Aetna Student Health
Plan Design and Benefits Summary
Preferred Provider Organization (PPO)

Western Washington University

Policy Year: 2026–2027
Policy Number: 686216
www.aetnastudenthealth.com
(877) 480-4161

This is a brief description of the Student Health Plan. The Plan is available for Western Washington University students and their eligible dependents. 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.

Western Washington Student Health Center

The WWU Student Health Center, located on the main campus, provides medical care to eligible WWU students. The clinic is staffed by physicians, nurse practitioners, psychiatrists, and support staff. It is open weekdays when classes are session from 8:30 a.m. to 4:00 p.m. during the academic year and from 8:30 a.m. to Noon and 1:00 to 4:00 p.m. during summer quarter. For more information, call the Health Services (360) 650-3400. In the event of an emergency, call 911.

Eligible students who have paid the mandatory, quarterly Counseling, Health and Wellness fee have unlimited access to the Student Health Center, without charge for nearly all office visits. This includes:

- Management of acute illness and injury
- Chronic disease diagnosis and management
- Behavioral health and psychiatric care
- Orthopedic care and rehab
- Sexual health
- Medical/mental health emergencies
- Referral to specialists as needed

The Student Health Center charges fees to students for the following services, which students will be provided a statement to submit to Aetna Student Health for reimbursement.

- Travel Services
- Minor surgical procedures
- Lab Tests
- Immunizations
- Prescription medications/devices dispensed at the Student Health Center

CVS Virtual Care®

From everyday illnesses and chronic conditions to mental health support, we've got your back. Once you tell us what you need, we'll connect you with trusted, in-network providers so you can schedule a virtual visit. Most mental health visits are available within two weeks. You can access 24/7 care through our virtual clinic. General Care: 100% coverage. Behavioral Health**:** See the schedule of benefits for more information. Go to CVS.com/virtual-care to register and schedule an appointment.

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 09/01/2026-12/31/2026	Winter 01/01/2027 - 03/19/2027	Spring/Summer 03/20/2027 - 08/31/2027	Spring 03/20/2027 - 06/11/2027	Summer 06/12/2027 - 08/31/2027
Student	**$3,129.00**	**$2,000.00**	**$4,232.00**	**$2,154.00**	**$2,078.00**
Spouse	**$3,129.00**	**$2,000.00**	**$4,232.00**	**$2,154.00**	**$2,078.00**
Each Child (2x Max)	**$3,129.00**	**$2,000.00**	**$4,232.00**	**$2,154.00**	**$2,078.00**

Enrollment Deadlines
Fall – 11/01/2026
Winter – 02/01/2027
Spring – 04/26/2027
Spring/Summer – 04/26/2027
Summer – 07/18/2027

Student Coverage

Who is eligible?

All Graduate Students taking two (2) or more credit hours or one (1) credit Thesis and all Undergraduate Domestic students enrolled in six (6) or more credit hours (or attending classes at one of the office Extended Education sites), and all Visiting Faculty, Scholars and Practical Training Students are eligible to enroll in this insurance plan.

Enrollment

As a student you can enroll yourself and your dependents if your plan includes coverage for dependents:

- During the enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section of your policy)

If you do not enroll yourself and your dependents when you first qualify for benefits, you may have to wait until the next enrollment period to join.

For online student enrollment or to enroll the dependent(s) of a covered student, please visit **wwu.myahpcare.com**, click on Enrollment tab and then select the appropriate enrollment link.

Dependent Coverage

Eligibility

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

Enrollment

To enroll the dependent(s) of a covered student, please complete visit **wwu.mycare26.com/enrollment**. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.

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

A newborn child or grandchild-Your newborn child or grandchild is covered on your plan for the first 60 days after birth

- When additional premiums are required, you must enroll the child within 60 days of birth to keep the newborn covered
- If you miss this deadline, your newborn will not have benefits after the first 60 days

An adopted child – You may put an adopted child on your plan on the date the child is placed for adoption

- "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child
- When additional premiums are required, you must enroll the child within 60 days of placement
- Your adopted child's coverage will start from the date of placement
- If you miss this deadline, your adopted child will not have benefits

A stepchild – You may put a child of your spouse or domestic partner on your plan

- You must enroll the child within 60 days of the date of your marriage or domestic partnership with your stepchild's parent
- The benefits for your stepchild will begin the first day of the month following the date we receive your completed enrollment information

If you need information or have general questions on dependent enrollment, please visit **wwu.myahpcare.com** or **help.ahpcare.com**.

