Student Health Insurance

Open Choice®
Preferred Provider Organization (PPO)
Medical and Outpatient Prescription Drug Plan

Schedule of Benefits

Prepared exclusively for:

Policyholder:	Saint Martin's University
Policyholder number:	686217
Student policy effective date:	August 31, 2024
Plan effective date:	August 31, 2024
Plan issue date:	August 21, 2024
Actuarial value and metallic level:	84.31% - Gold

Underwritten by Aetna Life Insurance Company
in the state of Washington

Schedule of benefits

This schedule of benefits lists the **policy year deductibles**, **copayments** and **coinsurance**, if any, that apply to the **eligible health services** you receive under this plan. You should review this schedule of benefits to become familiar with these and any limits that apply to the services and supplies.

How to read your schedule of benefits

- When we say:
  - "In-network coverage", we mean you get care from our **in-network providers**
  - "Out-of-network coverage", we mean you can get care from **out-of-network providers**
- The **policy year deductibles**, **copayments** and **coinsurance** listed in the schedule of benefits below reflects the **policy year deductibles**, **copayment** and **coinsurance** amounts under your plan.
- Any **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount that the plan pays. You are responsible for paying any remaining **coinsurance**.
- Sometimes we don't show a specific cost share for a benefit. Instead we say, "Covered based on the type of service and where it is received." That means your cost share will depend on the exact care you get and who provides it. For example, if you receive services for diabetes from a **health professional** in their office, you will pay the cost share listed in *Health professional services*. If you receive services for diabetes during a **hospital stay**, you will pay the cost share listed in *Hospital care*.
- You are responsible for paying any **policy year deductibles**, **copayments**, and your **coinsurance**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums. They are combined maximums for **network providers** and **out-of-network providers**, unless we state otherwise.
- At the end of this schedule of benefits you will find detailed explanations about any:
  - **Policy year deductibles**
  - **Copayments**
  - **Coinsurance**
  - **Maximum out-of-pocket limits**

Important note: All **covered benefits** are subject to any **policy year deductible**, **copayment** and **coinsurance** unless otherwise noted in the schedule of benefits below. *Your Rights and Protections Against Surprise Medical Bills and Balance Billing* explains your protections from a surprise bill. See your certificate for this consumer notice.

How to contact us for help

We are here to answer your questions.

- Log onto your Aetna® website at https://www.aetnastudenthealth.com
- Call Member Services at the toll-free number 1-877-480-4161

The coverage described in this schedule of benefits will be provided under **Aetna's student policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **student policy** for medical and pharmacy coverage. Keep this schedule of benefits with your certificate of coverage.

Important note about your medical cost sharing:

The way your medical cost sharing works under this plan, you pay the **policy year deductible** first. Then you pay any applicable copayment and **coinsurance**. Your emergency room **copayment** does not apply towards any **policy year deductible**. Any cost share for diabetic insulin applies towards your **policy year deductible**.

You are required to pay the **policy year deductible** before **eligible health services** are **covered benefits** under the plan, and then you pay any applicable **copayment** and **coinsurance**.

Here's an example of how your medical cost sharing works**:**

You pay your policy year deductible	**Your physician charges**	**Your physician collects from you**	**The plan pays 80% coinsurance**	**You pay 20% coinsurance**
$250	$120	$0	$96	$24

General coverage provisions

This section provides detailed explanations about:

- **Policy year deductibles**
- **Copayments**
- **Coinsurance**
- **Maximum out-of-pocket limits**

Policy year deductibles

Eligible health services applied to the out-of-network **policy year deductibles** will not be applied to satisfy the in-network **policy year deductibles**. **Eligible health services** applied to the in-network **policy year deductibles** will not be applied to satisfy the out-of-network **policy year deductibles**.

The in-network and out-of-network **policy year deductibles** may not apply to certain **eligible health services**. You must pay any applicable **copayments** for **eligible health services** to which the **policy year deductibles** do not apply. **Copayments** do not apply towards your **policy year deductible** except for any cost share for diabetic insulin**.**

Individual

This is the amount you owe for in-network and out-of-network **eligible health services** each **policy year** before the plan begins to pay for **eligible health services**. See the *Policy year deductibles* section of this schedule for any exceptions to this general rule. This **policy year deductible** applies separately. 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**.

