Aetna Student Health

Plan Design and Benefits Summary Harvey Mudd College

Policy Year: 2016 - 2017
Policy Number: 867938

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1-877-480-4161

This is a brief description of the Student Health Plan. The Plan is available for Harvey Mudd College students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to the Claremont Colleges Consortium and may be viewed online at **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits.

PLEASE NOTE THAT WE HAVE NOT YET RECEIVED APPROVAL FROM THE CALIFORNIA INSURANCE DEPARTMENT FOR THE 2016 BENEFITS DESCRIBED IN THIS PLAN DESIGN & BENEFIT SUMMARY GUIDE. AS PART OF THE APPROVAL PROCESS, THE DEPARTMENT MAY REQUIRE US TO MAKE CHANGES TO THE BENEFITS. IF THAT HAPPENS, WE WILL PROVIDE YOU WITH AN UPDATED PLAN DESIGN & BENEFIT SUMMARY GUIDE.

Student Health Services

The Student Health Services (SHS) is the Claremont Consortium's health facility. Staffed by doctors, nurse practitioners and medical support staff, it is open Monday, Tuesday and Friday 8:00 a.m. to 5:00 p.m., Wednesday 8:00 a.m. to 7:00 p.m. and Thursday 9:00 a.m. to 5:00 p.m. during the Fall and Spring semesters.

SHS is located in the Tranquada Student Services Building, 757 College Way, Claremont, CA 91711. For more information, call the Health Services at **(909) 621-8222**. In the event of an emergency, call 911 or the Campus Police at **(909) 607-2000**.

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 a.m. on the Coverage Start Date indicated below, and will terminate at 11:59 p.m. on the Coverage End Date indicated.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual*	08/30/2016	08/29/2017	09/30/2016
Fall*	08/30/2016	01/03/2017	09/30/2016
Spring/Summer	01/04/2017	08/29/2017	02/04/2017
Summer	05/13/2017	08/29/2017	06/13/2017

* Early Start students are eligible as of 8/1/2016.

Eligible Dependents: Coverage for dependents eligible under the Plan for the following Coverage Periods. Coverage will become effective at 12:01 a.m. on the Coverage Start Date indicated below and will terminate at 11:59 p.m. 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
Annual*	08/30/2016	08/29/2017	09/30/2016
Fall*	08/30/2016	01/03/2017	09/30/2016
Spring/Summer	01/04/2017	08/29/2017	02/04/2017
Summer	05/13/2017	08/29/2017	06/13/2017

* Early Start students are eligible as of 8/1/2016.

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as Claremont Colleges Consortium administrative fee.

Undergraduate Student Rate

	Annual	Fall Semester	Spring/Summer Semester
Student	**$1,890**	**$664**	**$1,236**
		Summer Semester	
		$571	

Undergraduate Dependent Rate

	Annual	Fall Semester	Spring/Summer Semester
Dependent	**$1,890**	**$664**	**$1,236**
		Summer Semester	
		$571	

Undergraduate Two or More Children Rate

	Annual	Fall Semester	Spring/Summer Semester
Two or More Children	**$3,758**	**$1,320**	**$2,458**
		Summer Semester	
		$1,136	

Student Coverage

Eligibility

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

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

Enrollment

Harvey Mudd College students who wish to enroll in SHIP may enroll by visiting **www.4studenthealth.com/harveymudd** and completing the online enrollment form. Enrollment must be completed by the Enrollment Deadline Date (see Coverage Periods). For questions about enrollment, please contact Ascension at **(800) 537-1777**.

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

Exception: A Covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro rata refund of premium will be made for such person, and any covered dependents, upon written request received by Aetna within 90 days of withdrawal from school.

Dependent Coverage

Eligibility

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

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

Preferred Provider Network

Aetna Student Health has arranged for you to access a Preferred Provider Network in your local community. To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services.

If a service or supply that a covered person needs is covered under the Plan but not available from a Designated Care Provider or Preferred Care Provider, covered persons should contact Member Services for assistance at the toll-free number on the back of the ID card. In this situation, Aetna may issue a pre-approval for a covered person to obtain the service or supply from a Non-Preferred Care Provider. When a pre-approval is issued by Aetna, covered medical expenses are reimbursed at the Preferred Care network level of benefits.

