



Aetna Student Health

Plan Design and Benefits Summary

Preferred Provider Organization (PPO)

Saint Martin's University

Policy Year: 2024 – 2025

Policy Number: 686217

<https://www.aetnastudenthealth.com>

(877) 480-4161



This is a brief description of the Student Health Plan. The Plan is available for Saint Martin's University students. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate of Coverage issued to you and may be viewed online at <https://www.aetnastudenthealth.com>. If there is a difference between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

Saint Martin’s University Health Services

The Saint Martin’s University Health Services is the on-campus health facility. It is open Monday, Wednesday, Thursday, and Friday from 10:00 a.m. to 4:00 p.m., during the Fall and Spring semesters. Summer hours are Wednesday’s only from 10:00 a.m. to 4:00 p.m. and closed during major federal holidays or school closures.

For more information, call the Student Health Center at (360) 412-6160, or email healthcenter@stmartin.edu. In the event of an emergency, please call 911.

Coverage Dates and Rates

Coverage for all insured students and eligible dependents will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

	Fall	Spring/Summer	Summer
Coverage Start Date	08/31/2024	01/13/2025	05/19/2025
Coverage End Date	01/12/2025	08/30/2025	08/30/2025
Student	\$1,581.40	\$2,687.20	\$1,210.56
Enrollment waivers must be submitted by:			
Fall – 09/18/2024			
Spring – 01/25/2025			

Student Coverage

Who is eligible?

All Domestic students enrolled half time or more attending Saint Martin’s University are automatically enrolled in this insurance plan unless proof of comparable coverage is furnished.

Waiver

If you have insurance that is comparable to the Student Health Insurance Plan (i.e. through an employer, spouse, parent/ guardian, scholarship, etc.), and DO NOT want to take part in your school's plan, you must complete the online waiver application process at stmartin.myahpcare.com by the waiver deadline or you will be responsible for the premium charge. Waivers are good for the academic year provided that the coverage listed has not changed.

Medicare Eligibility Notice

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

Termination and Refunds

Withdrawal from Classes – Leave of Absence:

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

Withdrawal from Classes – Other than Leave of Absence:

If you withdraw from classes other than under a school-approved leave of absence within 31 days after the policy effective date, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded. If the withdrawal is more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded. If you withdraw from classes to enter the armed forces of any country, coverage will terminate as of the effective date of such entry and a pro rata refund of premiums will be made if you submit a written request within 90 days of withdrawal from classes.

In-network Provider Network

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

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

Precertification

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification. Your in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to www.aetna.com.

Precertification Call

Precertification should be secured within the timeframes specified below. To obtain precertification, call Member Services at the toll-free number on your ID card. This call must be made:

Non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
An emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.
Outpatient non-emergency services requiring precertification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

We will provide a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 180 days as long as you remain enrolled in the plan.

Coordination of Benefits (COB)

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

Description of Benefits

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

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

Policy year deductible	In-network coverage	Out-of-network coverage
You have to meet your policy year deductible before this plan pays for benefits.		
Student	\$250 per policy year	\$500 per policy year
Individual deductible 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. 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. 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.		
Policy year deductible waiver The policy year deductible is waived for all of the following eligible health services: <ul style="list-style-type: none">• In-network care for:<ul style="list-style-type: none">- Preventive care and wellness services- Pediatric dental care - Type A services- Pediatric vision care services• In-network and out-of-network care for:<ul style="list-style-type: none">- Ambulance- Hospital emergency room services- Outpatient prescription drugs		
Maximum out-of-pocket limit per policy year		
Student	\$9,100 per policy year	\$18,200 per policy year
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.		

Eligible health services	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum age and visit limits per policy year through age 21	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.	
Maximum visits per policy year age 22 and over	1 visit	
The following are not covered under this benefit: <ul style="list-style-type: none">• Services for diagnosis or treatment of a suspected or identified illness or injury• Exams given during your stay for medical care• Services not given by or under a physician's direction• Psychiatric, psychological, personality or emotional testing or exams		
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
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.	
Your plan does not cover immunizations that are not considered preventive care.		
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Routine cancer screenings	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: <ul style="list-style-type: none"> 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 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 www.aetnastudenthealth.com or calling the toll-free number in the <i>How to contact us for help</i> section.	
Lung cancer screening maximum	1 screening every 12 months	
Prenatal care services (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
Lactation support and counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item
Contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Contraceptive prescription drugs and devices	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item

Eligible health services	In-network coverage	Out-of-network coverage
Voluntary sterilization - Inpatient & Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	60% (of the recognized charge)
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • The reversal of voluntary sterilization procedures, including any related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Contraception services received during an unrelated stay in a hospital or other facility for medical care 		
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) Includes telemedicine consultations)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing & Allergy injections treatment, including Allergy sera and extracts administered via injection, performed at a physician's or specialist'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 - 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)
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
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • The services of any other physician who helps the operating physician, unless medically necessary • Services of another physician for the administration of a local anesthetic 		
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Home Health Care	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	130	
The following are not covered under this benefit: <ul style="list-style-type: none">• Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)• Transportation• Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present• Homemaker or housekeeper services• Food or home delivered services• Maintenance therapy		
Hospice - Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospice - Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: <ul style="list-style-type: none">• Funeral arrangements• Pastoral counseling• Bereavement counseling• Financial or legal counseling, including estate planning and the drafting of a will• Homemaker or caretaker services, which are services not solely related to your care and may include:<ul style="list-style-type: none">- Sitter or companion services for either you or other family members- Transportation- Maintenance of the house		
Outpatient private duty nursing	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Skilled nursing facility - Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Emergency services and urgent care		
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
Non-emergency care in a hospital emergency room	Not covered	Not covered
Important note: <ul style="list-style-type: none">• 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 <i>Your Rights and Protections Against Surprise Medical Bills and Balance Billing in Washington State</i> 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.

Eligible health services	In-network coverage	Out-of-network coverage
Urgent Care	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

The following are not covered under this benefit:

- Non-emergency services in a hospital emergency room facility
- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

Pediatric dental care

(Limited to covered persons through the end of the month in which the person turns age 19)

Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	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

Pediatric Dental Care - Exclusions

In addition to the exclusions that apply to health coverage the following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene for those age 9 and older.
- Cosmetic services and supplies including:
 - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance
 - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Eligible health services under your plan* section
 - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
 - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
 - The tooth is an abutment to a covered partial denture or fixed bridge

- Dental implants and braces (that are determined not to be medically necessary), mouth guards and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
 - For splinting
 - To alter vertical dimension
 - To restore occlusion
 - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as specifically covered in this section
- Orthodontic treatment except as covered in the *Eligible health services under your plan – Pediatric dental care* section
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically described in the *Eligible health services under your plan – Pediatric dental care* section
- Services and supplies:
 - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
 - Provided for your personal comfort or convenience or the convenience of another person, including a provider
 - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider

Specific Conditions

Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Impacted wisdom teeth	80% (of the negotiated charge)	60% (of the recognized charge)
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

The following are not covered under this benefit:

- Dental implants

Accidental injury to sound natural teeth	80% (of the negotiated charge)	80% (of the recognized charge)
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The following are not covered under this benefit:

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

<ul style="list-style-type: none"> • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants 		
Eligible health services	In-network coverage	Out-of-network coverage
Specific Conditions (continued)		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: <ul style="list-style-type: none"> • Cosmetic treatment and procedures 		
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
Family planning services – other		
Abortion - Inpatient	100% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge)
Abortion - Outpatient	100% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge)
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
The following are not covered under this benefit: <ul style="list-style-type: none"> • Cosmetic services and supplies, unless they are medically necessary for treatment of gender identity disorder or gender dysphoria. Services include, but are not limited to the following: <ul style="list-style-type: none"> - Rhinoplasty - Face-lifting - Lip enhancement - Facial bone reduction - Blepharoplasty - Liposuction of the waist (body contouring) - Reduction thyroid chondroplasty (tracheal shave) - Hair removal (including electrolysis of face and neck) - Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing - Chin implants, nose implants, and lip reduction 		

Eligible health services	In-network coverage	Out-of-network coverage
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis	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
Mental Health & Substance Abuse Treatment		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Outpatient office visits (includes telemedicine consultations)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
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
Transplant services - 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	Covered	Covered
Lifetime Maximum Travel and Lodging Expenses for any one transplant	\$10,000	\$10,000
Maximum Lodging Expenses per IOE patient	\$50 per night	\$50 per night
Maximum Lodging Expenses per companion	\$50 per night	\$50 per night
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • Services and supplies furnished to a donor when the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness 		
Basic infertility 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
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists • All charges associated with: <ul style="list-style-type: none"> – Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, 		

including the biological father.

- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
- Services related to a gestational carrier's care. A gestational carrier is a female carrying an embryo to which she is not genetically related.
- Obtaining sperm from a person not covered under this plan.
- Home ovulation prediction kits or home pregnancy tests
- The purchase of donor embryos, donor oocytes, or donor sperm
- Reversal of voluntary sterilizations, including follow-up care
- Ovulation induction with menotropins, intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)

Eligible health services	In-network coverage	Out-of-network coverage
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient infusion therapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: <ul style="list-style-type: none"> • Enteral nutrition • Blood transfusions and blood products 		
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Combined for short-term rehabilitation services and habilitation therapy services		
Acupuncture therapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Chiropractic services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	35	

Eligible health services	In-network coverage	Out-of-network coverage
Other services and supplies		
Emergency ground, air, and water ambulance	\$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
The following is not covered under this benefit: <ul style="list-style-type: none">Ambulance services, for routine transportation to receive outpatient or inpatient services		
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: <ul style="list-style-type: none">WhirlpoolsPortable whirlpool pumpsSauna bathsMassage devicesOver bed tablesElevatorsCommunication aidsVision aidsTelephone alert systemsPersonal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a health professional		
Nutritional support	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: <ul style="list-style-type: none">Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in this section		
Prosthetic Devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following is not covered under this benefit: <ul style="list-style-type: none">Services covered under any other benefitTrusses, corsets, and other support itemsRepair and replacement due to loss, misuse, abuse or theft		
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	
The following are not covered under this benefit: <ul style="list-style-type: none">Any ear or hearing exam if the services are not within the health care provider's permitted scope of practiceHearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay		
Hearing aids	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aid maximum per ear	One hearing aid per ear every 3 years	

The following are not covered under this benefit:

- A replacement of:
 - A hearing aid that is lost, stolen or broken
 - A hearing aid installed within the prior 12-month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- Cochlear implants
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam if the services are not within the health care provider's permitted scope of practice
- Any tests, appliances and devices to:
 - Improve your hearing, including hearing aid batteries, amplifiers, and auxiliary equipment
 - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Eligible health services	In-network coverage	Out-of-network coverage
Podiatric (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

The following are not covered under this benefit:

- Services and supplies for:
 - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches
 - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
 - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet

Pediatric vision care

(Limited to covered persons through the end of the month in which the person turns age 19)

Pediatric routine vision exams & Pediatric comprehensive vision exams (including refraction)	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
Pediatric 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	1 visit every 5 policy years	
Pediatric vision care services and supplies - Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum	1 visit	
Pediatric vision care services & supplies - Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	60% (of the recognized charge) per item

Eligible health services	In-network coverage	Out-of-network coverage
Maximum number Per year: Eyeglass frames	One set of eyeglass frames	
Prescription lenses	One pair of prescription lenses	
Contact lenses	One year supply	
Maximum visits per policy year	1 visit	
Low vision Maximum	One comprehensive low vision evaluation every policy year	
Fitting of contact Maximum	1 visit	
*Important note: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.		
The following are not covered under this benefit: <ul style="list-style-type: none">• Special supplies such as non-prescription sunglasses• Non-prescription eyeglass frames, non-prescription lenses and non-prescription contact lenses• Special vision procedures, such as orthoptics or vision therapy• Eye exams during your stay in a hospital or other facility for health care• Acuity tests• Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures• Services to treat errors of refraction		

Outpatient prescription drugs		
Copayment/coinsurance waiver for risk reducing breast cancer drugs		
The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs		
The outpatient prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.		
Your outpatient prescription drug copayment will apply after those two regimens per policy year have been exhausted.		
Outpatient prescription drug copayment waiver for contraceptives		
The outpatient prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy.		
This means that such contraceptive methods are paid at 100% for:		
<ul style="list-style-type: none"> • Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. • If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%. 		
The outpatient prescription drug copayment will continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
Eligible health services	In-network coverage	Out-of-network coverage
Preferred generic prescription drugs (including specialty 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
More than a 30-day supply but less than 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

Eligible health services	In-network coverage	Out-of-network coverage
Preferred brand-name prescription drugs (including specialty 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
More than a 30-day supply but less than 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
Non-preferred generic prescription drugs (including specialty 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
More than a 30-day supply but less than 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
Non-preferred brand-name prescription drugs (including specialty 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
More than a 30-day supply but less than 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
Orally administered anti-cancer prescription drugs	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
For each fill up to a 30-day supply filled at a retail pharmacy		

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care drugs and supplements filled at a retail pharmacy For each 30-day supply	100% (of the negotiated charge per prescription or refill) No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30-day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30-day supply	100% (of the negotiated charge per prescription or refill) No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	

Outpatient Prescription Drugs – Exclusions

The following are not covered under this benefit:

- Allergy sera and extracts administered by injection
- Any services related to the dispensing, injection or application of a drug
- Biological sera unless specified on the preferred drug guide
- Compound prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA), including compounded bioidentical hormones
- Cosmetic drugs
 - Medications or preparations used for cosmetic purposes (unless medically necessary for gender affirming treatment)
- Devices, products and appliances, except those that are specifically covered
- Dietary supplements including medical foods
- Drugs or medications:
 - Administered or entirely consumed at the time and place it is prescribed or dispensed
 - Which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written, except as specifically provided above
- Drugs or medications:
 - That are therapeutically equivalent or a therapeutic alternative to a covered prescription drug unless a medical exception is approved
 - Provided under your medical benefits while an inpatient of a healthcare facility
 - Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by our Pharmacy and Therapeutics Committee
 - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)

- For which the cost is covered by a federal, state or government agency (for example: Medicaid or Veterans Administration)
- Not approved by the FDA or not proven to be safe and effective.
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our precertification and clinical policies
- Duplicative drug therapy (e.g. two antihistamine drugs)
- Genetic care
 - Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects
- Immunizations related to travel or work
- Immunization or immunological agents
- Implantable drugs and associated devices except where stated in the *Eligible health services under your plan – Preventive care and wellness and Outpatient prescription drugs* sections
- Infertility
 - Prescription drugs used primarily for the treatment of infertility except where stated in the *Eligible health services under your plan – Treatment of infertility* section
- Injectables:
 - Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us.
 - Needles and syringes, except those used for insulin administration.
- For any drug, which due to its characteristics, as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Prescription drugs:
 - Dispensed by other than retail, mail order and specialty pharmacies, unless otherwise specified above
 - Dispensed by an out-of-network mail order pharmacy, except in a medical emergency or urgent care situation, except where specially listed as covered in your Schedule of benefits
 - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or prescription drugs for the treatment of a dental condition unless dental benefits are provided under the plan
 - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the drug guide
 - That are not covered or related to a non-covered service
 - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the member identified on the ID card
- Replacement of lost or stolen prescriptions
- Tobacco use
 - Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). See the *Eligible health services under the plan – Outpatient prescription drugs* section.
- Test agents except diabetic test agents

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

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

Exclusions

The following are not **eligible health services** under your plan except as described in the *Eligible health services under your plan* section of this certificate of coverage or by an endorsement issued with this certificate of coverage.

Alternative health care

- Services and supplies given by a provider for alternative health care for which there is no federal or Washington licensure, such as aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, and hypnotherapy.

Armed forces

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

Behavioral health treatment

Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:

- Stay in a facility for treatment for dementia or amnesia without a behavioral disturbance as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Beyond legal authority

- Services and supplies provided by a health professional or other provider that is acting beyond the scope of its legal authority.

Cosmetic services and plastic surgery

- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons, except as covered in the *Eligible health services under your plan* section.

Court-ordered testing

- Court-ordered testing or care unless they are a covered benefit under your plan and our medical director or designee determines the treatment to be medically necessary.

Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs

Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, except where stated in the *Eligible health services under your plan-Hospital and other facility care* section
- Adult (or child) day care, or convalescent care
- Institutional care (including room and board for rest cures, adult day care and convalescent care)
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service performed by a person without any medical or paramedical training
- For behavioral health (mental health treatment and substance related disorders treatment):
 - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
 - Services given mainly to:
 - Maintain, not improve, a level of function
 - Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults

- Dental services for adults including services related to:
 - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, except as specifically described in the *Eligible health services under your plan* section
 - Dental services related to the gums
 - Apicoectomy (dental root resection)
 - Orthodontics
 - Root canal treatment
 - Soft tissue impactions
 - Alveolectomy
 - Augmentation and vestibuloplasty treatment of periodontal disease
 - False teeth
 - Prosthetic restoration of dental implants
 - Dental implants

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

Educational services

Examples of these services are:

- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services under your plan – Diabetic equipment, supplies and education* section. This includes:
 - Special education
 - Remedial education
 - Wilderness treatment program (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
 - Job training
 - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam (examples are examinations to get or keep a job, or examinations required under a labor agreement or other contract)
- Because a court order requires it
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

Experimental or investigational

- Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under the *Eligible health services under your plan-Experimental or investigational therapies* or *Eligible health services under your plan-Clinical trials (routine patient costs)* sections.

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Felony

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

Genetic care

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

Growth/Height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth.
- Surgical procedures, devices and growth hormones to stimulate growth

Incidental surgeries

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

Jaw joint disorder

- Surgical treatment of jaw joint disorders.
- Non-surgical treatment of jaw joint disorders.
- Jaw joint disorder treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to jaw joint disorders including associated myofascial pain.

This exclusion does not apply to covered benefits for treatment of TMJ as described in the *Eligible health services under your plan* section.

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the *Eligible health services under your plan – Habilitation therapy services* section.

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these include:
 - Sheaths
 - Bags
 - Elastic garments
 - Support hose
 - Bandages
 - Bedpans
 - Syringes
 - Blood or urine testing supplies
 - Other home test kits
 - Compresses
 - Other devices not intended for reuse by another patient

Medicare

- Services and supplies available under Medicare, if you are entitled to premium-free Medicare Part A or enrolled in Medicare Part B.

Non-U.S. citizen

- Services and supplies received by a covered person (who is not a United States citizen) within the covered person's home country, but only if the home country has a socialized medicine program.

Obesity (bariatric) surgery**Organ removal**

- Services and supplies given by a provider to remove an organ from your body for the purpose of selling the organ.

Personal care, comfort or convenience items

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

Riot

- Services and supplies that you receive from providers as a result of an injury from your “participation in a riot”. This means when you take part in a riot in any way such as inciting, or conspiring to incite, the riot. It does not include actions that you take in self-defense as long as they are not against people who are trying to restore law and order.

School health services

- Services and supplies normally provided either without charge or through a separate health fee by the policyholder’s:
 - School health services
 - Infirmary
 - Hospital
 - Pharmacy

Services provided by a family member

- Services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law or any household member, where you would not be charged in the absence of insurance.

Services, supplies and drugs received outside of the United States

- Non-emergency medical services, non-emergency outpatient prescription drugs, or supplies received outside of the United States. They are not covered even if they are covered in the United States under this certificate of coverage. Emergency prescription drugs received outside of the United States are covered.

Sexual dysfunction and enhancement

- Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
 - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ, provided however, this exclusion does not apply to services for treatment of gender identity disorder or gender dysphoria
 - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Sinus surgery

- Any services or supplies given by providers for sinus surgery except for acute purulent sinusitis.

Sports

- Any services or supplies given by providers as a result from play or practice of intercollegiate sports.

Store and forward technology

- Services for which there is no related office visit with the provider.
- Services for which Aetna does not have an agreement with the provider.
- Services using:
 - Telephone calls that are audio only
 - Faxes
 - Emails
 - Telemedicine kiosks
 - Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
 - Strength
 - Physical condition
 - Endurance
 - Physical performance

Students in mental health field

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

Telemedicine

- Services that are not provided in real time.
- Services that are not interactive, including:
 - Faxes
 - Emails

Therapies and tests

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

Tobacco cessation

Except where described in this certificate of coverage:

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
 - Counseling, except where stated in the *Eligible health services under your plan – Preventive care and wellness* section
 - Hypnosis and other therapies
 - Medications, except where stated in the *Eligible health services under your plan – Outpatient prescription drugs* section
 - Nicotine patches
 - Gum

Treatment in a federal, state, or governmental entity

Except where required by law:

- Charges you have no legal obligation to pay
- Charges that would not be made if you did not have coverage under the plan

Vision care for adults

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing
- Vision care services and supplies

Wilderness treatment programs

See *Educational services* within this section

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law.
- If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

The Saint Martin's University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student HealthSM is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

Sanctioned Countries

If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license.

For more information, visit <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call the number listed on your ID card at no cost.

Smartphone or Tablet

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

Non-discrimination notice

Aetna® complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity. We:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call us at 1-888-982-3862 (TTY: 711).

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity you can file a grievance with:

Civil Rights Coordinator
P.O. Box 14462, Lexington, KY 40512
(CA HMO customers: PO Box 24030 Fresno, CA 93779)
1-800-648-7817, TTY: 711
Fax: 859-425-3379 (CA HMO customers: 860-262-7705)
CRCoordinator@aetna.com

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

You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/online services/cc/pub/complaintinformation.aspx>

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

For language assistance in English call 1-888-982-3862 at no cost. (English)

TTY: 711

TTY:711

English	To access language services at no cost to you, call the number on your ID card.
Albanian	Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit.
Amharic	የ ቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመውደድዎት ላይ ያለውን ቁጥር ይደውሉ፡፡
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով սպլվճար խոսքիդաստվությունն ստանալու համար գանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հեռախոսահամարով
Bantu-Kirundi	Kugira uronke serivisi z'indimi ata kiguzi, hamagara inomero iri ku karangamuntu kawe
Bengali	আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন।
Burmese	သင့်အနေဖြင့် အခကြေးငွေ မပေးရဲဘဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပါတ်အား ခေါ်ဆိုပါ။
Catalan	Per accedir a serveis lingüístics sense cap cost per a vostè, telefoni al número indicat a la seva targeta d'identificació.
Cebuano	Aron maakses ang mga serbisyo sa lengguwahe nga wala kay bayran, tawagi ang numero nga anaa sa imong kard sa ID.
Chamorro	Para un hago' i setbision lengguañhi ni dibåtde para hægu, ågang i numiru gi iyo-mu kard aidentifikasion.
Cherokee	Ⴀႃႆ႔႗ Ⴄႛ႐ႇႏ႗ Ⴆ႙႕႗႒႗ Ⴀ Ⴀ႗႗႗ Ⴀႚႚ႗႒႗ ႞႗, ႕႐ႇ႗႗႓႗ ႕႗႗႗ Ⴀ႗႗႗ Ⴀ႗႗႗ ႕႗႗႗ ႕႗႗႗ ႕႗႗႗ ႕႗႗႗ ႕႗႗႗.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Choctaw	Anumpa tosholi i toksvli ya peh pilla ho ish i payahinla kvv chi holisso kallo iskitini holhtena takanli ma i payah
Chuukese	Ren omw kopwe angei anininisin eman chon awewei (ese kamé), kopwe kééri ewe nampa mei mak won noum ena katen ID
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
Dutch	Voor gratis taaldiensten, bel het nummer op uw ziekteverzekeringskaart.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કોલ કરવો.

Hawaiian	No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki 'ole 'ia kēia kōkua nei.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obula, kpọọ nomba nọ na kaadi njirimara gi
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢတၢ်ကၢၤန့ၣ်ဂီၣ်တၢ်မၤစၢၤအတၢ်ဖဲတၢ်မၤတဖၣ် လၢတၢ်အိၣ်ဒီးအပ္ပၤလၢနကတၢ်ဟ့ၣ်အိၣ်အဂီၢ်,ကိးဘၣ်လီၤတဲၣ်နီၣ်ဂံၢ်လၢအအိၣ်လၢနနီၣ်ဂီၤ (ID) အလီၤန့ၣ်တက့ၢ်.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بۆ دەستگیر ئەگەریتن بە خزمەتگوزاری زمان بەجی تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی (ID) کارتێ خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໃບຫາເບີໂທລະສັບໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डवरील क्रमांकावर फोन करा.
Marshallese	Ñan bōk jipañ kōn kajin ilo an ejjelok wōñean ñan kwe, kwōn kallok nōmba eo ilo kaat in ID eo am̧.
Micronesian-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាភាសាដែលគេគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'éhjí bee níká a'doowoł doo b'ááq'íh ílínígóó naaltsoos bee atah nílíggo nanitinígíí bee n'éého'dólzínígíí béésh bee hane'í biká'ígíí áají' hólne'.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të koor yin ran de wëër de thokic ke c'in wëu kor keek tënɔŋ yin. Ke yin cɔl ran ye koc kuony në namba de abac tö në ID kard duön de tiit de nyin de panakim köu.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.