Copayments

In-network coverage

This is a specified dollar amount or percentage that must be paid by you when you receive **eligible health services** from a **network provider.**

Coinsurance

Coinsurance is both the percentage of **eligible health services** that the plan pays and what you pay. The specific percentage that we have to pay for **eligible health services** is listed in the schedule of benefits below. **Coinsurance** is not a **copaymen**t.

Maximum out-of-pocket limits

Eligible health services that are subject to the **maximum out-of-pocket limits** include **covered benefits** provided under the medical plan and outpatient **prescription drug** benefits provided under the outpatient **prescription drug** benefit.

Eligible health services applied to the out-of-network **maximum out-of-pocket limit** will not be applied to satisfy the in-network **maximum out-of-pocket limit** and **eligible health services** applied to the in-network **maximum out-of-pocket limit** will not be applied to satisfy the out-of-network **maximum out-of-pocket limit**.

See *How to read your schedule of benefits* at the beginning of this schedule of benefits

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments**, **coinsurance** and **policy year deductibles** for **eligible health services** during the **policy year**. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual

Once the amount of the **copayments**, **coinsurance** and **policy year deductibles** you have paid for **eligible health services** during the **policy year** meets the individual **maximum out-of-pocket limits**, this plan will pay:

- 100% of the **negotiated charge** for in-network **covered benefits**
- 100% of the **recognized charge** for out-of-network **covered benefits**

that apply towards the limits for the rest of the **policy year** for that person.

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services
- Any out-of-pocket costs incurred for non-emergency use of the emergency room
- Any out-of-pocket costs incurred for non-urgent use of an **urgent care provider**

Plan features	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	$250 per **policy year**	$500 per **policy year**
Policy year deductible waiver		
The **policy year deductible** is waived for all of the following **eligible health services:** • In-network care for: – *Preventive care and wellness* services – *Pediatric dental care - Type A* services – *Pediatric vision care* services – *Abortion* – *Ambulance* • In-network and out-of-network care for: – *Hospital emergency room* services – *Outpatient prescription drugs*		

See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Maximum out-of-pocket limits

Maximum out-of-pocket limit per **policy year**.

Student	$9,100 per **policy year**	$18,200 per **policy year**

Coinsurance listed in the schedule of benefits

The **coinsurance** listed in the schedule of benefits below reflects the plan **coinsurance** percentage. This is the **coinsurance** amount that the plan pays. You are responsible for paying any remaining **coinsurance**.

School health services benefits

You may be eligible to receive some health care services for free through your Student Health Center. Check with your Student Health Center for details.

See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage	Out-of-network coverage
1. Preventive care and wellness		
Routine physical exams		
Performed at a **health professional's** office	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Covered persons through age 21: Maximum age and visit limits per **policy year**	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.	For details, contact your **health professional** or **Aetna** by logging onto your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.
Covered persons age 22 and over: Maximum visits per **policy year**	1 visit	
Preventive care immunizations		
Performed in a facility or at a **health professional's** office	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
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. For details, contact your **health professional** or **Aetna** by logging onto your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	

Well woman preventive visits, routine gynecological exams (including Pap smears)		
Performed at a **health professional's** office, such as an obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Maximum visits per **policy year**	1 visit	
Preventive screening and counseling services		
Obesity and/or healthy diet counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Misuse of alcohol and/or drugs counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Use of tobacco products counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Depression screening counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Sexually transmitted infection counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit

See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Genetic risk counseling for breast and ovarian cancer office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Age and frequency limitations	Not subject to any age or frequency limitations	
Routine cancer screenings (applies whether performed at a health professional's office or a facility)		
Routine cancer screenings, including diagnostic and supplemental breast exams	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Maximums	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, including colorectal cancer screenings for adults starting either at age 45, or earlier if at increased risk due to health factors or family history • The comprehensive guidelines supported by the Health Resources and Services Administration For details, contact your **health professional** or **Aetna** by logging onto your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	
Lung cancer screening maximums	1 screening every 12 months	
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		
Prenatal care services (provided by a health professional, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
Preventive care services only	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Important note: You should review the *Maternity care* section. They will give you more information on coverage levels for maternity care under this plan.		

