier 2 in-network care for Walk-in clinic visits, • Tier 2 in-network care for Hospital emergency room, • Tier 2 in-network care for Urgent care, • Tier 2 in-network care outpatient mental health and substance abuse office visits, • Tier 2 in-network care Ambulance services, • Tier 2 in-network care for hearing aid exams, • Tier 2 in-network care for routine adult vision exams, • Tier 2 in-network care for **Outpatient Prescription Drugs.** The Tier 1 in-network care **policy year deductible** applies to the following **eligible health services:** • Inpatient hospital (room and board) • Outpatient surgery (facility charges) • Treatment of infertility			
Individual This is the amount you owe for select care and in-network eligible health services each policy year before the plan begins to pay for eligible health services. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.			

	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna In-network coverage	Out-of-network coverage
Maximum out-of-pocket limits			
Student	$2,000 per policy year	$4,000 per policy year	Not Applicable
Spouse	$2,000 per policy year	$4,000 per policy year	Not Applicable
Each child	$2,000 per policy year	$4,000 per policy year	Not Applicable
Family	$6,000 per policy year	$12,000 per policy year	Not Applicable

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna 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	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Maximum age and visit limits per policy year through age 21	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents.		Not Applicable
Covered persons age 22 and over: Maximum visits per policy year	1 visit		Not Applicable
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	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention		Not Applicable
Routine gynecological exams (including Pap smears and cytology tests)			
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Maximum visits per policy year	1 visit		Not Applicable

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna In-network coverage	Out-of-network coverage
Preventive screening and counseling services			
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Stress management counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Chronic condition counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Maximum:	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration.		Not Applicable
Lung cancer screening maximums	1 screening every 12 months*		Not Applicable
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	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered
Lactation support and counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not covered

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna In-network coverage	Out-of-network coverage
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	100% (of the negotiated charge) per item No copayment or policy year deductible applies	Not covered
Family planning services – female contraceptives			
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit 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 For each 30 day supply or 12 month supply	100% (of the negotiated charge) per item No copayment or policy year deductible applies	100% (of the negotiated charge) per item No copayment or policy year deductible applies	Not covered
Female Voluntary sterilization-Inpatient & Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	100% (of the negotiated charge) No copayment or policy year deductible applies	Not covered
The following are not covered under this benefit: • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA			
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 No policy year deductible applies	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	Not covered
Allergy testing and treatment			
Allergy testing performed at a physician or specialist office	100% (of the negotiated charge) No policy year deductible applies	70% (of the negotiated charge)	Not covered

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna In-network coverage	Out-of-network coverage
Allergy injections treatment performed at a physician's, or specialist office [when you see the physician]	100% (of the negotiated charge) No policy year deductible applies	70% (of the negotiated charge)	Not covered
Allergy sera and extracts administered via injection at a physician's or specialist's office	100% (of the negotiated charge) No policy year deductible applies	70% (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)	100% (of the negotiated charge) No policy year deductible applies	70% (of the negotiated charge)	Not covered
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic			
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the negotiated charge) per visit	Not covered
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic			
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 thereafter No policy year deductible applies	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	Not covered

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna In-network coverage	Out-of-network coverage
Hospital and other facility care			
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	$500 copayment then the plan pays 100% (of the balance of the negotiated charge) per admission	70% (of the negotiated charge) per admission	Not covered
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	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the negotiated charge) per visit	Not covered
Alternatives to hospital stays			
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	$250 copayment then the plan pays 100% (of the balance of the negotiated charge)	70% (of the negotiated charge)	Not covered
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (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	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	70% (of the negotiated charge) per visit	Not covered
Maximum visits per policy year	100		Not applicable
The following are not covered under this benefit: • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities) • Transportation • Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy			