Pre-certification Program

Your Plan requires pre-certification for a hospital stay. Pre-certification simply means calling Aetna Student Health prior to treatment to get approval for a medical procedure or service. Pre-certification may be done by you, your doctor, the hospital, or one of your relatives. Requests for certification must be obtained by contacting Aetna Student Health at **1-877-480-4161**.

You'll need pre-certification for the following inpatient services:

- All inpatient admissions, including length of stay, to a hospital, skilled nursing facility, a facility established primarily for the treatment of substance abuse, or a residential treatment facility;
- All inpatient maternity care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- All partial hospitalization in a hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse.

Pre-certification does not guarantee the payment of benefits for your inpatient admission.

Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the student Accident and Sickness Plan.

Pre-certification of non-emergency inpatient admissions and partial hospitalization

Non-emergency admissions must be requested at least **three (3) business days** prior to the planned admission or prior to the date the services are scheduled to begin.

Pre-certification of emergency inpatient admissions

Emergency admissions must be requested within **one (1) business day** after the admission.

Description of Benefits

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. While this Plan Design and Benefits Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Master Policy issued to the Claremont Colleges Consortium, you may access it online at **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits. All coverage is based on Recognized Charges unless otherwise specified.

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

Metallic Level: Platinum, Tested at 91.80%

Policy Year Maximum	**Unlimited**	
DEDUCTIBLE	**Preferred Care**	**Non-Preferred Care**
The policy year deductible is waived for preferred care covered medical expenses that apply to Preventive Care Expense benefits. In addition, the Preferred Care deductible is waived for services performed at the Student Health Center and for Preferred Care referred by the Student Health Center. Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible. ***Annual Deductible does not apply to these services**	Individual: $100 Per Policy Year	Individual: $300 Per Policy Year

COINSURANCE	Preferred Care	Non-Preferred Care
Coinsurance is both the percentage of covered medical expenses that the plan pays, and the percentage of covered medical expenses that you pay. The percentage that the plan pays is referred to as "plan coinsurance" or the "payment percentage," and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.	Covered Medical Expenses are payable at the plan coinsurance percentage specified below, after any applicable Deductible.	
OUT-OF-POCKET MAXIMUMS	**Preferred Care**	**Non-Preferred Care**
Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year. The following expenses do not apply toward your plan's out-of-pocket limit: • expenses that are not Covered Medical Expenses, • penalties, and • other expenses not covered by this Plan.	Combined Out-of-Pocket: Individual: $5,000 Family: $12,700	
REFERRAL REQUIREMENTS		
A Student Health Services (SHS) referral is required for non-emergency care within a 25-mile radius from campus, unless SHS is closed. The Preferred care deductible is waived for services performed at the Student health Center and for Preferred Care referred by the student health center. A referral is not required in the following circumstances: • Treatment is for an Emergency Medical Condition. A referral is required for follow-up care. • Obstetric and Gynecological Treatment, • Pediatric Care, • Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness), • Prescribed Medicine Expenses, • Mental and Nervous Disorders Expenses, • The Student Health Center is closed, • For medical care rendered at another facility when classes are not in session, such as for official school breaks and holidays, • Medical care received when the student is more than 25 miles from campus, • Medical care received when a student is no longer able to use the SHC due to a change in student status. *Dependents are not eligible to use the services of the University Health Services and are therefore not subject to the referral requirements and penalties.		
INPATIENT HOSPITALIZATION BENEFITS	**Preferred Care**	**Non-Preferred Care**
Room and Board Expense	100% of the Negotiated Charge	90% of the Recognized Charge for a semi-private room
Miscellaneous Hospital Expense Includes, but not limited to: operating room, laboratory tests/X rays, oxygen tent, and drugs, medicines, dressings.	100% of the Negotiated Charge	90% of the Recognized Charge