See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Comprehensive lactation support and counseling services		
Lactation counseling services - facility or office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Breast feeding durable medical equipment		
Breast pump supplies and accessories	100% (of the **negotiated charge**) per item No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per item
Important note: See the *Breast feeding durable medical equipment* section of the certificate of coverage for limitations on breast pump and supplies.		
Family planning services		
Counseling services		
Contraceptive counseling services office visit	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Contraceptives (prescription drugs and devices)		
Contraceptive **prescription drugs** and devices provided, administered, or removed, by a **provider** or other **health professional** during an office visit	100% (of the **negotiated charge**) per item No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per item
Voluntary sterilization		
Inpatient	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Outpatient	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit

Eligible health services	In-network coverage	Out-of-network coverage
2. Physicians and other health professionals		
Health professional services		
Office hours visits (non-surgical and non-preventive care) by a **health professional** Includes **telemedicine** consultation or use of **store and forward technology**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Allergy testing and treatment		
Allergy testing performed at a **health professional's** office	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
Allergy sera and extracts administered via injection at a **health professional's** office	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
Physician and specialist - inpatient surgical services		
Inpatient **surgery** performed during your **stay** in a **hospital** or **birthing center** by a surgeon (includes anesthetist and **surgical** assistant expenses)	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Physician and specialist - outpatient surgical services		
Outpatient **surgery** performed at a **physician's** or **specialist's** office or outpatient department of a **hospital** or **surgery center** by a surgeon (includes anesthetist and **surgical** assistant expenses)	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
In-hospital non-surgical health professional services		
In-**hospital** non-surgical **health professional** services	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

Consultant services (non-surgical and non-preventive)		
Consultant office visits		
Office hours visits (non-surgical and non-preventive care) Includes **telemedicine** consultation or use of **store and forward technology**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Alternatives to physician or other health professional office visits		
Walk-in clinic visits		
Walk-in clinic (non-emergency visit)	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Important note: Some **walk-in clinics** can provide preventive care and wellness services. The types of services offered will vary by the **provider** and location of the clinic. If you get preventive care and wellness benefits at a **walk-in clinic,** they are paid at the cost-sharing shown in the *Preventive care and wellness* section.		

Eligible health services	In-network coverage	Out-of-network coverage
3. Hospital and other facility care		
Hospital care (facility charges)		
Inpatient **hospital** (**room and board**) and other services and supplies Subject to **semi-private room rate** unless intensive care unit required **Room and board** includes intensive care For **physician** charges, refer to the *Physician and specialist – inpatient surgical services* benefit	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission
Preadmission testing		
Preadmission testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Alternatives to hospital stays		
Outpatient surgery (facility charges)		
Facility charges for **surgery** performed in the outpatient department of a **hospital** or **surgery center** For **physician** charges, refer to the *Physician and specialist - outpatient surgical services* benefit	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Home health care		
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	130	

Hospice care		
Inpatient facility (**room and board**) and other services and supplies)	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Outpatient private duty nursing		
Outpatient private duty nursing	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Skilled nursing facility		
Inpatient facility (**room and board** and inpatient care services and supplies) Subject to **semi-private room rate** unless intensive care unit is required **Room and board** includes intensive care	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

Eligible health services	In-network coverage	Out-of-network coverage
4. Emergency services and urgent care		
Emergency services		
Hospital emergency room	$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 in-network coverage
Important note: • If you get **emergency services** from an **out-of-network provider** or **hospital**, the most the **provider** or **hospital** may bill you is your plan's in-network cost-sharing amount. You can't be balance billed for these **emergency services**. See *Your Rights and Protections Against Surprise Medical Bills and Balance Billing in Washington State* in the certificate of coverage for more information. A separate **hospital** emergency room **copayment** 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** will be waived and your inpatient **copayment** will apply. • **Covered benefits** that are applied to the **hospital** emergency room **copayment** cannot be applied to any other **copayment** under the plan. Likewise, a **copayment** that applies to other **covered benefits** under the plan cannot be applied to the **hospital** emergency room **copayment.** • Separate **copayment** 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** amounts may be different from the **hospital** emergency room **copayment**. 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** or **coinsurance** amounts.		
Non-emergency care in a **hospital** emergency room	Not covered	Not covered
Urgent care		
Urgent medical care provided by an **urgent care provider**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Non-urgent use of **urgent care provider**	Not covered	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
5. Pediatric dental care		
Limited to covered persons through the end of the month in which the person turns age 19		
Type A services	100% (of the **negotiated charge**) per visit No c**opayment** or **policy year deductible** applies	50% (of the **recognized charge**) per visit
Type B services	50% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Type C services	50% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Orthodontic services	50% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Dental emergency 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
Dental benefits are subject to the plan's **policy year deductibles** and **maximum out-of-pocket limit**s as explained on the schedule of benefits.		