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 covered 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
Spouse	$250 per policy year	$500 per policy year
Each child	$250 per policy year	$500 per policy year
Individual deductible This is the amount you owe for in-network and out-of-network covered services each policy year before the plan begins to pay for covered services. After the amount you pay for covered services reaches the policy year deductible, this plan will begin to pay for covered services for the rest of the policy year.		
Covered services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Covered 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 covered 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*		
Maximum out-of-pocket limit per policy year		
Student	$9,100 per policy year	$18,200 per policy year
Spouse	$4,500 per policy year	$9,000 per policy year
Each child	$4,500 per policy year	$9,000 per policy year
Family	$9,000 per policy year	$18,000 per policy year
Covered 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 covered 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.		

Covered services	In-network coverage	Out-of-network coverage
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
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: • 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 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 the Washington State Department of Health.	
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment		
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a health professional'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

Covered services	In-network coverage	Out-of-network coverage
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: • Evidence-based items that have in effect a rating of A or B in the 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 *How to contact us for help* 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

Covered 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)
The following are not preventive covered services: • 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		
Physician and specialist services (non-surgical and non-preventive)		
Physician, specialist including Consultants Offic visits (non-surgical/non-preventive care by a health professional or specialist includes telemedicine consultations 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 & Allergy injections treatment, including Allergy sera and extracts administered via injection, performed at a health professional'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 health professional'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
The following are not covered under this benefit: • 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	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

<table>
<tr><th>Covered services</th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td colspan="3">The following are not covered services:
All services and supplies provided in:
- Rest homes
- Any place considered a person’s main residence or providing mainly custodial or rest care
- Health resorts
- Spas
- Schools or camps</td></tr>
<tr><td>In-hospital non-surgical physician services</td><td>80% (of the negotiated charge) per visit</td><td>60% (of the recognized charge) per visit</td></tr>
<tr><td colspan="3">Alternatives to hospital stays</td></tr>
<tr><td>Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center</td><td>80% (of the negotiated charge) per visit</td><td>60% (of the recognized charge) per visit</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
A stay in a hospital. (A hospital stay is an inpatient hospital benefit. See the Covered services under your plan section.)
A separate facility charge for surgery performed in a physician’s office.
Services of another physician for the administration of a local anesthetic</td></tr>
<tr><td>Home Health Care</td><td>80% (of the negotiated charge) per visit</td><td>60% (of the recognized charge) per visit</td></tr>
<tr><td>Maximum visits per policy year</td><td colspan="2">130</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
Transportation
Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
Homemaker or housekeeper services
Food or home delivered services
Maintenance therapy</td></tr>
<tr><td>Hospice - Inpatient</td><td>80% (of the negotiated charge) per admission</td><td>60% (of the recognized charge) per admission</td></tr>
<tr><td>Hospice - Outpatient</td><td>80% (of the negotiated charge) per visit</td><td>60% (of the recognized charge) per visit</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
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:
- Sitter or companion services for either you or other family members
- Transportation
- Maintenance of the house</td></tr>
<tr><td>Outpatient private duty nursing</td><td>80% (of the negotiated charge) per visit</td><td>60% (of the recognized charge) per visit</td></tr>
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<table>
<tr><th>Covered services</th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td>Skilled nursing facility - Inpatient</td><td>80% (of the negotiated charge) per admission</td><td>60% (of the recognized charge) per admission</td></tr>
<tr><td colspan="3">Emergency services and urgent care</td></tr>
<tr><td>Emergency room</td><td>$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit

No policy year deductible applies</td><td>Paid the same as in-network coverage</td></tr>
<tr><td>Non-emergency care in an emergency room</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td colspan="3">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 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 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 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 l 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 emergency room that are not part of the emergency room benefit may be subject to copayment or coinsurance amounts.</td></tr>
<tr><td>Urgent Care</td><td>80% (of the negotiated charge) per visit</td><td>60% (of the recognized charge) per visit</td></tr>
<tr><td>Non-urgent use of urgent care provider</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
Non-emergency services in an emergency room facility
Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)</td></tr>
<tr><td colspan="3">Pediatric dental care
(Limited to covered persons through the end of the month in which the person turns age 19)</td></tr>
<tr><td>Type A services</td><td>100% (of the negotiated charge) per visit