INPATIENT HOSPITALIZATION BENEFITS (continued)	Preferred Care	Non-Preferred Care
Non-Surgical Physicians Expense Non-surgical services of the attending Physician, or a consulting Physician.	100% of the Negotiated Charge	90% of the Recognized Charge
SURGICAL EXPENSES	**Preferred Care**	**Non-Preferred Care**
Surgical Expense **(Inpatient and Outpatient)**	100% of the Negotiated Charge	90% of the Recognized Charge
Anesthesia Expense **(Inpatient and Outpatient)**	100% of the Negotiated Charge	90% of the Recognized Charge
Assistant Surgeon Expense **(Inpatient and Outpatient)**	100% of the Negotiated Charge	90% of the Recognized Charge
Ambulatory Surgical Expense	100% of the Negotiated Charge	90% of the Recognized Charge
OUTPATIENT EXPENSE	**Preferred Care**	**Non-Preferred Care**
Hospital Outpatient Department Expense	100% of the Negotiated Charge	90% of the Recognized Charge
Walk-in Clinic Visit Expense	After a $20 Copay per visit, 100% of the Negotiated Charge	After a $20 Deductible per visit, 90% of the Recognized Charge
Emergency Room Expense Important Notice: A separate hospital emergency room visit benefit deductible or copay applies for each visit to an emergency room for emergency care. If a covered person is admitted to a hospital as an inpatient immediately following a visit to an emergency room, the emergency room visit benefit deductible or copay is waived. Covered medical expenses that are applied to the emergency room visit benefit deductible or copay cannot be applied to any other benefit deductible or copay under the plan. Likewise, covered medical expenses that are applied to any of the plan's other benefit deductibles or copays cannot be applied to the emergency room visit benefit deductible or copay. Separate benefit deductibles or copays may apply for certain services rendered in the emergency room that are not included in the hospital emergency room visit benefit. These benefit deductibles or copays may be different from the hospital emergency room visit benefit deductible or copay, and will be based on the specific service rendered. Similarly, services rendered in the emergency room that are not included in the hospital emergency room visit benefit may be subject to coinsurance.	After a $100 Copay per visit, 100% of the Negotiated Charge	After a $100 Deductible per visit, 100% of the Recognized Charge

OUTPATIENT EXPENSE (continued)	Preferred Care	Non-Preferred Care
Important Note: Please note that Non-Preferred Care Providers do not have a contract with Aetna, the provider may not accept payment of your cost share (your deductible and 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. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.	After a $100 Copay per visit, 100% of the Negotiated Charge	After a $100 Deductible per visit, 100% of the Recognized Charge
Urgent Care Expense	After a $20 Copay per visit, 100% of the Negotiated Charge	After a $20 Deductible per visit, 90% of the Recognized Charge
Ambulance Expense	100% of the Negotiated Charge	100% of the Recognized Charge
Physician's Office Visit Expense This benefit includes visits to specialists and telemedicine services.	After a $20 Copay per visit, 100% of the Negotiated Charge	After a $20 Deductible per visit, 90% of the Recognized Charge
Consultant Expense	After a $20 Copay per visit, 100% of the Negotiated Charge	After a $20 Deductible per visit, 90% of the Recognized Charge
Telemedicine Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Laboratory and X-ray Expense	100% of the Negotiated Charge	90% of the Recognized Charge
High Cost Procedures Expense Includes CT scans, MRIs, PET scans and Nuclear Cardiac Imaging Tests.	100% of the Negotiated Charge	90% of the Recognized Charge
Physical Therapy Expense	100% of the Negotiated Charge	90% of the Recognized Charge
Therapy Expense Includes Speech, Occupational and Chiropractic expenses.	100% of the Negotiated Charge	90% of the Recognized Charge
Therapy Expense Includes chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Durable Medical and Surgical Equipment Expense	100% of the Negotiated Charge	90% of the Recognized Charge
Prosthetic and Orthotic Devices Expense Includes prosthetic devices to restore a method of speaking for laryngectomy patient.	100% of the Negotiated Charge	90% of the Recognized Charge