Diagnostic and preventive care (type A services)

Visits and images

- Periodic oral evaluation (limited to: 2 visits per year)
- Comprehensive oral evaluation, beginning before age 1 (limited to: 2 visits per year)
  - Complete dental and medical history
  - General health assessment
  - Evaluation of extra-oral and intra-oral hard and soft tissue
  - Evaluation and recording of:
    - Dental caries
    - Missing teeth
    - Unerupted teeth
    - Restorations
    - Occlusal relationships
    - Periodontal conditions
    - Periodontal charting
    - Hard and soft tissue anomalies
  - Oral cancer screening
- Routine comprehensive or recall examination, new or established patient (limited to 2 visits per year)
- Limited oral evaluations to evaluate the member for a specific dental problem or oral health complaint, dental emergency or referral for other treatment (limited to 2 per year)

- Screening or assessment to determine need for sealants, fluoride treatment or triage services (limited to 2 per year)
- Oral hygiene instructions (limited to 2 per year for children age 8 and under)
  - Individualized oral hygiene instructions
  - Tooth brushing techniques
  - Flossing
  - Use of oral hygiene aids
- Emergency palliative treatment, per visit
- Problem-focused examination
- Prophylaxis (cleaning) (limited to: 2 treatments per year)
- Topical application of fluoride (limited to: 3 applications per year, additional topical fluoride treatments by report)
- Topical application of fluoride varnish (limited to: 3 applications per year)
- Sealants, per tooth (limited to: 1 application per tooth every 3 years for permanent bicuspids and molars only)
- Sealant repair
- Bitewing images (limited to: 2 sets per year)
- Complete image series, including bitewings if **medically necessary** (limited to: 1 set every 3 years)
- Vertical bitewing images (limited to 1 set every 3 years)
- Periapical images
- Intra-oral, occlusal view
- Cephalometric film (limited to: 1 in a 2 year period)
- Panoramic film radiographic image (limited to 1 set every 3 years)
- Photographic images, when **medically necessary**
- Diagnostic casts

Space maintainers

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Recementation of space maintainer
- Removal of space maintainer
- Replacement space maintainers when dentally appropriate

Basic restorative care (type B services)

Visits and images

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- House or extended care facility visits
- Treatment of post-surgical complications
- Consultation provided by dentist other than the treating dentist

Images and pathology

- Extra-oral posterior dental radiographic image
- Accession of tissue examination of oral tissue

Oral surgery

- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants (baby teeth)
  - Surgical removal of erupted tooth or root tip
  - Removal of tooth (soft tissue)
  - Incision and drainage of abscess
- Impacted teeth
  - Surgical removal of impacted teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (fully bony)
  - Removal of tooth (complication)
  - Surgical removal of residual tooth roots
- Other surgical procedures
  - Alveoplasty, in conjunction with extractions, per quadrant
  - Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces per quadrant
  - Alveoplasty, not in conjunction with extraction, per quadrant
  - Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces per quadrant
  - Vestibulopasty
  - Excision of hyperplastic tissue
  - Removal of exostosis
  - Removal of torus palatinus
  - Removal of torus mandibularis
  - Crown exposure to aid eruption
  - Removal of foreign body from soft tissue
  - Frenulectomy/frenulopasty

Periodontics

- Periodontal scaling and root planing, 4 or more teeth per quadrant (limited to once per quadrant every 2 years)
- Periodontal scaling and root planing, 1 to 3 teeth per quadrant (limited to once per quadrant every 2 years)
- Periodontal maintenance procedures (limited to 2 per year)
- Gingivectomy or gingivoplasty, 4 or more teeth per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy or gingivoplasty, 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure, 4 or more teeth per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure, 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- Full mouth debridement (limited to 1 every 3 years)
- Osseous surgery, including flap and closure, 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- Osseous surgery, including flap and closure, 4 or more teeth per quadrant (limited to 1 per quadrant, every 3 years)
- Localized delivery of antimicrobial agents
- Occlusal adjustment (other than with an appliance or by restoration)

See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Endodontics

- Pulp capping (direct and indirect)
- Pulpotomy (therapeutic)
- Pulpal debridement
- Pulpal therapy, resorbable filling
- Pulpal regeneration
- Pulp vitality test
- Apexification/recalcification
- Apicoectomy
- Retrograde filling, per root
- Root amputation, per root
- Hemisection
- Root canal therapy, including **medically necessary** images, for:
  - Anterior tooth
  - Premolar tooth
  - Molar (excluding teeth 1, 16, 17 and 32)
- Retreatment of previous root canal therapy for:
  - Anterior tooth
  - Premolar tooth
  - Molar tooth