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna In-network coverage	Out-of-network coverage
Hospice-Inpatient	100% (of the negotiated charge) per admission No policy year deductible applies	70% (of the negotiated charge) per admission	Not covered
Hospice-Outpatient	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the negotiated charge) per visit	Not covered
The following are not covered under this benefit: • Funeral arrangements • Financial or legal counseling which includes estate planning and the drafting of a will • Homemaker or caretaker services that are services which are not solely related to your care and may include: - Sitter or companion services for either you or other family members - Transportation - Maintenance of the house			
Skilled nursing facility-Inpatient	$500 copayment then the plan pays 100% (of the balance of the negotiated charge)	70% (of the negotiated charge)	Not covered
Maximum days of confinement per policy year	unlimited		Not covered
Hospital emergency room	$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as Tier 1 in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered	Not covered
Important note: • As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply. • Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance. • Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room			

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

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

The following are not covered under this benefit:

- Non-emergency services in a hospital emergency room facility, freestanding emergency medical care facility or comparable emergency facility

Eligible health services	**Tier 1 (Monterey & Santa Cruz County providers) In-network coverage**	**Tier 2 Aetna In-network coverage**	**Out-of-network coverage**
Urgent care	$50 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	$50 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	$50 copayment then the plan pays 100% (of the balance of the recognized charge) per visit thereafter No policy year deductible applies
Non-urgent use of an urgent care provider	Not covered	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	Tier 1 providers do not provide dental services	100% (of the negotiated charge) per visit No copayment or deductible applies	Not covered
Type B services	Tier 1 providers do not provide dental services	80% (of the negotiated charge) per visit No copayment or deductible applies	Not covered
Type C services	Tier 1 providers do not provide dental services	50% (of the negotiated charge) per visit No copayment or deductible applies	Not covered
Orthodontic services	Tier 1 providers do not provide dental services	50% (of the negotiated charge) per visit No copayment or deductible applies	Not covered
Dental emergency services	Tier 1 providers do not provide dental services	Covered according to the type of benefit and the place where the service is received.	Not covered

Pediatric dental care exclusion

The following are not covered under this benefit:

- Asynchronous dental treatment
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material or
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants (that are determined not to be medically necessary mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in this section
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs
- Replacement of teeth beyond the normal complement of 32
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons, except as medically necessary
- Treatment by other than a dental provider

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna 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.	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.	Covered according to the type of benefit and the place where the service is received.	Not covered

The following are not covered under this benefit:

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna In-network coverage	Out-of-network coverage
Accidental injury to sound natural teeth	100% (of the negotiated charge) No policy year deductible applies	70% (of the negotiated charge)	Not covered

The following are not covered under this benefit:

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

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.	Not covered

The following are not covered under this benefit:

- Dental implants

Blood and body fluid exposure	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Not covered

The following are not covered under this benefit:

- Services and supplies provided for the treatment of an illness that results from your clinical related injury as these are covered elsewhere in the student policy

Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Not covered

The following are not covered under this benefit:

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e.

protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna In-network coverage	Out-of-network coverage
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.	Not covered
The following are not covered under this benefit: • Cosmetic treatment and procedures			
Obesity bariatric Surgery and services	Covered according to the type of benefit and the place where the service is received.	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 applicable
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 applicable
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 applicable
Maximum benefit payable for lodging expenses per companion for surgery stay	$100 per day, up to four days		Not applicable

The following are not covered under this benefit:

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

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna In-network coverage	Out-of-network coverage
Maternity care that is not considered preventive care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Not covered
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries			
Well newborn nursery care in a hospital or birthing center	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the negotiated charge) per visit No policy year deductible applies	Not covered
Family planning services – other			
Voluntary sterilization for males-inpatient surgical services	$50 copayment then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$100 copayment then the plan pays 100% (of the negotiated charge)	Not covered
Voluntary sterilization for males-outpatient surgical services	$50 copayment then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$100 copayment then the plan pays 100% (of the negotiated charge)	Not covered
Abortion			
Inpatient physician or specialist surgical services	100% (of the negotiated charge) No policy year deductible applies	100% (of the negotiated charge) No policy year deductible applies	Not covered
Outpatient physician or specialist surgical services	100% (of the negotiated charge) No policy year deductible applies	100% (of the negotiated charge) No policy year deductible applies	Not covered
Reversal of voluntary sterilization			
Inpatient physician or specialist surgical services	100% (of the negotiated charge) No policy year deductible applies	70% (of the negotiated charge)	Not covered

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna In-network coverage	Out-of-network coverage
Outpatient physician or specialist surgical services	100% (of the negotiated charge) No policy year deductible applies	70% (of the negotiated charge)	Not covered
Gender affirming treatment			
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the Behavioral health section	Covered according to the Behavioral health section	Not covered
Mental Health & Substance related disorders treatment Coverage provided under the same terms, conditions as any other **illness**.			
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	$500 copayment then the plan pays 100% (of the negotiated charge) per admission	100% (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 thereafter No policy year deductible applies	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	Not covered
Other outpatient treatment (includes skilled behavioral health services in the home)	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	Not covered
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.	Not covered
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.	Not covered
Transplant services-travel and lodging	Covered	Covered	Not applicable
Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	$10,000	$10,000	Not applicable
Maximum payable for Lodging Expenses per **IOE** patient	$50 per night	$50 per night	Not applicable
Maximum payable for Lodging Expenses per companion	$50 per night	$50 per night	Not applicable

The following are not covered under this benefit:

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna In-network coverage	Out-of-network coverage
Treatment of infertility			
Basic infertility services Inpatient and outpatient care - basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Not covered
Comprehensive infertility services. Inpatient and outpatient care	50% (of the negotiated charge)		Not covered
Artificial insemination maximum per policy year	6 attempts		Not applicable
Maximum number of intrauterine insemination cycles per policy year	6 attempts		Not applicable
Advanced reproductive technology (ART) services. Inpatient and outpatient care	50% (of the negotiated charge)		Not covered
Maximum number of cycles per policy year	1 course of treatment		Not applicable
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.	Not covered

The following are not covered services under the infertility treatment benefit:

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

sperm injection (ICSI) or ovum microsurgery) • ART services are not provided for out-of-network care			
Eligible health services	**Tier 1 (Monterey & Santa Cruz County providers) In-network coverage**	**Tier 2 Aetna In-network coverage (IOE facility)**	**Out-of-network coverage**
Specific therapies and tests			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	$100 copayment then the plan pays 100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the negotiated charge) per visit	Not covered
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the negotiated charge) per visit	Not covered
Outpatient Chemotherapy, Radiation & Respiratory Therapy	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	70% (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.	Covered according to the type of benefit and the place where the service is received.	Not covered
The following are not covered under this benefit: • Enteral nutrition • Blood transfusions and blood products			
Outpatient Cardiac and Pulmonary Therapy	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$40 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	Not covered
Outpatient physical, occupational, speech, and cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$40 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	Not covered

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna In-network coverage	Out-of-network coverage
Acupuncture therapy	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	70% (of the negotiated charge) per visit, after policy year deductible	Not covered
The following are not covered under this benefit: • Acupressure			
Chiropractic services	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	70% (of the negotiated charge) per visit, after policy year deductible	Not covered
Maximum visits per policy year	15 visits		Not applicable
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.	Not covered
Other services and supplies			
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	100% (of the negotiated charge) per trip No policy year deductible applies	100% (of the negotiated charge) per trip No policy year deductible applies	Paid the same in-network coverage
Durable medical and surgical equipment	100% (of the negotiated charge) per item No policy year deductible applies	70% (of the negotiated charge) per item	Not covered
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician			

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna In-network coverage	Out-of-network coverage
Nutritional support	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.	Not covered
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition			
Cochlear implants	100% (of the negotiated charge) per item No policy year deductible applies	70% (of the negotiated charge) per item	Not covered
Prosthetic devices including contact lenses for aniridia & Orthotics	100% (of the negotiated charge) per item No policy year deductible applies	70% (of the negotiated charge) per item	Not covered
The following are not covered under this benefit: • Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss or misuse • Communication aids			
Hearing Exams			
Hearing exam	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	Not covered
The following are not covered under this benefit: • Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay			
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)			
Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations)	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	Not covered
Low vision Maximum Fitting of contact Maximum	One comprehensive low vision evaluation every five years 1 visit		Not applicable

Eligible health services	Tier 1 (Monterey & Santa Cruz County providers) In-network coverage	Tier 2 Aetna In-network coverage	Out-of-network coverage
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	100% (of the negotiated charge) per item No policy year deductible applies	Not covered
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: one-year supply Extended wear disposable: one-year supply Non-disposable lenses: one-year supply		Not applicable
Optical devices	Covered according to the type of benefit and the place where the service is received.		Not applicable
Maximum number of optical devices per policy year	One optical device		Not applicable
*__Important note__: Refer to the Vision care section in the Certificate 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	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	Not covered
Maximum visits per policy year	1 visit		Not applicable
The following are not covered under this benefit: Adult vision care • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes Adult vision care services and supplies • Special supplies such as non-prescription sunglasses • Special vision procedures, such as orthoptics or vision therapy • Eye exams during your stay in a hospital or other facility for health care • Eye exams for contact lenses or their fitting • Eyeglasses or duplicate or spare eyeglasses or lenses or frames • Replacement of lenses or frames that are lost or stolen or broken • Acuity tests • Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures • Services to treat errors of refraction			

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs		
Outpatient prescription drug copayment/coinsurance waiver for risk reducing breast cancer		
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 copayment waiver for tobacco cessation prescription and over-the-counter drugs		
The outpatient prescription drug copayment will not apply to treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at an in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.		
Outpatient prescription drug copayment waiver for contraceptives		
The outpatient prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy. This means that such contraceptive methods are paid at 100% for: • All FDA approved contraceptive prescription drugs and devices, including over-the-counter (OTC) contraceptive prescription drugs and devices. Related services and supplies needed to administer covered devices will also be paid at 100%. • A therapeutic equivalent prescription drug or device when a prescription drug or device is not available or is deemed medically inadvisable by your provider when you are granted a medical exception. The Certificate explains how to get a medical exception.		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Preferred generic prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	$10 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered
Preferred brand-name prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	$35 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered
Non-preferred generic prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	$50 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered
Non-preferred brand-name prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	$50 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered
Specialty prescription drugs		
For each fill up to a 30- day supply filled at a specialty pharmacy or a retail pharmacy	$50 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
Contraceptives (birth control)		
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) 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 A brand name contraceptive is 100% (of the negotiated charge), No policy year deductible if there are no generic therapeutic equivalents.	Not covered
Orally administered anti-cancer prescription drugs- For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	Not covered
Preventive care drugs and supplements filled at a retail pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Not covered
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Not covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	Not applicable
Sexual enhancement or dysfunction prescription drugs-Up to 8 pills for each 30 day supply filled at a retail pharmacy	Paid according to the tier of drug in the schedule of benefits above	Not covered
Sexual enhancement or dysfunction prescription drugsUp to 27 pills for all fills greater than a 30 day supply but no more than a 90 day supply filled at a mail order pharmacy	Paid according to the tier of drug in the schedule of benefits above	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
Tobacco cessation prescription and over-the-counter drugs (Preventive care)-Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Not covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	Not applicable

Outpatient prescription drugs exclusions

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

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

licensed certified health professional in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the [preferred] drug guide.
  - That are drugs obtained for use by anyone other than the person identified on the ID card.
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- A manufacturer's product when the same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the preferred drug guide
- Any dosage or form of a drug when the same drug is available in a different dosage or form on our preferred drug guide

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug. The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Precertification 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 Tier 2 In-Network level of benefits.

General Exclusions

Alternative health care

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

Armed forces

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

Behavioral health treatment

- Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association:
  - Remedial education services that are non-medical and are not medically necessary to treat mental health disorders or substance use disorders
  - Services provided in conjunction with school, vocation, work or recreational activities that are not medically necessary to treat mental health disorders or substance use disorders
  - Sexual deviations and disorders except mental health disorders or substance use disorders listed in the most recent edition of the DSM and International Classification of Diseases (ICD)

Clinical trial therapies (experimental or investigational)

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

Cosmetic services and plastic surgery

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

This exclusion does not apply to:

- Surgery after an accidental injury when performed as soon as medically feasible. (Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.)
- Coverage that may be provided under the Eligible health services under your plan - Gender reassignment (sex change) treatment section.

Court-ordered services and supplies

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

Custodial care

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. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training
- For behavioral health (mental health treatment and substance use disorders treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function
    - Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults

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

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

Educational services

Examples of these services that are non-medical and are not medically necessary to treat mental health disorders or substance use disorders are:

- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services and exclusions – Diabetic services and supplies (including equipment and training)* section. This includes:
  - Special education
  - Remedial education
  - Job training
  - Job hardening programs

- Educational services, schooling or any such related or similar program

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

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

Facility charges
For care, services or supplies provided in:
- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

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

Gene-based, cellular and other innovative therapies (GCIT)
The following are not eligible health services unless you receive prior written approval from us:
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the *Medical necessity , referral and precertification requirements* section.

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

Growth/Height care
- A treatment, device, service or supply to increase or decrease height or alter the rate of growth
- **Surgical procedures** and devices to stimulate growth

Hearing aids
Any tests, appliances and devices to:
- Improve your hearing
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Incidental surgeries

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

Judgment or settlement

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

Medical supplies – outpatient disposable

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

Non-U.S. citizen

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

Other primary payer

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

Outpatient prescription or non-prescription drugs and medicines

- Outpatient **prescription drugs** or non-prescription drugs and medicines provided by the **policyholder**

Personal care, comfort or convenience items

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

Private duty nursing

School health services

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

  by **health professionals** who
  - Are employed by
  - Are Affiliated with
  - Have an agreement or arrangement with, or
  - Are otherwise designated by

the **policyholder**.

Services provided by a family member

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

Sexual dysfunction and enhancement

- Any treatment, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - **I**mplants, devices or preparations to correct or enhance erectile function or sensitivity
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Sinus surgery

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

Strength and performance

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

Students in mental health field

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

Telemedicine

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

Therapies and tests

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

Treatment in a federal, state, or governmental entity

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

The Stanford University Student Health Insurance Plan is underwritten by Aetna Health and 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.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-843-4708.

Smartphone or Tablet

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

Nondiscrimination Notice

Aetna does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, have questions about our non-discrimination policy, or have a discrimination-related concern that you would like to discuss, contact the number on your ID card. Not an Aetna member? Call us at 1-888-843-4708.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: P.O. Box 14462, Lexington, KY 40512 (HMO customers: P.O. Box 24030 Fresno, CA 93779)
- Email: CRCoordinator@aetna.com

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 discrimination complaint with the United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex by following the instructions on the Department's website: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Language accessibility statement

Interpreter services are available for free.

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-888-843-4708** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-843-4708** (TTY: **711**).

አማርኛ**/Amharic**

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-888-843-4708** (መስማት ለተሳናቸው: **711**).

العربية**/Arabic**

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-843-4708** (رقم الهاتف النصي: **711**).

Ɓàsɔ̀ɔ̀ Wùɖù/Bassa

Dè dɛ nìà kɛ dyɛ́ɖɛ́ gbo: Ɔ jǔ kɛ́ m̀ dyí Ɓàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìì à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpáa. Ɖá **1-888-843-4708** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-888-843-4708** (TTY: **711**)。

فارسی**/Farsi**

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-888-843-4708** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d'une assistance gratuite dans votre langue en composant le **1-888-843-4708** (TTY: **711**).

ગુજરાતી**/Gujarati**

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે. કૉલ કરો **1-888-843-4708** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-843-4708** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-888-843-4708** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-888-843-4708** (TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-888-843-4708** (TTY: **711**). Estes serviços são oferecidos gratuitamente.

Русский/Russian

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-888-843-4708** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-843-4708** (TTY: **711**).

Urdu/اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (TTY: **711**) **1-888-843-4708** پر کال کریں.

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-888-843-4708** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-888-843-4708** (TTY: **711**).