OUTPATIENT EXPENSE (continued)	Preferred Care	Non-Preferred Care
Hypodermic Needles Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Podiatric Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Osteoporosis Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Allergy Testing and Treatment Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Diagnostic Testing For Learning Disabilities Expense Once a covered person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Plan.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Dental Anesthesia Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Dental Injury Expense	100% of the Negotiated Charge	100% of the Recognized Charge
Dental Expense for Impacted Wisdom Teeth	100% of the Negotiated Charge	100% of the Recognized Charge
PREVENTIVE CARE	**Preferred Care**	**Non-Preferred Care**
Pap Smear Screening Expense	100% of the Negotiated Charge*	90% of the Recognized Charge
Mammogram Expense	100% of the Negotiated Charge*	90% of the Recognized Charge
Immunizations Expense Includes travel immunizations and flu shots.	100% of the Negotiated Charge*	90% of the Recognized Charge
HIV Testing Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Aids Vaccine Expense	100% of the Negotiated Charge*	90% of the Recognized Charge
Pediatric Preventive Care Expense Includes charges for the comprehensive preventive care of children 18 years of age or younger, consistent with the Recommendations for Preventive Pediatric health Care, as adopted by the American Academy of Pediatrics.	100% of the Negotiated Charge*	90% of the Recognized Charge
Routine Physical Exam Expense Includes routine tests and related lab fees.	100% of the Negotiated Charge*	90% of the Recognized Charge

PREVENTIVE CARE (continued)	Preferred Care	Non-Preferred Care
Routine Screening for Sexually Transmitted Disease Expense	100% of the Negotiated Charge*	90% of the Recognized Charge
Routine Colorectal Cancer Screening Expense Includes charges for colorectal cancer examination & laboratory tests, for any non-symptomatic person age 50 or more, or a symptomatic person under age 50.	100% of the Negotiated Charge*	90% of the Recognized Charge
Routine Prostate Cancer Screening For a male age 50 or over, one digital rectal exam and one prostate specific antigen test each Policy Year.	100% of the Negotiated Charge*	90% of the Recognized Charge
Pediatric Vision Care Exam Expense Exams are limited to 1 visit per Policy Year Supplies are limited to 1 pair of Glasses (lenses and frames) per Policy Year. Covered Medical Expenses include routine vision exam (including refraction & Glaucoma Testing), non-cosmetic eyeglass frames, prescription lenses or prescription contact lenses (not both). Benefits are provided to covered persons until the end of the month in which the covered person turns 19.	100% of the Negotiated Charge*	90% of the Recognized Charge
Pediatric Dental Diagnostic and Preventive Care Covered dental expenses include charges made by a dental provider for the dental services listed in the Pediatric Dental Care Schedule. To view the Pediatric Dental Care Schedule please refer to the school_name page on the Aetna Student Health website, **www.aetnastudenthealth.com**. Benefits are provided to covered persons until the end of the month in which the covered person turns 19.	100% of the Negotiated Charge*	90% of the Recognized Charge
Pediatric Dental Basic Restorative Care Covered dental expenses include charges made by a dental provider for the dental services listed in the Pediatric Dental Care Schedule. To view the Pediatric Dental Care Schedule please refer to the school_name page on the Aetna Student Health website, **www.aetnastudenthealth.com.** Benefits are provided to covered persons until the end of the month in which the covered person turns 19.	70% of the Negotiated Charge*	50% of the Recognized Charge
Pediatric Dental Major Restorative Care Covered dental expenses include charges made by a dental provider for the dental services listed in the Pediatric Dental Care Schedule. To view the Pediatric Dental Care Schedule please refer to the school_name page on the Aetna Student Health website, **www.aetnastudenthealth.com.** Benefits are provided to covered persons until the end of the month in which the covered person turns 19.	50% of the Negotiated Charge*	50% of the Recognized Charge
Routine Hearing Exam Expense Limited to 1 Routine Hearing exam per Policy Year.	100% of the Negotiated Charge*	90% of the Recognized Charge