Restorative dentistry

- Fillings consisting of amalgam and resin based composite restorations, limited to the following:
  - Maximum of 5 surfaces per tooth for permanent posterior teeth (except for upper molars)
  - Maximum of 6 surfaces per tooth for teeth 1, 2, 3, 14, 15 and 16
  - Maximum of 6 surfaces per tooth for permanent anterior teeth
  - Restorations on the same tooth are limited to:
    - 1 every 2 years
    - 2 occlusal restorations for the upper molars on teeth 1, 2, 3, 14, 15 and 16
- Amalgam restorations
- Resin-based composite restorations (other than for molars)
- Pins
  - Pin retention – per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
  - Prefabricated stainless steel
  - Prefabricated resin crown (excluding temporary crowns)
- Re-cementation
  - Inlay/onlays
  - Crowns
  - Fixed partial dentures (bridge)

General anesthesia, intravenous sedation, oral or parenteral conscious sedation with any covered dental procedure when medically necessary (15 minute increments)

- In connection with extractions of partially or completely bony impacted teeth
- To safeguard your health
- For a covered procedure performed in a dental office if **medically necessary** because a child is under 8 years of age, or is physically or developmentally disabled

See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services include:

- Evaluation – deep anesthesia or general anesthesia
- General anesthesia
- IV sedation
- Other drugs/medicines
- Drugs or medicaments when used with parenteral conscious sedation, deep sedation or general anesthesia
- Local anesthesia
- Regional block anesthesia including office-based oral or parenteral conscious sedation or general anesthesia
- Nitrous oxide and analgesia (limited to 1 administration per day)

Major restorative care (type C services)

Oral surgery

- Coronectomy

Periodontics

- Clinical crown lengthening
- Pedical soft tissue graft procedures

Restorative

- Inlays/onlays (limited to 1 per tooth every 5 years)
- Crowns (limited to 1 per tooth every 5 years)
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain/ceramic substrate
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - ¾ cast metallic or porcelain/ceramic
- Cast post and core or prefabricated post and core
- Core build-up, including pins

Prosthodontics

- Replacement of complete existing fixed bridges or dentures (limited to 1 every 5 years)
- Removable partial dentures, immediate partial dentures, resin based, cast metal framework with resin denture bases, flexible base and one piece cast metal – unilateral, including any conventional clasps, rests and teeth (limited to 1 every 3 years)
- Bridge/partial abutments (see inlays and crowns) (limited to 1 per tooth every 5 years)
- Pontics (limited to 1 per tooth every 5 years)
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal

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- One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics (limited to 1 per tooth every 5 years)
  - Fees for dentures and partial dentures include relines and rebases within 6 months from the seat date
  - Fees for adjustments to dentures and partial dentures include adjustments within 6 months from the seat date
- Complete dentures (limited to 1 every 5 years)
  - Fees for dentures include relines and rebases within 6 months after installation
  - Fees for adjustments to dentures include adjustments within 6 months after installation
  - Specialized techniques and characterizations are not eligible
- Resin partial dentures (limited to 1 every 3 years)
  - Fees for dentures and partial dentures include relines and rebases within 6 months after installation
  - Fees for adjustments to dentures and partial dentures include adjustments within 6 months after installation
  - Specialized techniques and characterizations are not eligible
- Immediate partial upper or lower, resin base (including any conventional clasps, rests and teeth)) (limited to 1 every 5 years)
  - Fees for adjustments to dentures and partial dentures include adjustments within 6 months after installation
  - Specialized techniques and characterizations are not eligible
- Immediate upper/lower partial denture – flexible base (including any clasps, rests and teeth) (limited to 1 every 5 years)
  - Fees for adjustments to dentures and partial dentures include adjustments within 6 months after installation
  - Specialized techniques and characterizations are not eligible
- Immediate partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
  - Fees for adjustments to dentures and partial dentures include adjustments within 6 months after installation
  - Specialized techniques and characterizations are not eligible
- Office reline (limited to within 6 months after installation)
- Laboratory relines (limited to within 6 months after installation)
- Special tissue conditioning, per denture (limited to within 6 months after installation)
- Rebase, per denture (limited to within 6 months after installation)
- Adjustment to complete and partial denture (more than 6 months after installation)
- Full and partial denture repairs:
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth
  - Adding teeth to existing partial denture:
    - Each tooth
    - Each clasp
- Complete upper denture (limited to 1 every 5 years)
- Complete lower denture (limited to 1 every 5 years)
- Immediate upper denture (limited to 1 every 5 years)
- Immediate lower denture (limited to 1 every 5 years)
- Stress breakers
- Overdenture, complete or partial upper and lower (limited to 1 every 5 years)