No copayment or deductible applies</td><td>50% (of the recognized charge) per visit</td></tr>
<tr><td>Type B services</td><td>50% (of the negotiated charge) per visit</td><td>50% (of the recognized charge) per visit</td></tr>
<tr><td>Type C services</td><td>50% (of the negotiated charge) per visit</td><td>50% (of the recognized charge) per visit</td></tr>
<tr><td>Orthodontic services</td><td>50% (of the negotiated charge) per visit</td><td>50% (of the recognized charge) per visit</td></tr>
</table>

Covered services	In-network coverage	Out-of-network coverage
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 in the *What your plan doesn't cover - general exclusions* section, the following are not covered under this benefit:

- Aesthetic dental procedures
  - Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.
- Antimicrobial agents
  - Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.
- Collection of cultures and specimens
- Connector bar or stress breaker cosmetic/reconstructive services and supplies
  - Cosmetic and/or reconstructive services and supplies are not covered unless deemed necessary by a licensed dental provider.
  - Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance (for example, bleaching of teeth).
  - Reconstructive means services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.
- Desensitizing
  - Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.
- Duplicate x-rays
- Fractures of the mandible (jaw)
  - Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.
- Gold-foil restorations
- Implants
  - Services and supplies provided in connection with implants, whether or not the implant itself is covered, including, but not limited to:
    - endodontic endosseous implants;
    - interim endosseous implants;
    - eposteal and transosteal implants;
    - sinus augmentations or lift;
    - implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
    - radiographic/surgical implant index; and
    - unspecified implant procedures.
- Interim partial or complete dentures
- Medications and supplies
  - Except as specifically provided in this Pediatric dental benefit, charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies are not covered.
- Occlusal treatment
  - Except as specifically provided in this Pediatric dental benefit, services and supplies provided in connection with dental occlusion, including occlusal analysis and adjustments are not covered.
- Oral surgery
  - Oral surgery treating any fractured jaw and orthognathic surgery. "Orthognathic surgery," refers to

surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

- Orthodontic dental services
  - Except as specifically provided in this Pediatric dental benefit, services and supplies provided in connection with orthodontics are not covered. The following services are not covered:
    - correction of malocclusion;
    - craniomandibular orthopedic treatment;
    - other orthodontic treatment;
    - preventive orthodontic procedures; and
    - procedures for tooth movement, regardless of purpose.
- Precision attachment
- Provisional splinting
- Replacements
  - Except as specifically provided under this Pediatric dental benefit, services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken are not covered.
- Separate charges
  - Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following:
    - any supplies;
    - local anesthesia; and
    - sterilization.
- Services performed in a laboratory
- Surgical procedures
  - Services and supplies provided in connection with the following surgical procedures:
    - exfoliative cytology sample collection or brush biopsy;
    - incision and drainage of abscess extraoral soft tissue, complicated or non-complicated;
    - radical resection of maxilla or mandible;
    - removal of nonodontogenic cyst, tumor or lesion;
    - surgical stent; or
    - surgical procedures for isolation of a tooth with rubber dam.
- Temporomandibular Joint (TMJ) disorder treatment
  - Services and supplies provided in connection with temporomandibular joint (TMJ) disorder.
- Tooth Transplantation
  - Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.
- Veneers

Covered services	**In-network coverage**	**Out-of-network coverage**
Specific Conditions		
Diabetic services and 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
Impacted wisdom teeth	80% (of the negotiated charge)	60% (of the recognized charge)
Temporomandibular joint dysfunction treatment (TMJ)	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

Covered services	In-network coverage	Out-of-network coverage
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)
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants		
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: • 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: • Cosmetic services and supplies, unless they are for treatment of gender identity disorder or gender dysphoria. Services include, but are not limited to the following: - 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		
Covered 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
Covered 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
The following are not covered under this benefit: • Services and supplies furnished to a donor when the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness		

Covered services	In-network coverage	Out-of-network coverage
Infertility treatment		
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
Infertility services exclusions The following are not covered under the infertility services benefit: • All infertility services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services. • Infertility medication, including but not limited to menotropins, hCG, and GnRH agonists. • Intrauterine (IUI)/intracervical insemination (ICI) services. Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue. • Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue. • The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers. • A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person. • All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father. • Home ovulation prediction kits or home pregnancy tests. • The purchase of donor embryos, donor eggs or donor sperm. • Obtaining sperm from a person not covered under this plan. • Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization. • Infertility treatment when infertility is due to a natural physiologic process such as age-related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's infertility clinical policy.		
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 health professional'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: • Enteral nutrition • Blood transfusions and blood products		