TREATMENT OF MENTAL AND NERVOUS DISORDERS	Preferred Care	Non-Preferred Care
Severe Mental Illness of persons of any age and Serious Emotional Disturbances of a Child Inpatient Expense	100% of the Negotiated Charge	90% of the Recognized Charge
Severe Mental Illness of persons of any age and Serious Emotional Disturbances of a Child Outpatient Expense	After a $20 Copay per visit, 100% of the Negotiated Charge	After a $20 Copay per visit, 90% of the Recognized Charge
Mental and Nervous Disorders Inpatient Expense	100% of the Negotiated Charge	90% of the Recognized Charge
Mental and Nervous Disorders Outpatient Expense	After a $20 Copay per visit, 100% of the Negotiated Charge	After a $20 Copay per visit, 90% of the Recognized Charge
ALCOHOLISM AND DRUG ADDICTION TREATMENT	**Preferred Care**	**Non-Preferred Care**
Inpatient Expense	100% of the Negotiated Charge	90% of the Recognized Charge
Outpatient Expense	After a $20 Copay per visit, 100% of the Negotiated Charge	After a $20 Copay per visit, 90% of the Recognized Charge
MATERNITY BENEFITS	**Preferred Care**	**Non-Preferred Care**
Maternity Expense Includes Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures of a high-risk pregnancy.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Prenatal Care/Comprehensive Lactation Support and Counseling Services	100% of the Negotiated Charge*	90% of the Recognized Charge
Breast Feeding Durable Medical Equipment	100% of the Negotiated Charge*	90% of the Recognized Charge
Well Newborn Nursery Care Expense	100% of the Negotiated Charge	90% of the Recognized Charge

Family Planning Expense

Unless specified below, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services provided as a result of complications resulting from a voluntary sterilization Procedure and related follow-up care;
- Services which are for the treatment of an identified illness or injury;
- Services that are not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA; Male contraceptive methods or devices;
- The reversal of voluntary sterilization procedures, including any related follow-up care

MATERNITY BENEFITS (continued)	Preferred Care	Non-Preferred Care
Voluntary Sterilization Coverage for tubal ligation for voluntary sterilization.	100% of the Negotiated Charge*	90% of the Recognized Charge
Voluntary Sterilization Coverage for vasectomy for voluntary sterilization.	100% of the Negotiated Charge	90% of the Recognized Charge
Contraceptives **Important Note:** Brand-Name Prescription Drug or Devices for a Preferred Provider will be covered at 100% of the Negotiated Charge, including waiver of per Policy Year Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.	100% of the Negotiated Charge*	90% of the Recognized Charge
PRESCRIPTION DRUG COVERAGE	**Preferred Care**	**Non-Preferred Care**
Prescribed Medicines Expense Prior Authorization may be required for certain Prescription Drugs and some medications may not be covered under this Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at **888 RX-AETNA** (available 24 hours). Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to **www.AetnaSpecialtyRx.com.** Covered Benefits include HIV prescription drug coverage for PrEP (pre and post exposure prophylaxis) and PEP (post exposure prophylaxis).	100% of the Negotiated Charge, following $60 Copay for each Non-Formulary Brand Name Prescription Drug, a $40 Copay for each Formulary Brand Name Prescription Drug or a $20 Copay for each Generic Prescription Drug.	Not Covered
ADDITIONAL BENEFITS	**Preferred Care**	**Non-Preferred Care**
Diabetic Testing Supplies Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Outpatient Diabetic Self-management Education Programs Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Temporomandibular Joint Dysfunction Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Nicotine Treatment Expense Covered Medical Expenses include treatment of nicotine use. Treatment may take place in facilities licensed to provide alcoholism or chemical dependency services. Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs, limited to two 90-day treatment regimens.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Dermatological Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Transfusion or Dialysis of Blood Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Clinical Trials Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Second Surgical Opinion Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Non-Prescription Enteral Formula Expense	100% of the Negotiated Charge	90% of the Recognized Charge
Elective Abortion Expense	100% of the Negotiated Charge	90% of the Recognized Charge
Acupuncture Expense	After a $20 Copay per visit, 100% of the Negotiated Charge	After a $20 Copay per visit, 90% of the Recognized Charge
Acupuncture In Lieu Of Anesthesia Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Phenylketonuria Services Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Mastectomy and Breast Reconstruction Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Hospice Benefit	100% of the Negotiated Charge	90% of the Recognized Charge
Home Health Care Expense	100% of the Negotiated Charge	90% of the Recognized Charge
Licensed Nurse Expense	100% of the Negotiated Charge	90% of the Recognized Charge
Skilled Nursing Facility Expense	100% of the Negotiated Charge	90% of the Recognized Charge
Rehabilitation Facility Expense	100% of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations	90% of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Human Organ Transplant Expense We cover transplants of organs, tissue, or bone marrow We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor Services at no charge	Payable in accordance with the type of expense incurred and the place where service is provided.	
Cochlear Implant Expense Internally implanted devices	100% of the Negotiated Charge	90% of the Recognized Charge
Bariatric Surgery Expense Includes services rendered as part of medically necessary bariatric surgery treatment for morbid obesity	Payable in accordance with the type of expense incurred and the place where service is provided.	
Gender Reassignment (Sex Change) Treatment Expense Includes charges made in connection with a medically necessary gender reassignment surgery (sometimes called sex change surgery) as long the covered student or their covered dependent has obtained precertification from Aetna. The covered student or their covered dependent must be at least 18 years of age or older to be eligible for this benefit. Covered medical expenses include: • Charges made by a physician for: o Performing the surgical procedure; and o Pre-operative and post-operative hospital and office visits. • Charges made by a hospital for inpatient and outpatient services (including outpatient surgery). • Charges made by a Skilled Nursing Facility for inpatient services and supplies. • Charges made for the administration of anesthetics. • Charges for outpatient diagnostic laboratory and x-rays. • Charges for blood transfusion and the cost of un-replaced blood and blood products. • Charges made by a behavioral health provider for gender reassignment counseling. • Charges incurred for injectable and non-injectable hormone replacement therapy. No benefits will be paid for covered medical expenses under this benefit unless they have been pre-certified by Aetna. Refer to the Precertification section for more information.	Payable in accordance with the type of expense incurred and the place where service is provided.	