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- Cleaning and inspection of complete and partial dentures
- Dental implant crown and abutment related procedures, one per member per tooth (limited to 1 every 5 years)
- Interim partial denture (stayplate), anterior only
- Occlusal guard
- Repairs
  - Crowns and bridges
  - Implant supported prosthesis or abutment
  - Repair of occlusal guards
- Removable appliance therapy
- Fixed appliance therapy

Behavioral management

- Behavioral management when **medically necessary** for children age 8 and under

Orthodontic services

- **Medically necessary o**rthodontic treatment for a severe, dysfunctional or disabling condition including cleft lip and palate, cleft palate and cleft lip with alveolar process involvement; and craniofacial anomalies for hemifacial microsomia, craniosynostosis syndromes, cleidocranial dental dysplasia, arthrogryposis or Marfan syndrome
  - Removal of appliance
  - Construction of retainer
  - Placement of retainer

Eligible health services	In-network coverage	Out-of-network coverage
6. Specific conditions		
Birthing center		
Inpatient (room and board and other services and supplies	Paid at the same cost-sharing as **hospital** care	Paid at the same cost-sharing as **hospital** care
Diabetic equipment, supplies and education		
Diabetic equipment, supplies and education	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
Temporomandibular joint dysfunction (TMJ)		
TMJ 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
Impacted wisdom teeth		
Impacted wisdom teeth	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Accidental injury to sound natural teeth		
Accidental i**njury** to **sound natural teeth**	80% (of the **negotiated charge**)	80% (of the **recognized charge**)
Dermatological treatment		
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
Maternity care		
Maternity 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
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling 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

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Autism spectrum disorder		
Autism spectrum disorder	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
Applied behavior analysis	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Behavioral health		
Mental health treatment - inpatient		
Inpatient (**room and board**) facility and other inpatient services and supplies, including **residential treatment facilities**	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission
Mental health treatment - outpatient		
Outpatient mental health treatment office visits to a **health professional** Includes **telemedicine** consultation or use of **store and forward technology**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Other outpatient **mental health disorders** treatment (includes skilled behavioral health services in the home, **partial hospitalization treatment** and **intensive outpatient program**)	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Substance abuse related disorders treatment - inpatient		
Inpatient (**room and board**) facility and other inpatient services and supplies, including **residential treatment facilities**	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

Substance abuse related disorders treatment - outpatient		
Outpatient **substance abuse** office visits to a **health professional** Includes **telemedicine** consultation or use of **store and forward technology**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Other outpatient **substance abuse** services, **partial hospitalization treatment** and **intensive outpatient program**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Reconstructive surgery and supplies		
Reconstructive surgery and supplies (includes reconstructive breast surgery)	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
Eligible health services	**In-network coverage (IOE facility)**	**Out-of-network coverage** (Includes **providers** who are otherwise part of **Aetna's** network but are non-IOE **providers**)
Transplant services		
Inpatient	80% per transplant	60% per transplant
Outpatient	80% per transplant	60% per transplant
Physician and **specialist** services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Transplant services - travel and lodging		
Transplant services - travel and lodging	Covered	
Maximum payable for travel and lodging expenses for any one transplant, including tandem transplant	$10,000	

Maximum payable for lodging expenses per patient	$50 per night	
Maximum payable for lodging per companion	$50 per night	
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Treatment of infertility		
Basic infertility services		
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

Eligible health services	In-network coverage	Out-of-network coverage
7. Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services		
Performed in the outpatient department of a **hospital** or other facility	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Diagnostic lab work and radiological services		
Diagnostic lab work and radiological services performed in a **health professional's** office, the outpatient department of a **hospital** or other facility	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Genetic and prenatal testing		
Genetic and prenatal testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient therapies		
Chemotherapy		
Chemotherapy	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Eligible health services	**In-network coverage (GCIT-designated facility/provider)**	**Out-of-network coverage** (Including **providers** who are otherwise part of **Aetna's** network but are not GCIT-designated facilities/**providers**)
Gene-based, cellular and other innovative therapies (GCIT)		
Services and supplies	Covered according to the type of benefit and the place where the service is received.	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient infusion therapy		
Performed in a **covered person's** home, **health professional'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
Outpatient radiation therapy		
Outpatient radiation therapy	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Specialty prescription drugs		
Specialty prescription drugs purchased and injected or infused by your **provide**r 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
Outpatient respiratory therapy		
Respiratory therapy	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Transfusion or kidney dialysis of blood		
Transfusion or kidney dialysis of blood	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
Cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation		
Cardiac rehabilitation	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Pulmonary rehabilitation		
Pulmonary rehabilitation	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