Covered services	In-network coverage	Out-of-network coverage
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient aural, physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
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	
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
Non-emergency ground, air, or water 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 recognized charge) per trip
The following is not covered under this benefit: • Ambulance services, for routine transportation to receive outpatient or inpatient services		
Clinical trials		
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
The following are not covered under this benefit: • Services and supplies related to data collection and analysis needs and are not used in your direct clinical management • Services and supplies provided by the trial sponsor for free • The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)		
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item

Covered services	In-network coverage	Out-of-network coverage
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a 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: • 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
Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item	80% (of the actual charge) per item
Cochlear implants	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following is not covered under this benefit: • Services covered under any other benefit • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft		
Hearing aids and 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	
The following are not covered under this benefit: • Any ear or hearing exam if the services are not within the health care provider’s permitted scope of practice • Hearing 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	

Covered services	In-network coverage	Out-of-network coverage
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		
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

Covered services	In-network coverage	Out-of-network coverage
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses	 One set of eyeglass frames One pair of prescription lenses One year supply	
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 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: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		

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: • 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.		
Covered 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

Covered 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
Diabetic insulin important note: Your cost share per 30 day supply of a covered diabetic prescription filled at an in-network pharmacy will not exceed: • $25 for preferred prescription insulin No deductible applies for insulin and any cost share will apply toward your deductible.		

<table>
<tr><th>Covered services</th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td colspan="3">Asthma inhaler important note:
Your cost share per 30 day supply of a covered asthma prescription filled at an in-network pharmacy will not exceed $35 for a preferred prescription of at least one covered inhaled corticosteroid and at least one covered inhaled corticosteroid combination.

No deductible applies for inhaled corticosteroids and any cost share will apply toward your deductible.</td></tr>
<tr><td colspan="3">Epinephrine Autoinjector important note:
Your cost share per 30 day supply of a covered anaphylaxis treatment prescription filled at an in-network pharmacy will not exceed $35 for a preferred prescription of at least one covered epinephrine autoinjector product containing at least two autoinjectors.

No deductible applies for epinephrine autoinjectors and any cost share will apply toward your deductible,</td></tr>
<tr><td colspan="3">Human immunodeficiency virus post-exposure prophylaxis important note:
Coverage includes a prescription for at least one 28 day regimen of human immunodeficiency virus post-exposure prophylaxis filled at a network pharmacy without cost share.</td></tr>
<tr><td colspan="3"><h2>Hormone therapy</h2></td></tr>
<tr><td>For each fill up to a 30 day supply filled at a retail pharmacy</td><td>Paid according to the type of drug per the schedule of benefits, above</td><td>Paid according to the type of drug per the schedule of benefits, above</td></tr>
<tr><td>More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy</td><td>Paid according to the type of drug per the schedule of benefits, above</td><td>Paid according to the type of drug per the schedule of benefits, above</td></tr>
<tr><td colspan="3">Hormone therapy important note:
Prescription hormone therapy may be dispensed in up to a 12-month supply at one time when prescribed, unless:
The enrollee requests a smaller supply
The prescribing provider determines a smaller supply is clinically appropriate, or
The prescription hormone therapy is a controlled substance, in which case dispensing is limited to the maximum quantity permitted under state and federal law
The 12-month supply requirement applies only to prescription hormone therapy that can be safely stored at room temperature without refrigeration. During periods of drug shortage, dispensing may be temporarily limited in accordance with applicable law.</td></tr>
<tr><td>Anti-cancer drugs taken by mouth - For each 30 day supply</td><td>100% (of the negotiated charge)

No policy year deductible applies</td><td>100% (of the recognized charge)

No policy year deductible applies</td></tr>
<tr><td>Preventive care drugs and supplements filled at a retail pharmacy

For each 30–day supply</td><td>100% (of the negotiated charge per prescription or refill

No copayment or policy year deductible applies</td><td>Paid according to the type of drug per the schedule of benefits, above</td></tr>
<tr><td>Risk reducing breast cancer prescription drugs filled at a pharmacy

For each 30–day supply</td><td>100% (of the negotiated charge) per prescription or refill

No copayment or policy year deductible applies</td><td>Paid according to the type of drug per the schedule of benefits, above</td></tr>
</table>

Covered services	In-network coverage	Out-of-network coverage
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.	
Contraceptives (birth control) Brand-name prescription drugs and devices are covered at 100% at network pharmacy when a generic is not available Includes oral and injectable drugs, vaginal rings and transdermal contraceptive patches		
For each fill up to a 30 day supply or up to 12 month supply of generic and OTC drugs and devices filled at a retail pharmacy or mail order pharmacy	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 or up to 12 month supply of brand-name prescription drugs and devices filled at a retail pharmacy or mail order 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
Important notes: Covered contraceptives can be filled up to a 12 month supply, unless you request a smaller supply or your prescriber decides you need a smaller supply. Brand-name prescription drugs and devices are covered at 100% at an in-network pharmacy when a generic is not available.		

Outpatient prescription drug exclusions

The following are not covered services:

- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones, unless we have approved a medical exception
- Cosmetic drugs including medication and preparations used for cosmetic purposes (unless for gender affirming treatment)
- Devices, products and appliances unless listed as a covered service
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided unless listed in the drug guide or we have approved a medical exception
  - Which do not require a prescription by law, even if a prescription is written, unless listed as a covered service or we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception

- Not approved by the FDA or not proven safe or effective
- Provided under your medical plan while inpatient at a healthcare facility
- Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
- That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a covered service
- That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications unless listed as a covered service
- That are drugs or growth hormones used to stimulate growth and prescribed only to treat idiopathic short stature

- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as a covered service
- Immunizations related to work
- Immunization or immunological agents unless listed as a covered service Implantable drugs and associated devices unless listed as a covered service
- Infertility:
  - Prescription drugs used primarily for the treatment of infertility
- Injectables including:
  - Any charges for the administration or injection of prescription drugs
  - Needles and syringes except for those used for insulin administration
  - 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, with the exception of Depo Provera and other injectable drugs for contraception, unless listed in the drug guide or we have approved a medical exception
- Prescription drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Prescription drugs indicated for the purpose of weight loss.
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- Tobacco cessation drugs unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

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

General Exclusions

Cosmetic services and plastic surgery

- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, including cosmetic drugs, medications, and preparations used for cosmetic purposes, except where described in the Covered services and exclusions section

Court-ordered testing

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

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 or changing containers and clamping tubing
- Watching or protecting you
- Respite care except in connection with hospice care, adult or child day care, or convalescent care
- Institutional care, including room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and substance related disorder treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function
    - Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults

- Dental services for adults including services related to:

- The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants except when part of an approved treatment plan for a **covered service** described in the *Covered services and exclusions – Reconstructive surgery and supplies* section.

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

Educational services
Examples of these are:
- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs, whether or not the program is part of a residential treatment **f**acility or otherwise licensed institution
  - Job training
  - Job hardening programs
- Any services that are schooling related or similar programs
- Therapeutic programs within a school, vocational, work, or recreational 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, investigational, or unproven
- Experimental, investigational, or unproven drugs, devices, treatments or procedures unless otherwise covered under clinical trials

Gene-based, cellular and other innovative therapies (GCIT)

The following are not covered services unless you receive prior written approval from us:

- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider.
- All associated services when GCIT services are not covered. Examples include:
  - Infusion
  - Lab
  - Radiology
  - Anesthesia
  - Nursing services

See the *Medical necessity and precertification requirements* section.

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

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 services for treatment of TMJ as described in the Covered services and exclusions –Temporomandibular joint dysfunction (TMJ)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.

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Compresses
  - Other devices not intended for reuse by another patient

Non-U.S. citizen

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

Obesity surgery

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the Covered services and exclusions section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
  - Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis, or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Personal care, comfort or convenience items

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

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 not permitted by law

- Some laws restrict the range of health care services a provider may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

Services provided by a family member

- Services provided by a spouse, domestic partner, 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. Emergency prescription drugs received outside of the United States are covered.

Sexual dysfunction and enhancement

- Except where described in the *Covered services and exclusions* section, any treatment, prescription drug 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 of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

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 using emails

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

Students in mental health field

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

Telemedicine

- Services that are not provided in real time.
- Services that are not interactive, including emails

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound 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 *Covered services under your plan – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except where stated in the *Covered 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

Voluntary sterilization

- Reversal of voluntary sterilization procedures, including related follow-up care

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

- Wilderness treatment programs, whether or not the program is part of a residential treatment facility or otherwise licensed institution

Work related illness or injuries

- Coverage available to you under workers' compensation or a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment

Important note: 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 Western Washington University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health^{SM} 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.

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 1-877-480-4161 (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

1-877-480-4161, TTY: 711

Fax: 859-425-3379

Email: 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/onlineservices/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).

TTY: **711**

English	**To access language services at no cost to you, call the number on your ID card.**
Amharic	እርስዎ ወጪ ሳያወጡ የቋንቋ አገልግሎቶችን ለመድረስ በመታወቂያ ካርድዎ (ID) ላይ ወዳለው ቁጥር ይደውሉ።
Arabic	للحصول على خدمات اللغة مجانًا، اتصل بالرقم الموجود على بطاقة العضوية الخاصة بك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard
Chinese Traditional	如欲使用免費語言服務，請致電您 ID 卡上的電話號碼。
Cushitic-Oromo	Tajaajila afaanii bilisaan argachuuf, lakkoofsa Waraqaa Eenyummeessaa (ID) keessan irra jiru irratti bilbilaa.
French	Pour accéder gratuitement aux services linguistiques, appelez le numéro figurant sur votre carte d'identité.
French Creole (Haitian)	Pou w jwenn aksè ak sèvis lang gratis pou ou, rele nimewo ki sou kat idantite w la.
German	Um kostenlos auf Sprachdienste zuzugreifen, rufen Sie die Nummer auf Ihrem Ausweis an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα
Gujarati	તમારે કોઇ પણ તના ખર્ચ ના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇ કાડપર રહેલ નંબર પર કૉલ
Hindi	बना कसी कमत के भाषा सेवाआ का उपयोग करने के लए, अपने आइड काडर् पर दए नंबर पर कॉल कर।
Hmong	Kom tau txais cov kev pab cuam txhais lus yam tsis sau nqi ntawm koj, thov hu rau tus xov tooj nyob ntawm koj daim npav ID.
Italian	Per accedere gratuitamente ai servizi linguistici, chiama il numero riportato sul tuo tesserino
Japanese	無料の言語サービスをご利用いただくには、ご自身のIDカードに記載されている番号にお電話ください。
Karen	လၢကမၤန့ၢ် ကိုဲ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိဉ်လၢ်ဘူဉ်လၢ်စ့ၤ လၢနဂီၢ်အဂီၢ်, ကိးနီဉ်ဂံၢ် လၢအအိဉ် ဖဲန ID
Korean	**무료로 언어 서비스를 이용하려면 ID 카드에 적힌 전화번호로 전화하세요.**
Laotian	ເພື່ອເຂົ້າເຖິງການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆແກ່ທ່ານ,
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទៅលេខដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó naaltsoos bee atah nílį́įgo nanitinígíí bee nééhoʼdólzinígíí béésh bee hane'í biká'ígíí áajį' hólne'.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبانی رایگان، با شماره مندرج روی کارت ID خود تماس بگیرید.
Polish	Aby uzyskać bezpłatny dostęp do usług językowych, zadzwoń pod numer podany na karcie ID.
Portuguese	Ligue para o número que está no seu cartão de identificação para receber assistência linguística gratuita.

Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆ ਪੰਜਾਬੀ ਸੇਵਾਵਾ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ‘ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Чтобы получить бесплатные языковые услуги, позвоните по номеру телефона, указанному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a servicios de idiomas sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܟܕ ܚܫܚܬܐ ܗ݇ܘܝܐ ܥܠ ܝܠܦܢ̈ܘܬܐ ܕܡܬܪܓܡܢܘܬܐ ܒܠܫܢ̈ܐ ܡܓܢܢܐܝܬ، ܩܪܘܢ ܡܢܝܢܐ ܥܠ ܦܬܩܐ ܡܙܕܥܢܘܬܐ ܕܝܠܘܟܘܢ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang wala kang babayaran, tawagan ang numero sa iyong ID card.
Thai	**หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน**
Ukrainian	Щоб безкоштовнј отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để truy cập dịch vụ ngôn ngữ miễn phí, hãy gọi đến số điện thoại trên thẻ ID của quý vị.