Exclusions

This Plan does not cover nor provide benefits for:

1. Expense incurred for services normally provided without charge by the Policyholder's Health Service; Infirmary or Hospital; or by health care providers employed by the Policyholder.

2. Expense incurred for eye refractions; vision therapy; radial keratotomy; eyeglasses; contact lenses (except when required after cataract surgery); or other vision or hearing aids; or prescriptions or examinations except as required for repair caused by a covered injury. (Please reference the Pediatric Vision Care Exam Expense on page 10 of this Summary of Benefits for more details on Pediatric Vision coverage).

3. Expense incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.

4. Expense incurred as a result of an injury sustained or sickness contracted while in the service of the Armed Forces of any country. Upon the covered person entering the Armed Forces of any country; the unearned pro-rata premium will be refunded to the Policyholder.

5. Expense incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.

6. Expense incurred for elective treatment or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.

7. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance whether or not for psychological or emotional reasons. This exclusion will not apply to the extent needed to: (a) Improve the function or create a normal appearance to the extent possible of a part of the body that is not a tooth or structure that supports the teeth and is malformed as a result of a congenital defect, including harelip, webbed fingers or toes, or as a direct result of disease or surgery performed to treat a disease or injury; (b) Repair an injury (including reconstructive surgery for prosthetic device for a covered person who has undergone a mastectomy) which occurs while the covered person is covered under this Policy. Surgery must be performed in the calendar year of the accident which causes the injury or in the next calendar year.

8. Expense covered by any other valid and collectible medical; health or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.

9. Expense incurred as a result of commission of a felony.

10. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits Provision.

11. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.

12. Expense incurred for any services rendered by a member of the covered person's immediate family or a person who lives in the covered person's home.

13. Treatment for injury to the extent benefits are payable under any state no-fault automobile coverage; first party medical benefits payable under any other mandatory No-fault law.

14. Expenses for treatment of injury or sickness to the extent that payment is made; as a judgment or settlement; by any person deemed responsible for the injury or sickness (or their insurers).

15. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.

16. Expense incurred for custodial care. Custodial care means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to: by whom they are prescribed; or by whom they are recommended; or by whom or by which they are performed.

17. Expense incurred for the removal of an organ from a covered person for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a covered person to a spouse; child; brother; sister; or parent.

18. Expenses incurred for or in connection with procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if: (a) There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or (b) If required by the FDA, approval has not been granted for marketing or a recognized national medical or dental society or regulatory agency has determined in writing that it is experimental, investigational, or for research purposes; or (c) The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility, or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental, investigational, or for research purposes. However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease if Aetna determines that: (a) The disease can be expected to cause death within one year in the absence of effective treatment; and (b) The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination; Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved; or (c) The covered person has been accepted into a phase I, II, III, or IV approved cancer clinical trial and the attending physician recommended the program. Also, this exclusion will not apply with respect to drugs that: (a) Have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or (b) Are being studied at the Phase III level in a national clinical trial; sponsored by the National Cancer Institute if Aetna determines that available, scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

19. Expenses incurred for breast reduction/mammoplasty.

20. Expenses incurred for gynecomastia (male breasts).

21. Expenses incurred for any sinus surgery; except for acute purulent sinusitis.

22. Expenses incurred for: care; treatment; services; or supplies for or related to obstructive sleep apnea; and sleep disorders; including CPAP; and UPP.

23. Expense incurred by a covered person; not a United States citizen; for services performed within the covered person’s home country; if the covered person’s home country has a socialized medicine program.

24. Expense incurred for alternative; holistic medicine; and/or therapy; including but not limited to; yoga and hypnotherapy.

25. Expense for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns; bunions; or calluses; (d) care of toenails; and (e) care of fallen arches; weak feet; or chronic foot strain; except that (c) and (d) are not excluded when medically necessary; because the covered person is diabetic; or suffers from circulatory problems.

26. Expense for injuries sustained as the result of a motor vehicle accident; to the extent that benefits are payable under other valid and collectible insurance; whether or not claim is made for such benefits. The Policy will only pay for those losses; which are not payable under the automobile medical payment insurance Policy.

27. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.

28. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B; even though the covered person is eligible; but did not enroll in Part B.

29. Expense for telephone consultations (except Telemedicine Services); charges for failure to keep a scheduled visit; or charges for completion of a claim form.

30. Expense for the cost of supplies used in the performance of any occupational therapy.

31. Expense for personal hygiene and convenience items; such as air conditioners; humidifiers; hot tubs; whirlpools; or physical exercise equipment; even if such items are prescribed by a physician.

32. Expense for services or supplies provided for the treatment of obesity and/or weight control, unless otherwise provided in the policy.

33. Expense for incidental surgeries; and standby charges of a physician.

34. Expense incurred for outpatient treatment in connection with the detection or correction by manual or mechanical means of structural imbalance; distortion; or subluxation; in the human body; for purposes of removing nerve interference as a result of or related to: distortion; misalignment; or subluxation in the vertebral column; except as provided elsewhere in the Policy.

35. Expense incurred as a result of dental treatment; except for medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures; treatment resulting from injury to sound; natural teeth or for extraction of wisdom teeth as provided elsewhere in this Policy.

36. Expense for contraceptive methods; devices or aids; and charges for services and supplies for or related to gamete intrafallopian transfer; artificial insemination; in-vitro fertilization (except as required by the state law); or embryo transfer procedures; elective sterilization or its reversal; or elective abortion; unless specifically provided for in this Policy.

37. Expenses incurred for massage therapy.

38. Expense for charges that are not recognized charges; as determined by Aetna; except that this will not apply if the charge for a service; or supply; does not exceed the recognized charge for that service or supply; by more than the amount or percentage; specified as the Allowable Variation.

39. Expense for treatment of covered students who specialize in the mental health care field; and who receive treatment as a part of their training in that field.

40. Expenses for routine physical exams; including expenses in connection with well newborn care; routine vision exams; routine dental exams; routine hearing exams; immunizations; or other preventive services and supplies; except to the extent coverage of such exams; immunizations; services; or supplies is specifically provided in the Policy.

41. Expense incurred for a treatment, service, or supply which is not medically necessary as determined by Aetna for the diagnosis care or treatment of the sickness or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending physician; or dentist. In order for a treatment, service, or supply to be considered medically necessary, the service or supply must:
(a) be care or treatment which is likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition; (b) be a diagnostic procedure which is indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition; and (c) as to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests. In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration: (a) information relating to the affected person's health status; (b) reports in peer reviewed medical literature; (c) reports and guidelines published by nationally recognized health care organizations that include supporting scientific data; (d) generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment; (e) the opinion of health professionals in the generally recognized health specialty involved; and (f) any other relevant information brought to Aetna's attention. In no event will the following services or supplies be considered to be medically necessary: (a) those that do not require the technical skills of a medical, a mental health, or a dental professional; or (b) those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any persons who is part of his or her family, any healthcare provider, or healthcare facility; or (c) those furnished solely because the person is an inpatient on any day on which the person's sickness or injury could safely and adequately be diagnosed or treated while not confined, or those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

The Harvey Mudd College 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).