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Rehabilitation and habilitation therapy services		
Rehabilitation therapy services		
Outpatient cognitive rehabilitation, physical, occupational and speech therapies Combined for rehabilitation services and habilitation therapy services	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	Unlimited	
Habilitation therapy services		
Outpatient aural, physical, occupation and speech therapies	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Cochlear implants	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Maximum visits per **policy year**	Unlimited	
Neurodevelopmental therapy services		
Neurodevelopmental therapy	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	Unlimited	
Chiropractic services		
Chiropractic services	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	35*	
*Note: A visit is equal to no more than 1 hour of therapy.		
Diagnostic testing for learning disabilities		
Diagnostic testing for learning disabilities	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

Eligible health services	In-network coverage	Out-of-network coverage
8. Other services and supplies		
Abortion		
Inpatient	100% (of the **negotiated charge**) per admission No policy year deductible applies	60% (of the r**ecognized charge**) per admission
Outpatient	100% (of the **negotiated charge**) No policy year deductible applies	60% (of the r**ecognized charge**)
Acupuncture		
Acupuncture	80% (of the **negotiated charge**)	60% (of the r**ecognized charge**)
Ambulance service		
Emergency use of **ambulance** (air, ground and water)	$100 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per trip No **policy year deductible** applies	Paid the same as in-network coverage
Non-emergency **ambulance**	$100 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per trip No **policy year deductible** applies	60% (of the r**ecognized charge**) per trip
Clinical trials (routine patient costs)		
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
Durable medical equipment (DME)		
Durable medical equipment	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item

Nutritional support		
Nutritional support	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Experimental or investigational therapies		
Experimental or investigational therapies	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
Prosthetic devices		
Prosthetic devices	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Hearing aids		
Hearing aids	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Hearing aids maximum per ear	One hearing aid per ear every 3 years	
Hearing exams		
Hearing exams	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Hearing exam maximum	One hearing exam every **policy year**	
Podiatric (foot care) treatment		
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
Travel and lodging expenses		
Travel and lodging reimbursement	100%, No **policy year deductible** applies	
Limit per **policy year**	$3,000	

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Vision care		
Pediatric vision care (limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	1 visit	
Pediatric comprehensive vision exams (including refraction)		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	1 visit	
Pediatric comprehensive low vision evaluations and services		
Performed by a legally qualified ophthalmologist or optometrist, including optical devices, services, training and instructions	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maximum visits per **policy year**	1 visit every 5 **policy years**	
Pediatric vision care services and supplies		
Eyeglass frames or **prescription** contact lenses	100% (of the **negotiated charge**) per item No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per item
Maximum number of eyeglass frames per **policy year**	One set of eyeglass frames	
Prescription eyeglass lenses	100% (of the **negotiated charge**) No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**)

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Maximum number of **prescription** eyeglass lenses per **policy year**	One pair of **prescription** eyeglass lenses	
Office visit for fitting of contact lenses	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Prescription contact lenses	100% (of the **negotiated charge**) No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**)
Maximum number of **prescription** contact lenses per **policy year**	One year supply	One year supply
Optical devices	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Important note: Refer to the *Vision care* section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for **prescription** lenses in a **policy year**, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.		

Eligible health services	In-network coverage	Out-of-network coverage
9. Outpatient prescription drugs		
Plan features		
Important note: Any outpatient **prescription drug** cost sharing amounts paid by another person on your behalf will be applied toward your applicable cost sharing or **maximum out-of-pocket limits**.		
Maximum for diabetic insulin		
The **prescription drug** cost share for diabetic insulin will not exceed $35 for a 30 day supply and any cost share will apply towards your **deductible**.		
Policy year deductible and copayment waiver for risk reducing breast cancer drugs		
The **prescription drug** cost share will not apply to risk reducing breast cancer **prescription drugs** when obtained at a **network pharmacy**. This means they will be paid at 100%.		
Policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs		
The **prescription drug** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a **retail network pharmacy**. This means they will be paid at 100%. Your **prescription drug** cost share will apply after those two programs have been exhausted.		

Policy year deductible and copayment waiver for contraceptives

The **prescription drug** cost share will not apply to contraceptive methods when obtained at a **network pharmacy**. This means they will be paid at 100% for:

- The following contraceptives that are **generic prescription drugs**:
  - Oral drugs
  - Injectable drugs
  - Vaginal rings
  - Transdermal contraceptive patches
- The following generic and brand-name contraceptive devices:
  - IUDs
  - Implantable rods
  - Diaphragms and cervical caps
  - Sponges
  - Spermicides
  - Condoms
- FDA approved:
  - Generic emergency contraceptives
  - Generic over-the-counter (OTC) emergency contraceptives

The **prescription drug** cost share will apply to **prescription drugs** that have a generic equivalent or biosimilar or generic alternative available within the same therapeutic drug class obtained at a **network pharmacy** unless you receive a medical exception. To the extent **generic prescription drugs** are not available, **brand-name prescription drugs** are covered. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or **injury**.

Tier 1 - Preferred generic prescription drugs (includes specialty prescription drugs)

For each fill up to a 30 day supply filled at a **retail pharmacy** or **specialty pharmacy**	$25 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$25 **copayment** per supply then the plan pays 50% (of the balance of the **recognized charge**) No **policy year deductible** applies
For each fill up to a 90 day supply filled at a **mail order pharmacy**	$62.50 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Not Covered

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Tier 2 - Preferred brand-name prescription drugs (includes specialty prescription drugs)		
For each fill up to a 30 day supply filled at a **retail pharmacy** or **specialty pharmacy**	$60 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$60 **copayment** per supply then the plan pays 50% (of the balance of the **recognized charge**) No **policy year deductible** applies
For each fill up to a 90 day supply filled at a **mail order pharmacy**	$150 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Not Covered
Tier 3 - Non-preferred generic and brand-name prescription drugs (includes specialty prescription drugs)		
For each fill up to a 30 day supply filled at a **retail pharmacy** or **specialty pharmacy**	$100 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$100 **copayment** per supply then the plan pays 50% (of the balance of the **recognized charge**) No **policy year deductible** applies
For each fill up to a 90 day supply filled at a **mail order pharmacy**	$250 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Not Covered
Important note: Specialty prescription drugs are not eligible for fill at a **mail order pharmacy**.		

Diabetic prescription drugs, supplies and insulin		
For each fill up to a 30 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the *schedule of benefits* above	Paid according to the type of drug per the *schedule of benefits* above
For each fill up to a 90 day supply filled at a **mail order pharmacy**	Paid according to the tier of drug per the *schedule of benefits* above	Paid according to the type of drug per the *schedule of benefits* above
Orally administered anti-cancer prescription drugs		
For each 30 day supply filled at a specialty **pharmacy**	$0 per **prescription** or refill	$0 per **prescription** or refill
Outpatient prescription contraceptive drugs and devices Includes oral and injectable drugs, vaginal rings and transdermal contraceptive patches		
For each 30 day supply of: • Generic and brand-name **prescription drugs** • Generic and brand-name devices • FDA-approved generic and brand-name emergency contraceptives (including those available over-the-counter)	$0 per **prescription** or refill	Paid according to the type of drug per the *schedule of benefits* above
Important note: Covered contraceptives can be filled for a 12 month supply, unless you request a smaller supply or your **provider** decides you need a smaller supply.		
Preventive care drugs and supplements		
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill	Paid according to the type of drug per the *schedule of benefits* above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, see the *How to contact us for help* section.	

Risk reducing breast cancer prescription drugs		
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill	Paid according to the type of drug per the *schedule of benefits* above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer **prescription drugs**, see the *How to contact us for help* section.	
Tobacco cessation prescription and over-the-counter drugs (preventive care)		
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill	Paid according to the type of drug per the *schedule of benefits* above
Limitations:	Coverage is limited to two, 90-day treatment programs only. Any additional treatment programs will be paid according to the tier of drug per the schedule of benefits, above. Coverage only includes **generic drug** when there is also a brand-name drug available. Coverage is subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, see the *How to contact us for help* section.	

Dispense As Written (DAW)

If a **provider** prescribes a covered **brand-name prescription drug** when **a generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost share for the brand-name drug. If a **provider** does not specify DAW and you request a covered **brand-name prescription drug**, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug.