Student Health Insurance

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

Schedule of Benefits

Prepared exclusively for:

Policyholder:	Western Washington University
Policyholder number:	686216
Student policy effective date:	September 1, 2025
Plan effective date:	September 1, 2025
Plan issue date:	September 18, 2025
Actuarial value and metallic level:	87.43% - Gold

Underwritten by Aetna Life Insurance Company
in the state of Washington

Schedule of benefits

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

How to read your schedule of benefits

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

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

How to contact us for help

We are here to answer your questions.

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

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

Important note about your medical cost sharing:

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

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

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

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

General coverage provisions

This section provides detailed explanations about:

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

Policy year deductibles

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

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

Individual

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

Copayments

In-network coverage

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

Coinsurance

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

Maximum out-of-pocket limits

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

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

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

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

Individual

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

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

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

Family

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

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

that apply towards the limits for the rest of the **policy year** for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the **policy year**, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a **policy year**.

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

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

Plan features	In-network coverage	Out-of-network coverage
Policy year deductibles		
You have to meet your **policy year deductible** before this plan pays for benefits.		
Student	$250 per **policy year**	$500 per **policy year**
Spouse	$250 per **policy year**	$500 per **policy year**
Each child	$250 per **policy year**	$500 per **policy year**

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

Policy year deductible waiver

The **policy year deductible** is waived for all of the following **eligible health services:**

- In-network care for:
  - *Abortion*
  - *Ambulance*
  - *Preventive care and wellness* services
  - *Pediatric dental care - Type A* services
  - *Pediatric vision care* services
- In-network and out-of-network care for:
  - *Hospital emergency room* services
  - *Outpatient prescription drugs*

Maximum out-of-pocket limits

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

Student	$4,500 per **policy year**	$9,000 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**

Coinsurance listed in the schedule of benefits

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

School health services benefits

You may be eligible to receive some health care services for free through your Student Health Center. Some services may include a charge, which may be submitted as a claim. In-network cost sharing will apply. Check with your Student Health Center for details. To submit a claim, see the *Claim procedures* section in your certificate of coverage or see the *How to contact us for help* section for assistance.

Eligible health services	In-network coverage	Out-of-network coverage
1. Preventive care and wellness		
Routine physical exams		
Performed at a **health professional's** office	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Covered persons through age 21: Maximum age and visit limits per **policy year**	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **health professional** or **Aetna** by logging onto your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	
Covered persons age 22 and over: Maximum visits per **policy year**	1 visit	
Preventive care immunizations		
Performed in a facility or at a **health professional's** office	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **health professional** or **Aetna** by logging onto your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	

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

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

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

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

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

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

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

Eligible health services	In-network coverage	Out-of-network coverage
4. Emergency services and urgent care		
Emergency services		
Emergency room	$100 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	Paid the same as in-network coverage
Important note: • If you get **emergency services** from an **out-of-network provider** or **hospital**, the most the **provider** or **hospital** may bill you is your plan's in-network cost-sharing amount. You can't be balance billed for these **emergency services**. See *Your Rights and Protections Against Surprise Medical Bills and Balance Billing in Washington State* in the certificate of coverage for more information. A separate emergency room **copayment** will apply for each visit to an emergency room. If you are admitted to a 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 emergency room that are not part of the emergency room benefit. These **copayment** amounts may be different from the 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.		
Non-emergency care in an emergency room	Not covered	Not covered
Urgent care		
Urgent medical care provided by an **urgent care provider**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Non-urgent use of **urgent care provider**	Not covered	Not covered

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

Diagnostic and preventive care (type A services)

Visits and images

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

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

Space maintainers

- Fixed (unilateral, per quadrant or bilateral)
- Removable (unilateral or bilateral)
- Recementation of space maintainer
- Removal of fixed unilateral space maintainer, per quadrant
- Removal of fixed bilateral space maintainer, upper/lower
- Replacement space maintainers when dentally appropriate

Basic restorative care (type B services)

Visits and images

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

Images and pathology

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

Oral surgery

- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants (baby teeth)
  - Surgical removal of erupted tooth or root tip
  - Removal of tooth (soft tissue)
  - Incision and drainage of abscess
- Impacted teeth
  - Surgical removal of impacted teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (fully bony)
  - Removal of tooth (complication)
  - Surgical removal of residual tooth roots
- Other surgical procedures
  - Alveoplasty, in conjunction with extractions, 4 or more teeth or tooth spaces per quadrant
  - Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces per quadrant
  - Alveoplasty, not in conjunction with extraction, 4 or more teeth or tooth spaces per quadrant
  - Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces per quadrant
  - Vestibulopasty
  - Excision of hyperplastic tissue – per arch
  - Removal of lateral exostosis (maxilla or mandible)
  - Removal of torus palatinus
  - Removal of torus mandibularis
  - Placement of device to facilitate eruption of impacted tooth
  - Removal of foreign body from soft tissue
  - Frenulectomy (upper/lower)

Periodontics

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

Endodontics

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

Restorative dentistry

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

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

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

Eligible health services include:

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

Major restorative care (type C services)

Oral surgery

- Coronectomy

Periodontics

- Clinical crown lengthening
- Pedical soft tissue graft procedures

Restorative

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

Prosthodontics

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

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

- Overdenture, complete or partial upper and lower (limited to 1 every 5 years)
- Cleaning and inspection of complete and partial dentures
- Dental implant crown and abutment related procedures, one per member per tooth (limited to 1 every 5 years)
- Implant maintenance procedures when a full arch fixed hybrid prosthesis or prostheses are removed and reinserted, including cleansing of prostheses and abutments, limited to 1 every 5 years
- Interim partial denture (stayplate), anterior only
- Occlusal guard
- Repairs
  - Crowns and bridges
  - Implant supported prosthesis or abutment
  - Repair of occlusal guards
- Removable appliance therapy
- Fixed appliance therapy

Behavioral management

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

Orthodontic services

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

Eligible health services	In-network coverage	Out-of-network coverage
6. Specific conditions		
Abortion		
Inpatient	100% (of the **negotiated charge**) per admission, no **policy year deductible** applies	60% (of the r**ecognized charge**) per admission
Outpatient	100% (of the **negotiated charge**), no **policy year deductible** applies	60% (of the r**ecognized charge**)
Birthing center		
Inpatient (room and board and other services and supplies	Paid at the same cost-sharing as **hospital** care	Paid at the same cost-sharing as **hospital** care
Diabetic equipment, supplies and education		
Diabetic equipment, supplies and education	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Temporomandibular joint dysfunction (TMJ)		
TMJ treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Impacted wisdom teeth		
Impacted wisdom teeth	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Accidental injury to sound natural teeth		
Accidental i**njury** to **sound natural teeth**	80% (of the **negotiated charge**)	80% (of the **recognized charge**)
Dermatological treatment		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maternity care		
Maternity care (includes delivery and postpartum care services in a **hospital** or **birthing center**)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Autism spectrum disorder		
Autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Behavioral health		
Mental health treatment - inpatient		
Inpatient (**room and board**) facility and other inpatient services and supplies, including **residential treatment facilities**	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission
Mental health treatment - outpatient		
Outpatient **mental health disorders** office visits to a **health professional** Includes **telemedicine** consultation or use of **store and forward technology**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Other outpatient **mental health disorders** treatment (includes skilled behavioral health services in the home, partial hospitalization treatment and intensive outpatient program)	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Substance related disorders treatment - inpatient		
Inpatient (**room and board**) facility and other inpatient services and supplies, including **residential treatment facilities**	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

Substance related disorders treatment - outpatient		
Outpatient **substance related disorders** office visits to a **health professional** Includes **telemedicine** consultation or use of **store and forward technology**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Other outpatient **substance related disorders** services, **partial hospitalization treatment** and **intensive outpatient program**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Reconstructive surgery and supplies		
Reconstructive surgery and supplies (includes reconstructive breast surgery)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage (IOE facility)	Out-of-network coverage (Includes **providers** who are otherwise part of **Aetna's** network but are non-IOE **providers**)
Transplant services		
Inpatient	80% per transplant	60% per transplant
Outpatient	80% per transplant	60% per transplant
Physician and **specialist** services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Transplant services - travel and lodging		
Transplant services - travel and lodging	Covered	
Maximum payable for travel and lodging expenses for any one transplant, including tandem transplant	$10,000	
Maximum payable for lodging expenses per patient	$50 per night	
Maximum payable for lodging per companion	$50 per night	

Eligible health services	In-network coverage	Out-of-network coverage
Infertility services		
Basic infertility services		
Treatment of basic infertility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

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

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient infusion therapy		
Performed in a **covered person's** home, **health professional's** office, outpatient department of a **hospital** or other facility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient radiation therapy		
Outpatient radiation therapy	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Specialty prescription drugs		
Specialty prescription drugs purchased and injected or infused by your **provide**r in an outpatient setting	Covered according to the type of benefit or the place where the service is received	Covered according to the type of benefit or the place where the service is received
Outpatient respiratory therapy		
Respiratory therapy	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Transfusion or kidney dialysis of blood		
Transfusion or kidney dialysis of blood	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation		
Cardiac rehabilitation	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Pulmonary rehabilitation		
Pulmonary rehabilitation	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Rehabilitation and habilitation therapy services		
Rehabilitation therapy services		
Outpatient cognitive rehabilitation, physical, occupational and speech therapies Combined for rehabilitation services and habilitation therapy services	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	Unlimited	

Habilitation therapy services		
Outpatient aural, physical, occupation and speech therapies	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Cochlear implants	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Maximum visits per **policy year**	Unlimited	
Neurodevelopmental therapy services		
Neurodevelopmental therapy	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	Unlimited	
Chiropractic services		
Chiropractic services	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	35*	
*Note: A visit is equal to no more than 1 hour of therapy.		
Diagnostic testing for learning disabilities		
Diagnostic testing for learning disabilities	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage	Out-of-network coverage
8. Other services and supplies		
Acupuncture		
Acupuncture	80% (of the **negotiated charge**)	60% (of the r**ecognized charge**)
Ambulance services		
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	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	Paid the same as in-network coverage
Clinical trials (routine patient costs)		
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Durable medical equipment (DME)		
Durable medical equipment	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Nutritional support		
Nutritional support	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Experimental or investigational therapies		
Experimental or investigational therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Prosthetic devices		
Prosthetic devices	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item

Hearing aids		
Hearing aids	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Hearing aids maximum per ear	One hearing aid per ear every 3 years	
Hearing exams		
Hearing exams	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Hearing exam maximum	One hearing exam every **policy year**	
Podiatric (foot care) treatment		
Non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Travel and lodging expenses		
Travel and lodging reimbursement	100%, No **policy year deductible** applies	
Limit per **policy year**	$3,000	
Vision care		
Pediatric vision care (limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	1 visit	
Pediatric comprehensive vision exams (including refraction)		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	1 visit	

Pediatric comprehensive low vision evaluations and services		
Performed by a legally qualified ophthalmologist or optometrist, including optical devices, services, training and instructions	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maximum visits per **policy year**	1 visit every 5 **policy years**	
Pediatric vision care services and supplies		
Eyeglass frames or **prescription** contact lenses	100% (of the **negotiated charge**) per item No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per item
Maximum number of eyeglass frames per **policy year**	One set of eyeglass frames	
Prescription eyeglass lenses	100% (of the **negotiated charge**) No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**)
Maximum number of **prescription** eyeglass lenses per **policy year**	One pair of **prescription** eyeglass lenses	
Office visit for fitting of contact lenses	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit

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

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

Policy year deductible and copayment waiver for contraceptives

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

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

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

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

For each fill up to a 30 day supply filled at a **retail pharmacy** or **specialty pharmacy**	$15 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$15 **copayment** per supply then the plan pays 50% (of the balance of the **recognized charge**) No **policy year deductible** applies
For each fill up to a 90 day supply filled at a **mail order pharmacy**	$37.50 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Not Covered

Tier 2 - Preferred brand-name prescription drugs (includes specialty prescription drugs)		
For each fill up to a 30 day supply filled at a **retail pharmacy** or **specialty pharmacy**	$35 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$35 **copayment** per supply then the plan pays 50% (of the balance of the **recognized charge**) No **policy year deductible** applies
For each fill up to a 90 day supply filled at a **mail order pharmacy**	$87.50 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Not Covered
Tier 3 - Non-preferred generic and brand-name prescription drugs (includes specialty prescription drugs)		
For each fill up to a 30 day supply filled at a **retail pharmacy** or **specialty pharmacy**	$70 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$70 **copayment** per supply then the plan pays 50% (of the balance of the **recognized charge**) No **policy year deductible** applies
For each fill up to a 90 day supply filled at a **mail order pharmacy**	$175 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Not Covered
Important note: Specialty prescription drugs are not eligible for fill at a **mail order pharmacy**.		
Diabetic prescription drugs, supplies and insulin		
For each fill up to a 30 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the *schedule of benefits* above	Paid according to the type of drug per the *schedule of benefits* above
For each fill up to a 90 day supply filled at a **mail order pharmacy**	Paid according to the tier of drug per the *schedule of benefits* above	Paid according to the type of drug per the *schedule of benefits* above

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

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

Outpatient prescription drugs important note:

Generic prescription drug substitution
If you or your **provider** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug. The cost difference does not apply toward your **maximum out-of-pocket limit**.

Behavioral health prescription drug substitution
The plan will not require you to substitute a nonpreferred drug with a preferred drug in a given therapeutic class, or increase your cost sharing amount mid-plan year for the drug if the **prescription** is for an initial or subsequent refill of an antipsychotic, antidepressant, antiepileptic, or other drug prescribed to treat a serious mental illness, you are medically stable on the drug, and a participating **provider** continues to prescribe the drug.

Student Health Insurance

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

Certificate of Coverage

Prepared exclusively for:

Policyholder:	Western Washington University
Policyholder number:	686216
Student policy effective date:	September 1, 2025
Plan effective date:	September 1, 2025
Plan issue date:	September 18, 2025

Underwritten by Aetna Life Insurance Company in the state of Washington

Notice of Non-Discrimination:
Aetna Life Insurance Company does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.

Welcome

Thank you for choosing **Aetna®**.

This is your certificate of coverage. It is one of three documents that together describe the benefits covered by your **Aetna** plan.

This certificate of coverage will tell you about your **covered benefits** – what they are and how you get them. It is your certificate of coverage under the **student policy**, and it replaces all certificates of coverage describing similar coverage that were previously sent to you. The second document is the schedule of benefits. It tells you how we share expenses for **eligible health services** and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the **student policy** between **Aetna Life Insurance Company** ("**Aetna**") and the **policyholder**. Ask the **policyholder** if you have any questions about the **student policy**.

Sometimes, we may send you endorsements. They change or add to the documents that they're part of. When you receive these, they are considered part of your **Aetna** plan for coverage.

Where to next? Take a look at the *Table of contents* section or try the *Let's get started!* section right after it. The *Let's get started!* section gives you a summary of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Aetna** plan.

Table of contents

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire certificate of coverage and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words

- When we say "you" and "your", we mean the **covered student** and any **covered dependents** , if dependent coverage is available under your plan
- When we say "us", "we", and "our", we mean **Aetna**
- Some words appear in **bold** type and we define them in the *Glossary* section

Sometimes we use technical medical language that is familiar to medical **providers**.

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible health services** for which your plan has the obligation to pay.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you are no longer a student. If your plan covers dependents, family members can lose coverage for many reasons. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your coverage ends* section.

Eligible health services

Health professional and **hospital** services are the foundation for many other services. You'll probably find the preventive care, **emergency services** and **urgent condition** coverage especially important. But the plan won't always cover the services you want. Sometimes it doesn't cover health care services your **health professional** will want you to have.

So what are **eligible health services**? They are health care services that meet these three requirements:

- They are listed in the *Eligible health services and exclusions* section.
- They are not carved out in the *What your plan doesn't cover – general exclusions* section. (We will refer to this section as the "*Exclusions*" section in the rest of this certificate of coverage)
- They are not beyond any limits in the schedule of benefits.

Paying for eligible health services– the general requirements

There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:

- The **eligible health service** is **medically necessary**
- You get the **eligible health service** from a **network provider** or **out-of-network provider**
- You or your **provider precertifies** the **eligible health service** when required

You will find details on **medical necessity** and **precertification** requirements in the *Medical necessity and precertification requirements* section. Your plan may include Health Care Benefit Managers. A list of Health Care Benefit Managers and services they provide can be found on our member website at www.aetna.com.

Paying for eligible health services– sharing the expense

Generally your plan and you will share the expense of your **eligible health services** when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense and sometimes you will. For more information see the *What the plan pays and what you pay* section, and see the schedule of benefits.

Disagreements

We know that people sometimes see things differently.

The plan tells you how we will work through our differences. And if we still disagree, an independent group of experts called an "external review organization" or ERO for short, will make the final decision for us.

For more information see the *When you disagree - claim decisions and appeals procedures* section.

How your plan works while you are covered in-network

Your in-network coverage helps you:

- Get and pay for a lot of – but not all – health care services
- Pay less cost share when you use a **network provider**

School health services

School health services can give you some of the care that you need. Contact them first before seeking care.

School health services will generally provide your routine care and send you to other **providers** when you need specialized care or services that **school health services** cannot provide.

Routine care generally includes:

- preventive care
- office visits
- lab
- x-ray
- mental health services for the diagnosis and treatment of anxiety and depression and medication management for stable mental health conditions

Acupuncture and routine eye exams are not included.

You don't have to access care through **school health services**. You may go directly to **network providers** for **eligible health services**. Your plan often will pay a bigger share for **eligible health services** that you get through **school health services**.

For more information about **network providers** and the role of **school health services**, see the *Who provides the care* section.

Aetna's network of providers

Aetna's network of **health professionals**, **hospitals** and other health care **providers** is there to give you the care that you need. You can find **network providers** and see important information about them most easily on our online **provider directory**. Just log in to your **Aetna** website at https://www.aetnastudenthealth.com.

If you can't find a **network provider** for a service or supply that you need, call Member Services at the toll-free number in the *How to contact us for help* section. We will help you find a **network provider**. If we can't find one, we will give you a pre-approval to get the service or supply from an **out-of-network provider**. When you get a pre-approval for an **out-of-network provider**, coverage will be provided at no greater cost than if the service was obtained from a **network provider**.

Service area

Your plan generally pays for **eligible health services** only within a specific geographic area, called a **service area**. There are some exceptions, such as for **emergency services**, urgent care and transplants. See the *Who provides the care* section.

The Washington service area is statewide without limitations.

How your plan works while you are covered out-of-network

The section above told you how your plan works while you are covered for network coverage. You also have coverage when you want to get your care from **providers** who are not part of the **Aetna** network

It's called out-of-network coverage. Your out-of-network coverage helps you get and pay for a lot of – but not all – health care services.

Your out-of-network coverage:

- Means you can get care from **providers** who are not part of the **Aetna** network.
- Means you may have to pay for services at the time that they are provided. You may be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible health services** that you paid directly to a **provider**.
- Means that when you use out-of-network coverage, it is your responsibility to start the **precertification** process with **providers**. Precertification can be requested by either you or your **out-of-network provider**.
- Means you may pay a higher cost share when you use an **out-of-network provider**.

You will find details on:

- **Precertification** requirements in the *Medical necessity and precertification requirements* section.
- **Out-of-network providers** and any exceptions in the *Who provides the care* section.
- Cost sharing in the *What the plan pays and what you pay* section, and your schedule of benefits.
- Claim information in the *When you disagree - claim decisions and appeals procedures* section.

Surprise bill

There may be times when you unknowingly receive services from an **out-of-network provider**, even when you try to stay in the network for your **covered services**. You may get a bill at the out-of-network rate that you didn't expect. This is called a surprise bill. Review *Your Rights and Protections Against Surprise Medical Bills and Balance Billing in Washington State* that is attached to this certificate.

If you receive a surprise bill or have any questions about what a surprise bill is, contact us.

How to contact us for help

We are here to answer your questions. You can contact us by:

- Calling our Member Services at the toll-free number on your ID card 1-877-480-4161
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156
- Visiting https://www.aetnastudenthealth.com to register and access your **Aetna** website

Aetna's online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

Your ID card

We issued to you a digital ID card which you can view or print by going to the website at https://www.aetnastudenthealth.com. When visiting **health professionals**, **hospitals**, and other **providers**, you don't need to show them an ID card. Just provide your name, date of birth and either your digital ID card or social security number. The **provider** office can use that information to verify your eligibility and benefits.

Remember, only you and your **covered dependents** can use your digital ID card. If you misuse your card by allowing someone else to use it, that is fraud and we may end your coverage. See the *Honest mistakes and intentional deception* section for details.

If you don't have internet access, call Member Services at the toll-free number in the *How to contact us for help* section. You can also access your ID card when you're on the go. To learn more, visit us at https://www.aetnastudenthealth.com/mobile.

Who the plan covers

The **policyholder** decides and tells us who is eligible for health care coverage.

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

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 physically 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.

International Eligibility: Western Washington University does NOT utilize the Aetna Student Health plan for their International Students. They are covered under a separate insurance policy.

Medicare eligibility

You are not eligible for health coverage under this **student policy** if you have **Medicare** at the time of enrollment in this student plan.

If you obtain **Medicare** after you enrolled in this student plan, your health coverage under this plan will not end.

As used here, "have **Medicare**" means that you are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

When you can join the plan

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 below)

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.

Who can be on your plan (who can be your dependent)

If your plan includes dependent coverage, you can enroll the following family members on your plan. They are referred to in this certificate of coverage as your "**covered dependents**" or "dependents".

- Your legal spouse
- Your domestic partner
- Your dependent children – your own or those of your spouse or domestic partner
  - The children must be under 26 years of age, and they include your:
    - Biological children
    - Stepchildren
    - Legally adopted children, including any children placed with you for adoption
    - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)

Important note: You may continue coverage for a disabled child past the age limit shown above. See *Continuation of coverage* in the *Special coverage options after your coverage ends* section for more information.

Adding new dependents

If your plan includes coverage for dependents, you can add the following new dependents any time during the year:

- A spouse – If you marry, you can put your spouse on your plan
  - We must receive your completed enrollment information not more than 60 days after the date of your marriage
  - The benefits for your spouse will begin the first day of the month following the date of marriage
- A domestic partner – If you enter a domestic partnership, you can put your domestic partner on your plan
  - We must receive your completed enrollment information not more than 60 days after the date of your domestic partnership
  - The benefits for your domestic partner will begin the first day of the month following the date of your domestic partnership
- 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

Inform us of any changes

It is important that you inform us of any changes that might affect your benefit status. This will help us effectively deliver your benefits. Please contact us as soon as possible with changes such as:

- Change of address or phone number
- Change in marital or domestic partnership status
- Change of **covered dependent** status
- You or a **covered dependent** enrolls in **Medicare** or any other plan

Special times you and your dependents can join the plan

You and your dependents, if your plan includes coverage for dependents, can enroll in these situations:

- You or your dependents did not enroll in this plan before because you:
  - Were covered by another plan, and now that coverage has ended
  - Were covered by Medicaid or an S-CHIP plan, and now no longer qualify
  - Had COBRA, and now that coverage has ended
- You or your dependents become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan
  - If you are eligible for medical assistance in Washington, the Department of Social and Health Services will send you a notice to enroll in this plan
  - You must complete your enrollment information and send it to us within 31 days after the notice
  - For dependent children, you must complete the enrollment information and send it to us within 60 days of the notice
- You have added a dependent because of marriage, domestic partnership, birth or adoption (see the *Adding new dependents* section for more information)
- A court orders that you cover a current spouse or domestic partner or a minor child on your plan
- You or your dependent lost minimum essential coverage (for reasons such as death, divorce, termination of domestic partnership, or loss of dependent status), unless coverage was lost due to misrepresentation of a material fact affecting coverage or fraud
- You or your dependent qualify for access to new plans because you have moved to a new permanent location
- Your policyholder decides to stop offering the health plan to the eligible class to which you belong
- When you are a victim of domestic abuse or spousal abandonment and you don't want to be enrolled in the perpetrator's health plan

We must receive your completed enrollment information from you within 60 days of that date on which you no longer have the other coverage mentioned above.

Important note: A court may order that you cover a minor child on your plan, even if you are not the custodial parent. If that happens, the **provider** or the custodial parent may file a claim for benefits without your approval. Any benefits to be paid will be paid to either the **provider** or to the custodial parent.

Effective date of coverage

Student coverage

If you were enrolled on or before the effective date of the **student policy** and you were eligible for health benefits at the time, your coverage will take effect as of the effective date of the **student policy**. Your coverage will take effect on this date if we received your completed enrollment application or you did not submit a waiver form to waive automatic enrollment in the student plan and any required **premium** contribution was paid.

If you enroll after the effective date of the **student policy** and you are eligible for health benefits at the time, your coverage will take effect as of that date as long as:

- We receive your completed request for enrollment
- You pay any **premium** contribution.

Dependent coverage

If your plan includes coverage for dependents, your dependent's coverage will take effect when we receive completed enrollment information and you pay any required **premium** contribution. See the *Adding new dependents* section for details.

Late enrollment

If we receive your enrollment application and **premium** contribution more than 60 days after the date you become eligible, coverage will only become effective if, and when the late enrollment is due to:

- An administrative error caused by your **policyholder**, or
- A life-changing event (see the *Special times you and your dependent can join the plan* section above)

Medical necessity and precertification requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible health services.** See the *Eligible health services and exclusions* and *General exclusions* sections plus the schedule of benefits.

Your plan pays for its share of the expense for **eligible health services** only if the general requirements are met. They are:

- The **eligible health service** is **medically necessary**
- You or your **provider precertifies** the **eligible health service** when required

This section addresses the **medical necessity** and **precertification** requirements. You will find the requirement to use a **network provider** and any exceptions in the *Who provides the care* section.

Medically necessary; medical necessity

As we said in the *Let's get started!* section, **medical necessity** is a requirement for you to receive a **covered benefit** under this plan.

The **medical necessity** requirements are in the *Glossary* section, where we define "**medically necessary, medical necessity**". That's where we also explain what our medical directors or a **physician** they assign consider when determining if an **eligible health service** is **medically necessary**.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

Precertification

You need pre-approval from us for some **eligible health services**. Pre-approval is also called **precertification**.

In-network: Your **network provider** is responsible for obtaining any necessary **precertification** before you get the care. For precertification of outpatient **prescription drugs**, see *Eligible health services under your plan – Outpatient prescription drugs – What precertification requirements apply*. If your **network provider** doesn't get a required **precertification**, we won't pay the **provider** who gives you the care. You won't have to pay either if your **network provider** fails to ask us for **precertification**. If your **network provider** requests **precertification** and we refuse it, you can still get the care but the plan won't pay for it. You will find details on requirements in the *What the plan pays and what you pay – Important note – when you pay all* section.

Out-of-network: When you go to an **out-of-network provider**, you are responsible to make sure that **precertification** is obtained from us for any services and supplies on the **precertification** list. **Precertification** can be requested by either you or your **out-of-network provider**. If **precertification** is not received, the plan may not pay. The list of services and supplies that require **precertification** appears later in this section.

You should get **precertification** within the timeframes listed below. For **emergency services**, **precertification** is not required, but you should notify us within the timeframes listed below. To obtain **precertification**, you must notify us. See the *How to contact us for help* section.

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

We will tell you and your **health professional** in writing, of the **precertification** decision. If your **precertified** services are approved, the approval is valid for 180 days as long as you remain enrolled in the plan**.**

When you have an inpatient **stay** in a facility, we will tell you, your **health professional** and the facility about your **precertified** length of **stay**. If your **health professional** recommends that your **stay** be extended, additional days will need to be **precertified**. You, your **health professional**, or the facility will need to call us at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. We will review and process the request for an extended **stay**. We will tell you and your **health professional** in writing of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered benefits**, we will explain why and how our decision can be appealed. You or your **provider** may request a review of the **precertification** decision. See the *When you disagree – claim decisions and appeal procedures* section.

What if you don't obtain the required precertification?

If you don't obtain the required **precertification**:

- The plan may not pay any benefits.
- You will be responsible for the unpaid balance of the bills.
  Any additional out-of-pocket expenses incurred will not count toward your out-of-network **policy year deductibles** or **maximum out-of-pocket limits**.

Sometimes, unforeseen events prevent your **network provider** from obtaining the required **precertification**. These are called extenuating circumstances. For example, if your **network provider** could not reasonably:

- Determine who to request **precertification** from
- Anticipate the need for **precertification** before providing the services
- Request **precertification** for services needed after a **stay**, such as home health care, before the services are required

Your **network provider** can let us know if any extenuating circumstances kept them from obtaining **precertification**. We will work with your **network provider** to make a decision on whether or not the **precertification** requirement should be waived. But, we will still review the claim to make sure that the services were **covered benefits**.

What types of services require precertification?

Precertification is required for the following types of services and supplies:

Inpatient –

- Gender affirming treatment
- Gene-based, cellular and other innovative therapies (GCIT)
- **Stays** in a **hospice facility**
- **Stays** in a **hospital**, except for stays due to involuntary commitment to a state **hospital**
- **Stays** in a rehabilitation facility
- **Stays** in a **residential treatment facility** for treatment of **mental health disorders** and **substance related disorders**
- **Stays** in a **skilled nursing facility**

Outpatient –

- Applied behavior analysis
- Certain **prescription drugs** and devices
- **Cosmetic** and reconstructive **surgery**
- Gender affirming treatment
- Gene-based, cellular and other innovative therapies (GCIT)
- Home health care
- **Hospice care**
- Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
- Non-emergency transportation by airplane
- Private duty nursing services

Important note: **Precertification** is not required for:

- At least two business days, excluding weekends and holidays, in a **residential treatment facility** that provides
  - inpatient or
  - residential substance related disorders treatment
- At least three days in a **residential treatment facility** that provides withdrawal management services.

If the **residential treatment facility** is out-of-network, we may not pay a greater rate than would be paid had the facility been in your network. The **residential treatment facility** may not bill you for the balance of the charges. You also have other rights regarding balance billing. See the section **Know your rights under the Balance Billing Protection Act** at the end of this Certificate.

You can contact us to get a list of the services that require **precertification**. The list may change from time to time.

*For a current listing of the **prescription drugs** and medical **injectable drugs** that require **precertification**, contact Member Services by calling the toll-free number in the How to contact us for help section or by logging in to the **Aetna** website at https://www.aetnastudenthealth.com.*

Sometimes you or your **provider** may want us to review a service that doesn't require **precertification** before you get care. This is called a predetermination, and it is different from **precertification**. Predetermination means that you or your **provider** requests the pre-service clinical review of a service that does not require **precertification**.

For certain **drugs** covered under your **prescription drug** plan, your **provider** needs to get approval from us before we will agree to cover the **prescription drug** or device for you. The requirement for getting approval in advance helps guide appropriate use of certain **drugs** and makes sure they are **medically necessary**.

There is another type of **precertification** for **prescription drugs**, and that is **step therapy**. **Step therapy** is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

Contact us or go online to get the most up-to-date precertification requirements and list of step therapy prescription drugs.

Requesting a medical exception

Sometimes you or your **provider** may ask for a medical exception for **prescription drugs** that are not covered or for which coverage was denied. You, someone who represents you or your **provider** can contact us. You will need to provide us with the required clinical documentation. Any exception granted is based upon an individual and is a case by case decision that will not apply to other **covered persons**.
For directions on how you can submit a request for a review:

- Contact Member Services at the toll-free number 1-877-480-4161
- Go online at https://www.aetnastudenthealth.com
- Submit the request in writing to CVS Health, ATTN: **Aetna** PA, 1300 E Campbell Road, Richardson, TX 75081

You, someone who represents you or your **provider** may seek a quicker medical exception when the situation is urgent. It's an urgent situation when you have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug.

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your **provider** of our decision. If approved by us, the exception will apply for the entire time you have an urgent situation.

If you are denied a medical exception based on the above processes, you may have the right to a third party review by an independent external review organization. If our claim decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send you. That notice also will describe the external review process. We will tell you, someone who represents you or your **provider** of the coverage determination of the external review no later than 72 hours after we receive your request. If the medical exception is approved, coverage will be provided for the entire time of the prescription. For quicker medical exceptions in urgent situations, we will tell you, someone who represents you or your **provider** of the coverage determination no later than 24 hours after we receive your request. If the quicker medical exception is approved, coverage will be provided for the entire time you have an urgent situation.

Eligible health services and exclusions

The information in this section is the first step to understanding your plan's **eligible health services**. These services are:

- Described in this section.
- Not listed as exclusions in this section or the *General exclusions* section.
- Not beyond any limitations in the schedule of benefits.
- Not prohibited by law. See *Services not permitted by law* in the *General exclusions* section for more information.

If you have questions about this section, see the *How to contact us for help* section.

Your plan covers many kinds of health care services and supplies, such as **physician** care and **hospital stays**. But sometimes those services are not covered at all or are covered only up to a limit.

For example:

- **Physician** care generally is covered but **custodial care** is not covered. **Custodial care** is an exclusion.
- Home health care is generally covered but may only be covered up to a set number of visits per year. This is a limitation.
- Your **provider** may recommend services that are considered **experimental, investigational, or unproven** services. But an **experimental, investigational, or unproven** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of **eligible health services** below.

We explain **eligible health services** and exclusions in this section. You can find out about general exclusions in the *General exclusions* section and about limitations in the schedule of benefits.

We've grouped the health care services below to make it easier for you to find what you're looking for.

1. Preventive care and wellness

This section describes the **eligible health services** and supplies available under your plan when you are well.

You will see references to the following recommendations and guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- United States Preventive Services Task Force
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

When these recommendations are updated, they will apply to this plan. The updates will be effective on the first day of the plan year, one year after the updated recommendation or guideline is issued.

- Diagnostic testing is not covered under the preventive care benefit. You will pay the cost sharing specific to **eligible health services** for diagnostic testing.
- Gender-specific preventive care benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

- **Eligible health services** include screening for physical, mental, sexual, and reproductive health care needs as well as **medically necessary** services and **prescription** medications for the treatment of physical, mental, sexual, and reproductive health care needs that arise from a sexual assault.
- To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **health professional** or see the *How to contact us for help* section. This information can also be found at the https://www.healthcare.gov website.

Routine physical exams

Eligible health services include office visits to your **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **health professional** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- 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
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
    - Depression screening, including screening for maternal depression
  - Screening for gestational diabetes for women
  - High-risk Human Papillomavirus (HPV) DNA testing for women
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial **hospital** checkup

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

Eligible health services include immunizations provided by your **health professional** for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

The following is not covered under this benefit:

- Any immunization that is not considered to be preventive care

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **health professional**, such as an obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes Pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **health professional** and lab.

- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.

Preventive screening and counseling services

Eligible health services include screening and counseling by your **health professional** for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting.

- **Obesity and/or healthy diet counseling**
  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**
  Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment

- **Use of tobacco products**
  Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:
  - Preventive counseling visits
  - Treatment visits
  - Class visits

  Tobacco product means a substance containing tobacco or nicotine such as:
  - Cigarettes
  - Cigars
  - Smoking tobacco
  - Snuff
  - Smokeless tobacco
  - Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**
  Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**
  Eligible health services include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms, including 3-D mammograms (tomosynthesis), supplemental and diagnostic breast examinations, which may include MRI, ultrasound or mammography
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies (includes:
  - Bowel preparation medications
  - Anesthesia
  - Removal of polyps performed during a screening procedure
  - Pathology exam on any removed polyps)
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

Prenatal care

Eligible health services include your routine prenatal physical exams as preventive care, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height
- Preeclampsia screening

This also includes complications of pregnancy. You can get this care at your **health professional's** office, including your OB's, GYN's, or OB/GYN's office.

Important note:
You should review the benefit under *Eligible health services and exclusions – Maternity and related newborn care* section of this certificate of coverage for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services

Eligible health services include comprehensive lactation support (help and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast-feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support **provider**.

Breast feeding durable medical equipment

Eligible health services include renting or buying **durable medical equipment** you need to pump and store breast milk as follows:

Breast pump

Eligible health services include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**
- The buying of either:
  - An electric breast pump (non-**hospital** grade). Your plan will cover this cost once every 12 months) or
  - A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous 12 month period, the purchase of another electric breast pump will not be covered until one of these things happens:

- A 12 month period has elapsed since the last purchase
- The initial electric breast pump is broken and no longer covered under a warranty

Breast pump supplies and accessories

Eligible health services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose. It also includes the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Family planning services

Eligible health services include family planning services such as:

Counseling services

Eligible health services include counseling services provided by a **provider** or other **health professional**, such as an OB, GYN, or OB/GYN, on contraceptive methods. These will be covered when you get them in either a group or individual setting.

Devices

Eligible health services include contraceptive devices (including any related services or supplies) when they are provided, administered or removed by a **health professional**.

Voluntary sterilization

Eligible health services include charges billed separately by the **provider** for voluntary sterilization procedures and related services and supplies. This also could include tubal ligation, vasectomy and sterilization implants.

The following are not covered under this benefit:

- 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

Important note: See the following sections for more information.

- *Maternity and related newborn care*
- *Outpatient prescription drugs - preventive contraceptives*
- *Treatment of basic infertility*

2. Physicians and other health professionals

Physician and other health professional services (non-surgical and non-preventive)

Eligible health services include services provided by your **health professional** to treat an **illness** or **injury**. You can get those services:

- At the **health professional's** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine** or **store and forward technology**

Important note:
Your **student policy** covers **telemedicine** and **store and forward technology**. All in-person **physician** or **specialist** office visits that are **covered benefits** are also covered if you use **telemedicine** or **store and forward technology** instead.

Allergy testing and treatment

Eligible health services include the services and supplies that your **health professional** may provide for:

- Allergy testing
- Allergy injections treatment
- Allergy sera and extracts administered via injection

Physician and specialist – inpatient surgical services

Eligible health services include the services of:

- The surgeon who performs your **surgery** while you are confined in a **hospital** or birthing center
- Your surgeon who you visit before and after the **surgery**
- A licensed mid-wife

Anesthetist
Covered benefits for your **surgery** include the services of an anesthetist or anesthesiologist. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant.

Surgical assistant
Covered benefits for your **surgery** include the services of a surgical assistant. A "surgical assistant" is a **health professional** trained to assist in **surgery** and during the periods before and after **surgery**. A surgical assistant is under the supervision of a **physician**.

Physician and specialist – outpatient surgical services

Eligible health services include the services of:

- The surgeon who performs your **surgery** in the outpatient department of a **hospital** or **surgery center**
- Your surgeon who you visit before and after the **surgery**
- Another surgeon who you go to for a second opinion before the **surgery**

Covered benefits include **hospital** or **surgery center** services provided within 24 hours of the **surgical procedure**.

Anesthetist
Covered benefits for your **surgery** include the services of an anesthetist who is not employed or retained by the **hospital** or **surgery center** where the **surgery** is performed.

Surgical assistant
Covered benefits for your **surgery** include the services of a surgical assistant. A "surgical assistant" is a **health professional** trained to assist in **surgery** and during the periods before and after **surgery**. A surgical assistant is under the supervision of a **physician**.
The following are not covered under this benefit:

- Services of another **physician** for the administration of a local anesthetic

In-hospital non-surgical health professional services

During your **stay** in a **hospita**l for **surgery**, **eligible health services** include the services of **health professionals** employed by the **hospital** to treat you. The **health professional** does not have to be the one who performed the **surgery**.

Consultant services (non-surgical and non-preventive)

Eligible health services include the services of a consultant to confirm a diagnosis made by your **health professional** or to determine a diagnosis. Your **health professional** must make the request for the consultant services.

Covered benefits include treatment by the consultant.

The consultation by your **health professional** may happen by way of **telemedicine.**

Important note:
Your **student policy** covers **telemedicine** and **store and forward technology**. All in-person consultant office visits provided by a **health professional** that are **covered benefits** are also covered if you use **telemedicine** or **store and forward technology** instead.

Alternatives to physician or other health professional office visits

Walk-in clinic

Eligible health services include, but are not limited to, health care services provided at **walk-in clinics** for:

- Scheduled and unscheduled visits for **illnesses** and **injuries** that are not **emergency medical conditions**
- Preventive care immunizations administered within the scope of the clinic's license

3. Hospital and other facility care

Hospital care (facility charges)

Eligible health services include inpatient and outpatient **hospital** care. This includes involuntary commitment to a state **hospital**. This also includes:

- Semi-private **room and board**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge
- Services of **health professionals** employed by the **hospital**, including services for inpatient respite care
- Administration of blood and blood products
- Dialysis services

The following are not **eligible health 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

Preadmission testing

Eligible health services include pre-admission testing on an outpatient basis before a scheduled **surgery**.

For your preadmission testing to be eligible for coverage, the following conditions must be met:

- The testing is related to the scheduled **surgery**
- The testing is done within the 7 days before the scheduled **surgery** and
- The testing is not repeated in, or by, the **hospital** or **surgery center** where the **surgery** is done

Alternatives to hospital stays

Outpatient surgery (facility charges)

Eligible health services include facility services provided and supplies used in connection with outpatient **surgery** performed in a **surgery center** or a **hospital's** outpatient department.

Important note:
Some **surgeries** can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician** services and not a separate fee for facilities.

The following are not covered under this benefit:

- A **stay** in a **hospital.** (A **hospital stay** is an inpatient **hospital** benefit. See the *Eligible health services under your plan* section.)A separate facility charge for **surgery** performed in a **physician's** office.

Home health care

Eligible health services include home health care services and home dialysis services provided by a **home health care agency** in the home, but only when all of the following criteria are met:

- You are **homebound**
- Your **health professional** orders them
- The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**, or you are unable to receive the same services outside your home
- The services are part of a **home health care plan**
- The services are **skilled nursing services**, **home health aide** services or medical social services, or are short-term speech, physical or occupational therapy
- **Home health aide** services are provided under the supervision of a registered nurse (**R.N.**)
- Medical social services are provided by or supervised by a **physician**, other **health professional** or social worker

Short-term physical, speech and occupational therapy provided in the home are subject to the conditions and limitations imposed on therapy provided outside the home. See the *Rehabilitation therapy services and Habilitation therapy service*s sections and the schedule of benefits.

Home health care services do not include **custodial care**.

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
- Homemaker or housekeeper services
- Food or home delivered services
- Maintenance therapy

Hospice care

Eligible health services include inpatient and outpatient **hospice care** when given as part of a **hospice care.**

The types of **hospice care** services that are eligible for coverage include:

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a **hospice care agency** or **hospice care** provided in a **hospital**
- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day
- Part-time or intermittent **home health aide** services to care for you up to eight hours a day
- Medical social services under the direction of an appropriate **health professional** such as:
  - Assessment of your social, emotional and medical needs, and your home and family situation
  - Identification of available community resources
  - Assistance provided to you to obtain resources to meet your assessed needs
- **Respite care**
- Palliative care

Hospice care services provided by the **providers** below may be covered, even if the **providers** are not an employee of the **hospice care agency** responsible for your care:

- A **physician** or other **health professional** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient **prescription drugs**
  - Psychological counseling
  - Dietary counseling
  - Palliative care

The following are not covered under this benefit:

- Funeral arrangements
- Pastoral counseling
- Bereavement counseling
- Financial or legal counseling which includes estate planning and the drafting of a will
- Homemaker or caretaker services that are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

Outpatient private duty nursing

Eligible health services include private duty nursing care provided by an **R**.**N**. or **L**.**P**.**N**. for non-hospitalized acute **illness** or **injury** if your condition requires skilled nursing care and visiting nursing care is not adequate.

Skilled nursing facility

Eligible health services include inpatient **skilled nursing facility** care.

The types of **skilled nursing facility** care services that are eligible for coverage include:

- **Room and board**, up to the **semi-private room rate**
- Services and supplies that are provided during your **stay** in a **skilled nursing facility**, including respite care, and treatment of **mental health disorders** or **substance related disorders**

4. Emergency services and urgent care

Eligible health services include services and supplies for the treatment of an **emergency medical condition** or an **urgent condition**.

Emergency services

Emergency services coverage for an **emergency medical condition** includes your use of:

- An ambulance
- A hospital emergency room or an independent freestanding emergency department facility, along with their staff **health professional** services

As always, you can get **emergency services** from **network providers**. However, you can also get **emergency services** from **out-of-network providers**.

Your coverage for **emergency services** will continue until the following conditions are met:

- You are evaluated and your condition is stabilized
- Your attending **physician** determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another **provider** if you need more care

For follow-up care, you are covered when:

- Your **network provider** provides the care.
- You use an **out-of-network provider** to provide the care. If you use an **out-of-network provider** to receive follow up care, you may be subject to a higher out-of-pocket expense.

In case of a medical emergency

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance assistance. If possible, call your **health professional** but only if a delay will not harm your health.

Non-emergency condition

If you go to an emergency room for what is not an **emergency medical condition**, the plan will not cover your expenses. An **emergency medical condition** is a recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, **illness**, or **injury** is of a severe nature. See the *Glossary* section for additional details on what an **emergency medical condition** is.

Urgent care

In case of an urgent condition

Urgent condition

If you need care for an **urgent condition**, you should first seek care through your **health professional.** If your **health professional** is not reasonably available to provide services, you may access urgent care from an **urgent care facility**.

Non-urgent care

If you go to an **urgent care facility** for what is not an **urgent condition,** the plan may not cover your expenses. See the *Exclusions* section and the schedule of benefits for specific plan details.

Examples of non-urgent care are:

- Routine or preventive care (this includes immunizations)
- Follow-up care
- Physical therapy
- Any diagnostic lab work and radiological services which are not related to the treatment of the **urgent condition**

The following is 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)

5. Pediatric dental care

Eligible health services include dental services and supplies provided by a **dental provider** as found in the *Pediatric dental care* section of the schedule of benefits.

Dental emergencies

Eligible health services also include dental services provided for a **dental emergency**. Services and supplies provided for a **dental emergency** will be covered even if services and supplies are provided by an **out-of-network provider**.

If you have a **dental emergency**, you should consider calling your network **dental provider** who may be more familiar with your dental needs. If you cannot reach your network **dental provider**, you may get treatment from any **dentist**. The care received from an **out-of-network provider** must be for the temporary relief of the **dental emergency** until you can be seen by your network **dental provider**. Services given for other than the temporary relief of the **dental emergency** by an **out-of-network provider** can cost you more. To get the maximum level of benefits, services should be provided by your network **dental provider**.

If you get treatment from an **out-of-network provider** for a **dental emergency**, the plan pays a benefit at the network cost-sharing level of coverage.

Follow-up care will be paid at the cost-sharing level that applies to the type of **provider** that gives you the care.

Orthodontic treatment

Orthodontic treatment is covered for a severe, dysfunctional, disabling condition as determined by the Washington Modified Handicapping Labiolingual Deviation (HLD) Index Score with a score of 25 or higher and conditions that result in a score of less than 25 on a case-by-case basis. Such as:

- Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement
- The following craniofacial anomalies:
  - Hemifacial microsomia
  - Craniosynostosis syndromes
  - Cleidocranial dental dysplasia
  - Arthrogryposis
  - Marfan syndrome
- Anomalies of facial bones and/or oral structures
- Facial trauma resulting in functional difficulties

If you suffer from one of these conditions, the orthodontic services that are eligible for coverage include:

- Pre-orthodontic treatment visit
- Comprehensive orthodontic treatment
- Orthodontic retention (removal of appliances, construction and placement of retainers)

Not covered under this benefit are:

- Replacement of broken appliances
- Re-treatment of orthodontic cases
- Changes in treatment necessitated by an accident
- Maxillofacial surgery
- Myofunctional therapy
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces")
- Removable acrylic aligners (i.e. "invisible aligners")

Replacements

The plan's "replacement rule" applies to:

- Crowns
- Inlays
- Onlays
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

The "replacement rule" means that replacements of, or additions to, these dental services are covered only when:

- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay, onlay, complete denture, or fixed partial denture was installed at least 5 years before its replacement.
- Removable partial dentures, immediate partial dentures, resin-based, cast metal framework with resin denture bases, flexible bases and one piece cast metal (unilateral), including any conventional clasps, rests and teeth were installed at least 3 years before its replacement.
- You had a tooth (or teeth) extracted. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Missing teeth that are not replaced

The plan covers installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years.

Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

An advance claim review

The advance claim review gives you an idea of what we might pay for services before you receive them. Knowing this ahead of time can help you and your **dental provider** make informed decisions about the care you are considering.

When we do the advance claim review, we will look at other procedures, services or courses of dental treatment for your dental condition.

You do not have to get an advance claim review. It's voluntary. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

Important note:
The advance claim review is not a guarantee of coverage and payment. It is an estimate.

When to get an advance claim review

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $350. Here are the steps to get an advance claim review:

1. Ask your **dental provider** to write down a full description of the treatment you need, using either an **Aetna** claim form or an American Dental Association (ADA) approved claim form
2. Before treating you, your **dental provider** should send the form to us
3. We may request supporting images and other dental records.
4. Once all of the information has been gathered, we will review the proposed treatment plan and provide you and your **dental provider** with a statement outlining the benefits payable
5. You and your **dental provider** can then decide how to proceed

What is a course of dental treatment?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more **dental providers** to treat a dental condition. The dental condition is diagnosed by your **dental provider** after they have examined you. A course of treatment begins on the date your **dental provider** starts to correct or treat the dental condition.

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, except to the extent coverage is specifically provided in the *Eligible health services and exclusions* 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 above and in the *Eligible health services and exclusions – 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 and exclusions – 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**

6. Specific conditions

Abortion

Eligible health services include services provided and supplies used in connection with an abortion. An abortion is also covered when the pregnancy is the result of rape or incest, or if it places the woman's life in serious danger.

Birthing center

Eligible health services include prenatal and postpartum care and obstetrical services from your **provider.** After your child is born, **eligible health services** include:

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery

Eligible health services also include charges made by:

- An operating **health professional** for:
  - Delivery
  - Pre- and post-natal care
  - Administration of an anesthetic
- A **physician** for administering an anesthetic (other than a local anesthetic)

A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care.

Diabetic services and supplies and education

Eligible health services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Diabetic needles, syringes and pens
  - Test strips for blood glucose, ketone and urine monitoring, including visually readable strips
  - Injection aids
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Glucagon emergency kits
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Training
  - Self-management training provided by a health care **provider** certified in diabetes self-management training

This coverage is for the treatment of insulin dependent (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy. See the *Outpatient prescription drugs* section for diabetic supplies that you can get at a **pharmacy**.

Temporomandibular joint dysfunction treatment (TMJ)

Eligible health services include:

- Diagnostic or therapeutic services including treatment of associated myofascial pain
- Medical and dental surgical treatment
- Medical and dental non-surgical treatment including prosthesis placed directly on the teeth for **TMJ** by a **provider.**

The following are not covered under this benefit:

- Dental implants

Impacted wisdom teeth

Eligible health services include the services and supplies of a **dental provider** for the removal of one or more impacted wisdom teeth.

Accidental injury to sound natural teeth

Eligible health services include the services and supplies of a **dental provider** to treat an **injury** to **sound natural teeth**.

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

Eligible health services include the diagnosis and treatment of skin disorders by a **health professional.**

The following are not covered under this benefit:

- Acne treatment
- **Cosmetic** treatment and procedures

Maternity care

Eligible health services include:

- Prenatal and postpartum care
- Obstetrical services
- Low-risk delivery in a home setting as determined by a **health professional**
- Complications of pregnancy
- Services and supplies needed for circumcision by a **provider**

After your child is born, **eligible health services** include:

- A minimum of 48 hours of inpatient care in a hospital after a vaginal delivery
- A minimum of 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **health professional**, with the consent of the mother, discharges the mother or newborn earlier

Coverage for a newborn child will be the same as child's mother for no less than 21 days.

Gender affirming treatment

Eligible health services include certain services and supplies for gender affirming treatment.

Eligible health services include:

- The surgical procedure
- **Health professional** pre-operative and post-operative **hospital** and office visits
- Inpatient and outpatient services (including outpatient surgery)
- **Skilled nursing facility** care
- Administration of anesthetics
- Outpatient diagnostic testing, lab work and radiological services
- Blood transfusions and the cost of un-replaced blood and blood products as well as the collection, processing and storage of self-donated blood after the surgery has been scheduled
- Gender affirming counseling by a **behavioral health provider**
- Injectable and non-injectable hormone replacement therapy

The following are not covered under this benefit:

- **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:
  - 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

Important note:
Visit https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html for detailed information about this benefit, including eligibility and **medical necessity** requirements. You can also call at the toll-free number in the *How to contact us for help* section.

Autism spectrum disorder

Autism Spectrum Disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

Eligible health services include the services and supplies provided by a **health professional** for the diagnosis, testing and treatment of autism spectrum disorders. We will only cover this treatment if a **health professional** orders it as part of a treatment plan.

We will cover certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior
- That are responsible for observable improvements in behavior

Important note: Applied behavioral analysis requires **precertification** by **Aetna.** The network **provider** is responsible for obtaining **precertification**. You are responsible for making sure that **precertification** is obtained if you are using an **out-of-network provider**. **Precertification** can be requested by either you or your **out-of-network provider**.

Behavioral health

Mental health treatment

Eligible health services include the treatment of **mental health disorders** provided by or in a **hospital**, **psychiatric hospital**, **residential treatment facility**, a home setting, or **health professional** as follows:

- **Inpatient room and board** at the **semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Other services and supplies related to your condition that are provided during your **stay** in a general medical **hospital**, **psychiatric hospital**, or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultations or **store and forward technology**)
  - Other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**, other **health professional** or **behavioral health provider**
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**, other **health professional** or **behavioral health provider**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are **homebound**
      - Your **health professional** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - Observation
    - Peer counseling support by a peer support specialist (including **telemedicine** consultation or **store and forward technology**)

Substance related disorders treatment

Eligible health services include the treatment of **substance related disorders** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility**, approved treatment program (certified by the Department of Social and Health Services), or in a home setting, or by a **health professional** as follows:

- **Inpatient room and board** at the **semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Other services and supplies that are provided during your **stay** in **hospital**, **psychiatric hospital** or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
  - Office visits to a **provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultations or **store and forward technology**)
  - Other outpatient **substance related disorders** treatment such as:
    - Outpatient **detoxification**
    - Partial hospitalization treatment provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**, other **health professional** or **behavioral health provider**
    - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**, other **health professional** or **behavioral health provider**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are **homebound**
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness**, or disease
    - Ambulatory **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Peer counseling support by a peer support specialist (including **telemedicine** consultation or **store and forward technology**)

Behavioral health important note:
A peer support specialist serves as a role model, mentor, coach, and advocate. A peer support specialist must be supervised by a **behavioral health provider**.

Telemedicine important note:
Your **student policy** covers **telemedicine** or **store and forward technology** for **mental health disorders** and **substance related disorders**. All in-person **physician** or **behavioral health provider** office visits that are **covered benefits** are also covered if you use **telemedicine** or **store and forward technology** provided by a **physician** or **behavioral health provider** instead.

Reconstructive surgery and supplies

Eligible health services include all stages of reconstructive **surgery** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it even with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema and prostheses.

- Your **surgery** corrects an accidental **injury**. The **surgery** must be performed as soon as medically feasible. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected. **Surgery** to fix teeth injured due to an accident is covered when:
  - Teeth are sound natural teeth. This means the teeth were stable, functional and free from decay or disease at the time of the **injury**.
  - The **surgery** returns the injured teeth to how they functioned before the accident.
- Your **surgery** is needed to improve a significant functional impairment of a body part.
- Your **surgery** corrects a gross anatomical defect present at birth or appearing after birth (but not the result of an **illness** or **injury**). The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part.
  - The purpose of the **surgery** is to improve function.

Transplant services

Eligible health services include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types:

- Solid organ
- Artificial organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy for FDA-approved treatments
- Thymus tissue for FDA-approved treatments
- Cornea or cartilage transplants
  - Cornea (corneal graft with amniotic membrane)
  - Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as **Institutes of Excellence™ (IOE) facilities** in your **provider directory**.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the **IOE facility** we designate to perform the transplant you need. Transplant services received from an **IOE facility** are subject to the in-network **copayment**, **coinsurance**, **policy year deductible**, maximum out-of-pocket and limits, unless stated differently in this certificate and the schedule of benefits. You may also get transplant services at a non-IOE facility, but your cost share will be higher. Transplant services received from a non-IOE facility are subject to the out-of-network **copayment**, **coinsurance**, **policy year deductible**, maximum out-of-pocket and limits, unless stated differently in this certificate and the schedule of benefits.

Important note:
If there are no **IOE facilities** assigned to perform your transplant type in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your transplant services at the facility we designate your cost share will be higher.

Many pre and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. If your transplant care is being coordinated by the National Medical Excellence Program® (NME), all medical services must be managed through the NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the **eligible health service** is not directly related to your transplant.

Travel and lodging expenses
If a patient lives 100 or more miles from the **facility, eligible health services** include travel and lodging expenses for the patient and a companion to travel between the patient's home and the **facility**. **Eligible health services** will be reimbursed by the plan and include coach class round-trip air, train, or bus travel and lodging costs.

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**

Infertility services

Basic infertility

Eligible health services include seeing a network **provider**:

- To diagnose and evaluate the underlying medical cause of infertility.
- To do **surgery** to treat the underlying medical cause of infertility. Examples are endometriosis **surgery** or, for men, varicocele **surgery.**
- For artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination

See the *Eligible health services and exclusions-Outpatient prescription drugs* section for information on coverage of infertility **prescription drugs**.

Infertility services exclusions

The following are not covered under the infertility services benefit:

- Infertility medication. See the *Eligible health services and exclusions-Outpatient prescription drugs* section for information on coverage of infertility **prescription drugs**.
- 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.
- 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.

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Eligible health services include complex imaging services by a **provider**, including:

- Ultrasound imaging
- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans

Diagnostic lab work and radiological services

Eligible health services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests. See *Diagnostic complex imaging services* section above for more information.

Genetic and prenatal testing

Eligible health services include:

- Genetic testing to establish a molecular diagnosis of an inheritable disease, including:
  - One test per lifetime by a **health professional** or lab
  - One test per lifetime by a genetic counselor to read the test results and provide treatment options
- Prenatal testing of a fetus, including screenings and other diagnostic tests, if they are performed:
  - When you are pregnant, to detect congenital or inherited disorders of the fetus
  - By a **hospital**, diagnostic lab facility or **health professional**

Outpatient therapies

Chemotherapy

Eligible health services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**. **Covered benefits** for chemotherapy include anti-nausea **prescription drugs**.

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

Eligible health services include GCIT provided by a **physician**, **hospital** or other **provider**.

Key Terms

Here are some key terms we use in this section. These will help you better understand GCIT.

Gene

A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Molecular

Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Therapeutic

Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. We call these "GCIT services."

Eligible health services for GCIT include:

- Cellular immunotherapies.
- Genetically modified viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for treatment of certain conditions.
- All human gene therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza® (Nusinersen).
  - siRNA.
  - mRNA.
  - microRNA therapies.

Facilities/providers for gene-based, cellular and other innovative therapies
We designate facilities to provide GCIT services or procedures. GCIT **physicians**, **hospitals** and other **providers** are GCIT-designated facilities/**providers** for **Aetna** and CVS Health.

Important note:
You must get GCIT **eligible health services** from a GCIT-designated facility/**provider**. If there are no GCIT-designated facilities/**providers** assigned in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your GCIT services at the facility/**provider** we designate, they will not be **eligible health services**.

Important note:
You must get GCIT **eligible health services** from a GCIT-designated facility/**provider**. If there are no GCIT-designated facilities/**providers** assigned in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your GCIT services at the facility/**provider** we designate, they will not be **eligible health services**.

The following are not **eligible health 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

Outpatient infusion therapy

Eligible health services include infusion therapy you receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a **hospital**
- A **health professional** in their office
- A home care **provider** in your home

See the *How to contact us for help* section to learn how you can access the list of preferred infusion locations.

Infusion therapy is the administration of prescribed medications or solutions through an IV.
Certain infused medications may be covered under the outpatient **prescription drug** section. You can access the list of **specialty prescription drugs.** See the *How to contact us for help* section to determine if coverage is under the outpatient **prescription drug** section or this section.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care limits.

The following are not covered under this benefit:

- Enteral nutrition
- Blood transfusions and blood products

Outpatient radiation therapy

Eligible health services include the following radiology services provided by a **health professional**:

- Radiological services
- Gamma ray
- Accelerated particles
- Mesons
- Neutrons
- Radium
- Radioactive isotopes

Specialty prescription drugs

Eligible health services include **specialty prescription drugs** when they are:

- Purchased by your **provider**
- Injected or infused by your **provider** in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a **hospital**
  - A **health professional** in the office
  - A home care **provider** in your home
- Listed on our **specialty prescription drug** list as covered under this certificate of coverage

You can access the list of **specialty prescription drugs.** See the *How to contact us for help* section to determine if coverage is under the outpatient **prescription drug** section or this section.

Certain infused medications may be covered under the outpatient **prescription drug** section. You can access the list of **specialty prescription drugs.** See the *How to contact us for help* section to determine if coverage is under the outpatient **prescription drug** section or this section.

When injectable or infused services and supplies are provided in your home, they will not count toward any applicable home health care limits.

Outpatient respiratory therapy

Eligible health services include outpatient respiratory therapy services you receive at a **hospital, skilled nursing facility** or **health professional's** office but only if those services are part of a treatment plan determined by your risk level and ordered by your **health professional**.

Transfusion or kidney dialysis of blood

Eligible health services include services and supplies for the transfusion or kidney dialysis of blood. **Covered benefits** include:

- Whole blood
- Blood components
- The administration of whole blood and blood components

Cardiac and pulmonary rehabilitation services

Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation

Eligible health services include cardiac rehabilitation services you receive at a **hospital, skilled nursing facility** or **health professional's** office, but only if those services are part of a treatment plan determined by your risk level and ordered by your **health professional**.

Pulmonary rehabilitation

Eligible health services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if it is part of a treatment plan ordered by your **health professional**.

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it's:

- Performed at a **hospital, skilled nursing** facility or **health professional's** office
- Used to treat reversible pulmonary disease states
- Part of a treatment plan ordered by your **health professional**

Rehabilitation and habilitation and neurodevelopmental therapy

Rehabilitation therapy services

Rehabilitation therapy services are services needed to restore or develop your skills and functioning for daily living.

Eligible health services include rehabilitation therapy services your **health professional** prescribes. The services have to be provided by a:

- Licensed or certified physical, occupational or speech therapist
- **Hospital**, **skilled nursing facility**, or **hospice facility**
- **Home health care agency**
- **Physician** or other appropriate **health professional**

Rehabilitation therapy services have to follow a specific treatment plan, ordered by your **health professional**.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute **illness**, **injury** or **surgical procedure**

- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness**, **injury** or **surgical procedure** or
  - Relearn skills so you can significantly regain your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to:
  - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute **illness, injury** or **surgical procedure**
  - Improve delays in speech function development caused by a gross anatomical defect present at birth

  Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive rehabilitation therapy associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

Your therapy should include an ongoing, written plan of care from your **health professional**. This plan of care should include specific short-term and long-term goals. These goals allow your improvement to be measured in an objective way. Therefore, when we say "significantly improve" in this section, we mean that the goals in your plan of care are expected to result in clinically significant improvement.

Habilitation therapy services

Habilitation therapy services are services needed to keep, learn, or improve your skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).

Eligible health services include habilitation therapy services your **health professional** prescribes. The services have to be performed by a:

- Licensed or certified physical, occupational or speech therapist
- **Hospital**, **skilled nursing facility**, or **hospice facility**
- **Home health care agency**
- **Physician** or other appropriate **health professional**

Habilitation therapy services have to follow a specific treatment plan, ordered by your **health professional**.

Outpatient aural, physical, occupational, and speech habilitation therapy

Eligible health services include:

- Aural therapy, including cochlear implants.
- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function.
- Occupational therapy (except for vocational rehabilitation or employment counseling or services provided in an educational or training setting), if it is expected to develop any impaired function.
- Speech therapy (except for services provided in an educational or training setting or to teach sign language), provided the therapy is expected to develop speech function as a result of delayed development. Speech function is the ability to express thoughts, speak words and form sentences.

Neurodevelopmental therapy services

Eligible health services include rehabilitative and habilitative speech, physical or occupational therapy, but only if it is expected to:

- Restore or improve speech or a body function
- Develop speech or a body function that was lost or delayed because of an illness or because of a condition you had when you were born
- Maintain speech or a body function that would get worse because of an illness or because of a condition you had when you were born

Chiropractic services

Eligible health services include chiropractic services to correct a muscular or skeletal problem.

Your **provider** must establish or approve a treatment plan that details the treatment, and specifies frequency and duration.

Diagnostic testing for learning disabilities

Eligible health services include diagnostic testing for:

- Attention deficit disorder
- Attention deficit hyperactive disorder
- Dyslexia

Once you are diagnosed with one of these conditions, the treatment is covered under the Mental health treatment section.

8. Other services

Acupuncture

Eligible health services include acupuncture. The service performed must be within the scope of an East Asian Medicine Practitioner's license, as regulated by Washington state law.

Administration of blood and blood products

Eligible health services include the administration and costs of blood, blood storage, blood products and blood banks.

Ambulance service

An ambulance is a vehicle staffed by medical personnel and is equipped to transport an ill or injured person by ground, air, or water.

Emergency

Eligible health services include emergency transportation when your condition is unstable and requires medical supervision and rapid transport. These emergency ambulance services are limited to transportation by a licensed ambulance.

- To the first facility, including a behavioral health emergency **provider**, to provide **emergency services**
- From one facility to another facility if the first can't provide the **emergency services** you need

Non-emergency

Eligible health services also include non-emergency transportation when an ambulance is the only safe way to transport you. These non-emergency ambulance services are limited to transportation by a licensed ambulance:

- To the nearest facility, including a behavioral health emergency **provider**, able to treat your condition
- From a facility to your home by ground ambulance

The following is not an **eligible health service**:

- Ambulance services for routine transportation to receive outpatient or inpatient care

Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred by you from a **provider** in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. Life-threatening disease or condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

An approved clinical trial must satisfy one of the following:

- Federally funded trials:
  - The study or investigation is approved or funded by one or more of the following:
    - The National Institutes of Health (NIH)
    - An NIH cooperative group or center (a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program)
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs
    - The Department of Defense
    - An institutional review board of a Washington institution that has a multiple project contract approval by the Office of Protection for the Research Risks of the NIH

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 without charge to you
- The experimental item, device, or service itself
- Services and supplies that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

Durable medical equipment (DME)

Eligible health services include the expense of renting or buying **DME**, including sales tax, and accessories you need to operate the item from a **DME** supplier. Your plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase **DME**, that purchase is only eligible for coverage if you need it for long-term use.

Coverage includes:

- One item of **DME** for the same or similar purpose.
- Repairing **DME** due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new **DME** item you need because your physical condition has changed. It also covers buying a new **DME** item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.
- The fitting and adjustment of such **DME** items.

We:

- Assume no responsibility
- Make no express or implied warranties

concerning the outcome of any covered **DME** items.

We reserve the right to limit the payment of charges up to the most cost-efficient and least restrictive level of service or item that can be safely and effectively provided. It is our decision whether to rent or purchase the **DME** item.

Coverage is limited to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment that you purchase or rent for personal convenience or mobility.

Your plan only covers the same type of **DME** that **Medicare** covers. But there are some **DME** items **Medicare** covers that your plan does not.

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

Eligible health services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria, an inherited disease of amino and organic acids or eosinophilic gastrointestinal disorder.

For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **health professional** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

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 described above

Experimental or investigational therapies

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** only when you have cancer or **terminal illness** and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- Published, peer-reviewed scientific evidence that you may benefit from the treatment.
- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The study is approved by an Institutional Review Board that will oversee the investigation.
- The study is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The study conforms to standards of the NCI or other, applicable federal organization.
- The study takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Prosthetic devices

Eligible health services include the initial provision and subsequent replacement of a prosthetic device that your **health professional** orders and administers.

Prosthetic device means:

- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of **illness** or **injury** or congenital defects

Coverage includes:

- The prosthetic device, including braces, splints, prostheses, orthopedic appliances and orthotic devices and supplies
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- The fitting, instruction and other services (such as attachment or insertion) so you can properly use the device

The following are 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

Eligible health services include prescribed hearing aids and hearing aid services as described below.

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid impaired human hearing
- Parts, attachments, or accessories

Hearing aid services are:

- Audiometric hearing exam and evaluation for a hearing aid **prescription** performed by:
  - A **physician** certified as an otolaryngologist or otologist
  - An audiologist who is legally qualified in audiology, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select and adjust or fit a hearing aid

Hearing aids alternate treatment rule

Sometimes there are several types of hearing aids that can be used to treat a medical condition, all of which provide acceptable results. When alternate hearing aids can be used, the plan's coverage may be limited to the cost of the least expensive device that is:

- Customarily used nationwide for treatment
- Deemed by the medical profession to be appropriate for treatment of the condition in question. The device must meet broadly accepted standards of medical practice for your physical condition.

You should review the differences in the cost of alternate treatment with your **health professional**. Of course, you and your **health professional** can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover for hearing aids.

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

Hearing exams

Eligible health services include hearing exams for evaluation and treatment of **illness**, **injury** or hearing loss when performed by a hearing **specialist**.

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**

Podiatric (foot care) treatment

Eligible health services include non-routine foot care for the treatment of **illness** or **injury** of the feet by **a health professional**.

Non-routine treatment means:

- It would be hazardous for you if someone other than a **health professional** provided the care
- You have an **illness** that makes the non-routine treatment essential
- The treatment is routine foot care but it's part of an **eligible health service** (e.g., debriding of a nail to expose a subungual ulcer, or treatment of warts)
- The treatment you need might cause you to have a change in your ability to walk.

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

Telemedicine

Eligible health services include **telemedicine** consultations and **store and forward technology** when provided by a **health professional** or other **telemedicine provider** acting within the scope of their license.

Eligible health services for **telemedicine** consultations and **store and forward technology** are available from a number of different kinds of **providers** under your plan. Log in to your **Aetna** website at https://www.aetnastudenthealth.com to review our **telemedicine provider** listing. Contact us to get more information about your options, including specific cost sharing amounts.

Vision care - Pediatric vision care

Eligible health services include a routine vision screening. See the *Preventive care and wellness – Routine physical exams* section of the schedule for more information.

Comprehensive vision exams

Eligible health services include a comprehensive vision exam provided by an ophthalmologist or optometrist. The exam will include refraction, dilation and glaucoma testing.

Low vision evaluations and services

Eligible health services include a low vision evaluation provided by an ophthalmologist or optometrist, including optical devices, services, training and instructions.

Vision care supplies

We provide vision eyewear coverage that can help pay for **prescription** eyeglasses or **prescription** contact lenses. You have access to an extensive network of vision locations. The vision eyewear coverage is automatically available only from network vision locations. When making your appointment, confirm your **provider** is a network vision location for pediatric vision services. If it is not a network vision location, you will have to pay for the eyewear and submit a claim form for reimbursement. If you have questions, see the *How to contact us for help* section.

Eligible health services include:

- Office visits to an ophthalmologist or optometrist related to the fitting of **prescription** contact lenses
- Eyeglass frames, **prescription** lenses or **prescription** contact lenses

In any one 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:

- 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

9. Outpatient prescription drugs

Your prescription drug rights

You have the right to safe and effective pharmacy services. You also have the right to know what drugs are covered by your plan and the limits that apply. If you have a question or concern about your **prescription drug** benefit, please contact us by calling the number on your ID card or visit https://www.aetnastudenthealth.com. If you would like to know more about your rights, or if you have concerns about your plan, you may contact the Washington state Office of the Insurance Commissioner at 800-562-6900 or www.insurance.wa.gov. If you have a concern about the pharmacists or **pharmacies** serving you, please contact the Washington state department of health at 360-236-4700, www.doh.wa.gov, or HSQACSC@doh.wa.gov.

What you need to know about your outpatient prescription drug covered benefits
Read this section carefully so that you know:

- How to access **network pharmacies**
- How the **drug guide** works
- **Eligible health services** under your plan
- Other services
- How you get an emergency **prescription** filled
- Where your schedule of benefits fits in
- What **precertification** requirements apply
- How can I request a medical exception
- Prescribing units

Some **prescription drug**s may not be covered or coverage may be limited. This may happen because:

- A **prescription drug** is not included on the **drug guide**. See the *How the drug guide works* section. The **drug guide** may change at any time. A copy of the **drug guide** is available at your request. Or you can find it on the **Aetna** website at https://www.aetnastudenthealth.com.
- A **prescription drug** is a therapeutic alternative to a **prescription drug** on the **drug guide**, but you do not have an approved medical exception. See the *How can I request a medical exception?* section.
- Precertification or **step therapy** is required. See the *What precertification requirements apply* section.

This does not keep you from getting **prescription drug**s that are not **covered benefits**. You can still fill your **prescription**, but you have to pay for it yourself. For more information see the schedule of benefits.

A **pharmacy** may refuse to fill a **prescription** order or refill when in the professional judgment of the pharmacist the **prescription** should not be filled.
Your plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication's U.S. Food and Drug Administration (FDA) approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

The **pharmacy** may substitute a **generic prescription drug** for a **brand-name prescription drug**. Your cost share may be less if you use a generic drug when it is available.

Any **prescription drug** made to work beyond one month shall require the **copayment** amount that equals the expected duration of the medication.

How to access network pharmacies

You can find a **network pharmacy** online or by phone. See the *How to contact us for help* section for details. The **network pharmacy** will submit your claim. You will pay any cost sharing directly to the **network pharmacy**.

How the drug guide works

Your outpatient **prescription drug** plan is based on the drugs in the **drug guide**. The **drug guide** includes both **brand-name prescription drugs** and **generic prescription drugs**. Your pharmacist may substitute **generic prescription drugs** for **brand-name prescription drugs**. Your out-of-pocket costs may be less if you use a **generic prescription drug** when available. You can call us at the number on your ID card or log on to your Aetna member website at https://www.aetnastudenthealth.com to see if a **prescription drug** that is not listed on the **drug guide** is covered.

The **drug guide** contains **prescription drugs** that have been reviewed by **Aetna**'s Pharmacy and Therapeutics Committee. This Committee:

- Reviews the entire **drug guide** at least annually
- Meets regularly to review new drugs and new information about drugs that already are in the marketplace
- Reviews available information concerning safety, effectiveness, and current use in therapy
- Reviews information from a variety of sources, including peer reviewed journals and databases, and information from medical professional associations, national commissions, and federal government agencies

Using this information, the Committee evaluates the therapeutic effectiveness of new **prescription drugs** and places them into one of six categories:

- **Category 1:** Provides effective therapy for a disease not adequately treated by any marketed drug, or improved effectiveness or safety
- **Category 2:** Therapeutically similar to other available products, and clinical differences are not significant
- **Category 2+:** Therapeutically similar to other available products, but has clinical advantages (clinical efficacy, adverse effects, drug interactions, etc.)
- **Category 2-:** Therapeutically similar to other available products, but has clinical disadvantages (clinical efficacy, adverse effects, drug interactions, etc.)
- **Category 3:** Not appropriate for the **drug guide**, usually because of significant disadvantages
- **Category 4:** May have an important role for certain patient populations, or as a second- or third-line alternative

We will make a decision to include or not include **prescription drugs** on the **drug guide** based on these categories. For **prescription drugs** that are therapeutically similar, we also consider the cost and effectiveness, and any new or changing regulations.

It is important to review the **drug guide** often. The **drug guide** may change at any time. We may add or remove **prescription drugs**. Or a **prescription drug** may move to a different tier, which may affect the amount you have to pay. This may happen because:

- A new **prescription drug** may have received approval
- A **prescription drug** is no longer being prescribed
- A **generic prescription drug** may have become available

If a change in the **drug guide** affects a **prescription drug** you are taking, you or your **provider** should contact us. See the *How can I request a medical exception?* section.

A copy of the **drug guide** or information about the availability of a specific **prescription drug** may be requested by calling **Aetna** Member Services at the toll-free number on your ID card. Or you can find it on the **Aetna** website at https://www.aetnastudenthealth.com.

We reserve the right to include only one manufacturer's product on the **drug guide** when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more manufacturers.

We reserve the right to include only one dosage or form of a drug on the **drug guide** when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our **drug guide** will be covered at the applicable **copayment** or **coinsurance**.

Eligible health services under your plan

Eligible health services include any **pharmacy** service that meets these three requirements:

- They are listed in the *Eligible health services and exclusions* section
- They are not listed in the *What your plan doesn't cover – general exclusions* section
- They are not beyond any limits in the schedule of benefits

Your pharmacy services are covered when you follow the plan's general rules:

- You need a **prescription** from your **provider**.
- Your drug needs to be **medically necessary**. See the *Medical necessity and precertification requirements* section.
- You need to show your ID card to the **pharmacy** when you get a **prescription** filled.

Prescription drugs covered by this plan are subject to misuse, waste and/or abuse utilization review by us, your **provider** and/or your **network pharmacy**. The outcome of this review may include:

- Limiting coverage of the applicable drug(s) to one prescribing **provider** and/or one **network pharmacy**
- Limiting the quantity, dosage or day supply
- Requiring a partial fill or denial of coverage

Your **provider** may give you a **prescription** in different ways, including:

- Writing out a **prescription** that you then take to a **network pharmacy**
- Calling or e-mailing a **network pharmacy** to order the medication
- Submitting your **prescription** electronically

Once you receive a **prescription** from your **provider**, you may fill the **prescription** at a **network retail**, **mail order** or **specialty pharmacy**.

The **pharmacy** may substitute a **generic prescription drug** for a **brand-name prescription drug**. Your cost share may be less if you use a generic drug when it is available.

Any **prescription drug** made to work beyond one month shall require the **copayment** amount that equals the expected duration of the medication.

Prescription drug synchronization

If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, your **in-network pharmacy** may be able to coordinate that for you. This is called synchronization. We will apply a prorated daily cost share rate to a partial fill of a maintenance drug, if needed, to synchronize your **prescription drugs**.

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 30 day supply of a **prescription drug**. You should show your ID card to the **network pharmacy** every time you get a **prescription** filled.

You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

All **prescriptions** and refills over a 30 day supply must be filled at a network **mail order pharmacy**.

See the schedule of benefits for details on supply limits and cost sharing.

Mail order pharmacy

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. A **mail order pharmacy** may be used for up to a 90 day supply of a **prescription drug**. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a network **mail order pharmacy**.

Prescriptions can be filled at an in-network **mail order pharmacy**.

Specialty pharmacy

Specialty prescription drugs are covered when dispensed through a **network retail** or **specialty pharmacy**.

Specialty prescription drugs typically include high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected ways of giving them. You can access the list of **specialty prescription drugs**. See the *How to contact us for help* section for how.

How to access out-of-network pharmacies

You can directly access an **out-of-network pharmacy** to get covered outpatient **prescription drugs**.
If you use an **out-of-network pharmacy** to obtain outpatient **prescription drugs**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying any applicable out-of-network outpatient **prescription drug deductible**
- Your out-of-network **copayment**
- Your out-of-network **coinsurance**
- Any charges over the **recognized charge**
- Submitting your own claims

How to get an emergency prescription filled

You may not have access to **network pharmacy** in an emergency or urgent situation or when the **network pharmacy** contacts us after business hours for **precertification**, when we can't reach your **provider** for consultation. If you must fill a **prescription** in any of these situations, we will reimburse you as shown in the table below:

Type of pharmacy	Your cost share is
Network pharmacy	The plan cost share
Out-of-network pharmacy	The full cost of the **prescription**

When you pay the full cost of the **prescription** at an **out-of-network pharmacy**:

- You will fill out and send a **prescription drug** refund form to us, including all itemized **pharmacy** receipts.
- Coverage will be limited to items obtained in connection with the out-of-area emergency or urgent situation.
- Submission of the refund form doesn't guarantee a refund. If approved, you will be reimbursed the cost of the **prescription** less your network cost share.

Other covered services

Abortion drugs

Eligible health services include **prescription drugs** used for elective termination of pregnancy.

Anti-cancer drugs taken by mouth

Eligible health services include any drug prescribed for cancer treatment, including chemotherapy drugs. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

Contraceptives (birth control)

Eligible health services include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at a **network pharmacy**. At least one form of each FDA-approved contraception method is an **eligible health service**. Your outpatient **prescription drug** plan also covers related services and supplies needed to administer covered devices. You can access a list of covered drugs and devices. See the *How to contact us for help* section for how.

Covered contraceptives can be filled for a 12 month supply, unless:

- You request a smaller supply
- Your **provider** decides you need a smaller supply

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each method of birth control approved by the FDA at no cost to you. Visit https://www.fda.gov/media/135111/download for more information. Note that not all drugs or devices in each contraceptive method are covered. If a generic drug or device is not available for a certain method, we will cover the **brand-name prescription drug** or device at no cost share.

Preventive contraceptives important note:
You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **eligible health services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review. If the exception is approved, the **brand-name prescription drug** contraceptive will be covered at 100%.

Diabetic supplies

Eligible health services include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid
- Injection devices including insulin syringes, needles and pens
- Continuous glucose monitors
- Insulin infusion disposable pumps
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine monitoring, including visually readable strips

See the *Diabetic services and supplies (including equipment and training)* provision for medical **eligible health services**.

Immunizations
Eligible health services include preventive immunizations as required by the ACA when given by a **network pharmacy**. You can find a participating **network pharmacy** by contacting us. Check with the **pharmacy** before you go to make sure the vaccine you need is in stock. Not all **pharmacies** carry all vaccines.

Off-label use
U.S. Food and Drug Administration (FDA) approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your symptom(s). Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your symptom(s) in one of the following standard compendia:
  - *American Society of Health-System Pharmacists Drug Information* (AHFS Drug Information)
  - *Thomson Micromedex DrugDex System* (DrugDex)
  - *Clinical Pharmacology* (Gold Standard, Inc.)
  - *The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium*
- Use for your symptom(s) is proven as safe and effective by at least one well-designed controlled clinical trial, (i.e., a Phase III or single center controlled trial, also known as Phase II). Such a trial is published in a peer reviewed medical journal known throughout the U.S. and either:
  - The dosage of a drug for your symptom(s) is equal to the dosage for the same symptom(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above.
  - The dosage is proven safe and effective for your symptom(s) by one or more well-designed controlled clinical trials. Such a trial is published in a peer reviewed medical journal.

Health care services related to off-label use of these drugs may be subject to **precertification**, **step therapy** or other requirements or limitations.

Over-the-counter (OTC) drugs
Eligible health services include certain OTC medications when you have a **prescription** from your **provider**, except for FDA-approved over-the-counter contraceptives, which do not require a prescription. You can see a list of covered OTC drugs by logging in to your **Aetna** website.

Preventive care drugs and supplements
Eligible health services include preventive care drugs and supplements, including OTC ones, as required by the ACA when prescribed by a **provider** and the **prescription** is submitted to the pharmacist for processing:

- Aspirin: Available to adults to prevent cardiovascular disease and preeclampsia in women
- Oral fluoride supplements: Available to children whose primary water source is deficient in fluoride
- Folic acid supplements: Available to adult females planning to become pregnant or capable of pregnancy
- Iron supplements: Available to children without symptoms of iron deficiency but who are at an increased risk for iron deficiency anemia
- Vitamin D supplements: Available to adults to promote calcium absorption and bone growth
- Pre-exposure prophylaxis (PrEP) for the prevention of HIV infection for people at high risk of infection

Risk reducing breast cancer prescription drugs
Eligible health services include **prescription drugs** used to treat people who are at:

- Increased risk for breast cancer
- Low risk for medication side effects

Tobacco cessation prescription and OTC drugs
Eligible health services include FDA approved **prescription** and OTC drugs to help stop the use of tobacco products. You must receive a **prescription** from your **provider** and submit the **prescription** to the **pharmacy** for processing.

Outpatient prescription drug exclusions

The following are not **eligible health services**:

- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- **Cosmetic** drugs including medication and preparations used for **cosmetic** purposes (unless **medically necessary** for gender affirming treatment)
- Devices, products and appliances unless listed as an **eligible health service**
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a **prescription** by law, even if a **prescription** is written, except as specifically provided above, or unless 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 an **eligible health 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 except as described in the certificate
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the **covered person** meets one or more clinical criteria detailed in our **precertification** and clinical policies
- Duplicative drug therapy; 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 an **eligible health service**
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
- Infertility:
  - **Prescription drugs** used primarily for the treatment of infertility
- Injectables including:
  - Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by us
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics 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

- **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
  - 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
- 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**

Where your schedule of benefits fits in

You are responsible for paying your part of the cost sharing. The schedule of benefits shows any benefit limitations and any out-of-pocket costs you are responsible for. Keep in mind that you are responsible for costs not covered under this plan.

Your outpatient **prescription drug** costs are based on:

- The type of **prescription drug** you are prescribed
- Where you fill your **prescription**

The plan may, in certain circumstances, make some preferred **brand-name prescription drugs** available to **covered persons** at the **generic prescription drug copayment** level.

What precertification requirements apply

Why do some drugs need precertification?

For certain drugs, you, your **provider** or your pharmacist needs to get approval from us before we will cover the drug. This is called "**precertification**". The requirement for getting approval in advance guides appropriate use of precertified drugs and makes sure they are **medically necessary**. For the most up-to-date information, call us or go online. See the *How to contact us for help* section for details.

Step therapy

There is another type of **precertification** for **prescription drugs**, and that is **step therapy**. **Step therapy** is a type of **precertification** where we require you to first try certain **prescription drugs** to treat your medical condition before we will cover another **prescription drug** for that condition.

You will find the **step therapy prescription drugs** on the **drug guide**. For the most up-to-date information, call us or go online. See the *How to contact us for help* section for details.

How can I request a medical exception?

Sometimes you or your **provider** may ask for a medical exception for prescription drugs that are not covered or for which coverage was denied**.** You, someone who represents you or your **provider** can contact us. You will need to provide us with the required clinical documentation. We will make a coverage determination within 72 hours after we receive your request and any information that supports it. We will tell you and your **provider** of our decision. Any exception granted is based upon an individual and is a case by case decision that will not apply to other **covered persons**. If approved by us, you may receive the non-preferred benefit level and the exception will apply for the entire time of the **prescription**.

For directions on how you can submit a request for a review:

- Contact Member Services at the toll-free number 1-877-480-4161
- Go online at https://www.aetnastudenthealth.com
- Submit the request in writing to CVS Health ATTN: **Aetna** PA, 1300 E Campbell Road Richardson, TX 75081

You, someone who represents you, or your **provider** may seek a quicker medical exception when the situation is urgent. It's an urgent situation when you have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug.

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your **provider** of our decision. If approved by us, the exception will apply for the entire time you have an urgent situation.

If you are denied a medical exception based on the above processes, you may have the right to a third party review by an independent external review organization. If our claim decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send you. That notice also will describe the external review process. We will tell you, someone who represents you or your **provider** of the coverage determination of the external review no later than 72 hours after we receive your request. If the medical exception is approved, coverage will be provided for the entire time of the **prescription**. For quicker medical exceptions in urgent situations, we will tell you, someone who represents you or your **provider** of the coverage determination no later than 24 hours after we receive your request. If the quicker medical exception is approved, coverage will be provided for the entire time you have an urgent situation.

Prescribing units

Some **prescription drugs** are subject to quantity limits. These quantity limits help your **provider** and pharmacist check that your **prescription drug** is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these quantity limits.

Any **prescription drug** that is made to work beyond one month shall require the number of **copayments** per **prescription** that is equal to the anticipated duration of the medication. For example, one injection of a drug that works for three months would require three **copayments**.

Specialty prescription drugs may have limited access or distribution and are limited to no more than a 30 day supply.

What your plan doesn't cover – general exclusions

In this section we tell you about the general exclusions that apply to your plan. And just a reminder, you'll find benefit and coverage limitations in the schedule of benefits.

General exclusions

The following are not **eligible health services** under your plan except as described in:

- The *Eligible health services and exclusions* section of this certificate of coverage or
- A rider or amendment issued to you for use with this certificate of coverage

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:
  - 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

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, 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
- 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 service that can be 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 except when part of an approved treatment plan for an **eligible health service** described in the *Eligible health services and exclusions – Reconstructive surgery and supplies* section.

  This exclusion 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 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 include examinations to get or keep a job, and examinations required under a labor agreement or other contract
- 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 or investigational** drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (**experimental or investigational**) or covered under clinical trials (routine patient costs). See the *Eligible health services and exclusions – Other services* section.

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 benefits** for treatment of **TMJ** as described in the *Eligible health services and exclusions –Temporomandibular joint dysfunction (TMJ) treatment* 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 and services

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, step-child, 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** 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, 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

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:
  - Faxes
  - 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:
  - Faxes
  - 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

- 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 as specifically provided in the *Eligible health services and exclusions – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Eligible health services and exclusions – Outpatient prescription drugs* section
  - Nicotine patches
  - Gum

Treatment in a federal, state, or governmental entity

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

Vision care for adults

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

Voluntary sterilization

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

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.

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.

Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible health services**, the foundation for getting covered care is the network. This section tells you about network and **out-of-network providers**. This section also tells you about the role of **school health services**.

School health services

School health services can give you some of the care that you need. Contact them first before seeking care from other **providers**.

In-network providers

We have contracted with **providers** to provide **eligible health services** to you. These **providers** make up the network for your plan. For you to receive the in-network level of benefits you must use **in-network providers** for **eligible health services**. There are some exceptions:

- **Emergency services** and urgent care – refer to the description of **emergency services** and urgent care in the *Eligible health services and exclusions* section
- Transplants – see the description of transplant services in the *Eligible health services and exclusions – Specific conditions* section

You may select an **in-network provider** from the **directory** through your **Aetna** website at https://www.aetnastudenthealth.com. You can search our online **directory** for names and locations of **providers**.

You will not have to submit claims for treatment received from **in-network providers**. Your **in-network provider** will take care of that for you. And we will directly pay the **in-network provider** for what the plan owes.

Out-of-network providers

You also have access to **out-of-network providers.** This means you can receive **eligible health services** from an **out-of-network provider.** If you use an **out-of-network provider** to receive **eligible health services**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network **policy year deductible**
- Your out-of-network **coinsurance**
- Any charges over our **recognized charge**
- Submitting your own claims
- Ensuring **precertification** is obtained by either you or your **out-of-network provider**

Keeping a provider you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the network
- You are already covered under another **Aetna** plan and your **provider** stops being in our network

But in some cases, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

If this situation applies to you, contact us for details. If you are undergoing treatment for an acute or chronic condition and your **provider** didn't leave the network based on fraud or lack of quality standards, you'll be able to receive transitional care from your **provider** for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

If you are pregnant and in your second trimester, transitional care will be through the time required for postpartum care directly related to the delivery.

You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.

What the plan pays and what you pay

Who pays for your **eligible health services** – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your **policy year deductible**
- Your **copayments**
- Your **coinsurance**
- Your **maximum out-of-pocket limit**

We also remind you that sometimes you will be responsible for paying the entire bill – for example, if you get care that is not an **eligible health service**.

The general rule

The schedule of benefits lists how much the plan pays and how much you pay for each type of health care service. In general, when you get **eligible health services**:

- You pay for the entire expense up to any **policy year deductible** limit

And then

- The plan and you share the expense up to any **maximum out-of-pocket limit**. Your share is called a **copayment** or **coinsurance**.

And then

- The plan pays the entire expense after you reach your **maximum out-of-pocket limit**

When we say "expense" in this general rule, we mean **negotiated charge** for a **network provider**, and **recognized charge** for an **out-of-network provider**. If your **provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. The **recognized charge** is the maximum amount **Aetna** will pay for a covered expense. See the *Glossary* section for what these terms mean.

See the schedule of benefits for any exceptions to this general rule.

Important note – when your plan pays all

Your plan pays the entire expense for all in-network **eligible health services** under the *Preventive care and wellness* benefit.

Important note – when you pay all

You pay the entire expense for an **eligible health service**:

- When you get a health care service or supply that is not **medically necessary.** See the *Medical necessity and precertification requirements* section.

- When your plan requires **precertification**, it was requested, and we refused it, or you get an **eligible health service** without **precertification**. See the *Medical necessity and precertification requirements* section.

In all these cases, the **provider** may require you to pay the entire charge. Any amount you pay will not count towards your **policy year deductible** or towards your **maximum out-of-pocket limit**.

One more important exception – when you go to the emergency room

When you have to visit an emergency room for **emergency services**, the general rule described earlier doesn't apply.

Instead:

- You pay your initial share, a **copayment**, for each visit. The **copayment** amount is shown in the schedule of benefits.

And then

- If you haven't satisfied your **policy year deductible**, you pay any remaining expense for the visit, up to the amount of your **policy year deductible**.

And then

- Once the **policy year deductible** has been satisfied, the plan and you share the remaining expense up to any **maximum out-of-pocket limit**. The schedule of benefits lists what percentage of this remaining amount your plan pays. Your share is called **coinsurance**.

And then

- The plan pays any remaining expense after you reach your **maximum out-of-pocket limit**.

As with the general rule, when we say "expense" we mean the **negotiated charge** for an **in-network provider**, and **recognized charge** for an **out-of-network provider**.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the **negotiated charge**
- Standby charges made by a **physician**

Where your schedule of benefits fits in

The schedule of benefits shows any benefit limitations that apply to your plan. It also shows any out-of-pocket costs you are responsible for when you receive **eligible health services**. And any **maximum out-of-pocket limits** that apply.

Limitations include things like maximum age, visits, days, hours, admissions and other limits. Out-of-pocket costs include things like **policy year deductibles**, **copayments** and **coinsurance**.

Keep in mind that you are responsible for paying your part of the cost sharing. You are also responsible for costs not covered under this plan.

When you disagree - claim decisions and appeals procedures

In the previous section, we explained how you and we share responsibility for paying for your **eligible health services**.

When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

These procedures apply to claims involving **out-of-network providers**.

Submit a claim

- You should notify and request a claim form from us
- The claim form will provide instructions on how to complete and where to send the form
- If you are unable to complete a claim form, you may send us:
  - A description of services
  - A bill of charges
  - Any medical documentation you received from your **provider**

Proof of loss (claim)

- When you have received a service from an eligible provider, you will be charged. The information you receive for that service is your proof of loss
- Complete a claim form and any additional information required by us
- You or your **provider** must send us notice and proof within 12 months of the date you received services, unless you are legally unable to notify us or within 3 years if we are acting as a third party to your Medicaid coverage

Benefit payment

- Written proof must be provided for all benefits
- If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss
- Benefits will be paid as soon as the necessary proof to support the claim is received

Types of claims and communicating our claim decisions

You or your **provider** will send us a claim. Completed claim forms must be received by us as soon as reasonably possible. We will review that claim for payment to the **provider** or to you as appropriate.

You can request a claim form from us. See the *How to contact us for help* section for details on how to reach us. We will provide a claim form to you within 15 days of your request

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim

An urgent claim is one for which the **provider** treating you decides that a delay in getting medical care, could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim
A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them.

Post-service claim
A post service claim is a claim that involves health care services you have already received.

Concurrent care claim extension
A concurrent care claim extension occurs when you ask us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**.

Concurrent care claim reduction or termination
A concurrent care claim reduction or termination occurs when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization.

During this continuation period, you are still responsible for your share of the costs, such as **copayments**, **coinsurance** and **policy year deductibles** that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows the different types of claims and how much time we have to tell you about our decision.

We may need to tell your **health professional** about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the **hospital.**

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial decision by us	48 hours	5 days	30 calendar days	No later than 24 hours for urgent request* (or 72 hours if clinical information is required and received more than 24 hours after request) and 5 days for non-urgent request
Extensions	Not applicable	within 5 calendar days	15 calendar days	
If we request more information	24 hours	5 calendar days	15 calendar days	
Time you have to send us additional information	48 hours	45 calendar days	45 calendar days	

Important note for concurrent care urgent requests:
We have to receive the request at least 24 hours before the previously approved health care services end.

Adverse benefit determinations
We pay many claims at the full rate **negotiated charge** with a **network provider** and the **recognized charge** with an **out-of-network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an “adverse benefit determination” or “adverse decision”. It is also an “adverse benefit determination” if we rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

If we make an adverse benefit determination, we will tell you in writing.

The difference between a grievance and an appeal

A grievance

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call Member Services at the toll-free number in the *How to contact us for help* section or write us. Your grievance should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the grievance**.** We will let you know if we need more information to make a decision.

An appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us verbally or in writing.

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination. Or you can call us at the toll-free number in the *How to contact us for help* section. You need to include:

- Your name
- The **policyholder's** name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by calling us at the toll-free number in the *How to contact us for help* section. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

Important note: For language assistance, call us at the number on your ID card TTY:711 or visit: www.aetna.com/individuals-families/contact-aetna/information-in-other-languages.html. The hearing and speech impaired may call our toll-free TDD (Telecommunications Device for the Deaf) telephone number 1-800-628-3323. To serve visually impaired enrollees, Aetna's Voice Advantage is an automated, speech recognition system that is available 24 hours a day, 7 days a week. The content of materials may be read aloud to enrollees.

Urgent care or pre-service claim appeals

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out a form.

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

Timeframes for deciding an appeal

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	Within 72 hours	14 days, or 20 days for an **experimental or investigational** treatment. We will let you know within 72 hours that we have received your appeal.	14 days, or 20 days for an **experimental or investigational** treatment. We will let you know within 72 hours that we have received your appeal.	As appropriate to type of claim
Extensions to respond (us)	None	16 additional days if we notify you and provide a reason. We will get your written permission if we need more time beyond the 16 additional days.	16 additional days if we notify you and provide a reason. We will get your written permission if we need more time beyond the 16 additional days.	

Exhaustion of appeals process

In most situations you must complete the appeal process with us before you can pursue arbitration, litigation or other type of administrative proceeding.

But sometimes you do not have to complete the appeals process before you may take other actions. These situations are:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally. See the *How to contact us for help* section for details on how to reach us.
- We did not follow all of the claim determination and appeal requirements of Washington or of the Federal Department of Health and Human Services. You will not be able to proceed directly to external review if the violation was:
  - Minor and not likely to influence a decision or harm you.
  - For a good cause or beyond our control.
  - Part of an ongoing, good faith exchange between you and us.

At any time you may contact the Washington Office of the Insurance Commissioner at 800-562-6900 to request an investigation of a grievance or appeal.

External review

External review is a review done by people in an organization outside of **Aetna**. This is called an external review organization (ERO). Sometimes, this is called an independent review organization (IRO).

You have a right to external review if:

- Our claim decision involved medical judgment
- We decided the service or supply is not **medically necessary** or not appropriate
- We decided the service or supply is **experimental, investigational, or unproven**
- You have received an adverse determination

You may also request external review if you want to know if the federal surprise bill law applies to your situation.

The notice of adverse benefit determination or final adverse benefit determination we send you will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To **Aetna**
- Within 180 calendar days of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

You will pay for any information that you send and want reviewed by the ERO. We will pay for information we send to the ERO plus the cost of the review.

Aetna will:

- Contact the ERO that will conduct the review of your claim

The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Accept additional written information from you for up to five business days after the ERO accepts its assignment
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the ERO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an ERO decision?

We will tell you of the ERO decision not more than 45 calendar days after we receive your Request for External Review Form with all the information you need to send in.

Sometimes you can get a faster external review decision. Your **provider** must call us or send us a Request for External Review Form.

There are two scenarios when you may be able to get a faster external review:

For initial adverse determinations

Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function or
- Be much less effective if not started right away (usually for **experimental or investigational** treatment)

For final adverse determinations

Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (usually for **experimental or investigational** treatment) or
- The final adverse determination concerns an admission, availability of care, continued **stay** or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.

Recordkeeping

We will keep the records of all grievances and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you when you submit a grievance or appeal.

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).

Key terms

Here are some key terms we use in this section. These terms will help you understand this COB section.

Allowable expense means:

- A health care expense that any of your health plans cover to any degree. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, **custodial care** is not an allowable expense under this plan.

In this section when we talk about "other plans" through which you may have other coverage for health care expenses, we mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- Medicare or other government benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Different rules apply if you have **Medicare**. See the *How COB works with Medicare* section below for those rules.

Here's how COB works

- The primary plan pays first. When this is your primary plan, we pay your claims first as if there is no other coverage
- The secondary plan pays after the primary plan. When this is your secondary plan:
  - We calculate payment as if the primary plan does not exist. Then we reduce our payment based on any amount the primary plan paid.
  - We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable submitted expenses.

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. A plan that does not contain a COB provision is always the primary plan.

COB rule	Plan that pays first (primary plan)	Plan that pays next (secondary plan)
Student or dependent	Plan covering you as a student	Plan covering you as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the **calendar year** (Birthday rule)	Plan of parent whose birthday is later in the **calendar year**

COB rule	Plan that pays first (primary plan)	Plan that pays next (secondary plan)
Child – parents separated, divorced, or not living together with court order	Plan of the parent who the court said is responsible for health coverage But if that parent has no coverage then their spouse's plan pays first	Plan of other parent pays next But if that parent has no coverage, then the plan of the other parent's spouse (if any) pays next
Child – parents separated or divorced or not living together with no court order	Plan of the custodial parent pays first But if the custodial parent has no coverage, then their spouse's plan (if any) pays first But if the custodial parent or their spouse (if any) has no coverage, then the noncustodial parent's plan (if any) pays first If the • custodial parent • their spouse (if any), or • noncustodial parent has no coverage, then the noncustodial parent's spouse's plan (if any) pays	The custodial parent's spouse's plan (if any) pays next The noncustodial parent's plan (if any) pays next The noncustodial parent's spouse's plan (if any) pays next
Child – covered by individuals who are not parents (i.e., stepparent or grandparent)	Same rule as parent	Same rule as parent
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

How COB works with Medicare

This section explains how the benefits under this plan interact with benefits available under **Medicare**. Keep in mind, if you have **Medicare** you are not eligible to enroll in this plan. But you might get **Medicare** after you are already enrolled in this plan, so these rules will apply.

You have **Medicare** when you are entitled to premium-free **Medicare** Part A or enrolled in **Medicare** Part B or Premium Part A, or both, by reason of:

- Age
- Disability
- ALS / Lou Gehrig's disease or
- End stage renal disease (ESRD)

When you have **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before **Medicare** pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after **Medicare**.

Who pays first?

- **Medicare** pays first when you have **Medicare** because of:
  - Age
  - Disability
  - ALS / Lou Gehrig's disease
- When you have **Medicare** because of ESRD:
  - We pay first for the first 3 months unless you take a self-dialysis course.
  - If you take a self-dialysis course, there is no **Medicare** waiting period and **Medicare** becomes primary payer on the first of the month of dialysis.
  - If a transplant takes place within the 3-month waiting period, **Medicare** becomes primary payer on the first of the month in which the transplant takes place.

ESRD important note:
If you have **Medicare** due to age and then later have it due to ESRD, **Medicare** will remain your primary plan and this plan will be secondary.

How are benefits paid?

Plan status	How we pay
We are primary	We pay your claims as if there is no **Medicare** coverage.
Medicare is primary	We calculate our benefit as if there were no **Medicare** coverage. We reduce our benefit so that when combined with the **Medicare** payment, the total payment is no more than 100% of the allowable expense.

Charges that satisfy your Part B deductible will be applied in the order received. We will apply the largest charge first when two or more charges are received at the same time.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly. See the *How to contact us for help* section for details.

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid or
- Any other plan that is responsible under these COB rules

Notice to covered persons

If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your **provider** should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within 30 calendar days.

CAUTION: All health plans have timely claim filing requirements. If you or your **provider** fails to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your **provider** will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your **providers** and plans any changes in your coverage.

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends and when you may still be able to continue coverage.

When will your coverage end?

Your coverage under this plan will end when:

- This plan is discontinued
- The **student policy** ends
- You are no longer eligible for coverage
- You do not make the required **premium** contribution
- You withdraw from the school because of entering the armed forces of any country

If your coverage ends because you are no longer eligible for coverage, you will remain covered for the period for which you enrolled and paid the **premium**. If your coverage ends because this plan is discontinued or the student policy ends, any **premiums** you paid for coverage beyond the coverage end date will be refunded. If your coverage ends because you withdraw from school to enter the armed forces, **premiums** will be refunded, on a pro-rata basis, when we receive your request to terminate coverage within 90 days from the date of the withdrawal.

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 **premium** payment has been received. No **premium** will be refunded.

Withdrawal from classes – other than leave of absence

- If you withdraw from classes within 31 days after the policy effective date, you will be considered ineligible for coverage. Your coverage will be terminated retroactively, and any **premium** paid will be refunded.
- If you withdraw from classes more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which **premium** payment has been received. No **premium** will be refunded.
- If you withdraw from classes to enter the armed forces of any country, your coverage will end as of the date of such entry. We will refund your **premium**, on a pro-rata basis, if you submit a written request within 90 days from the date you withdraw.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage.
- You do not make the required **premium** contribution toward the cost of dependents' coverage.
- Your coverage ends for any of the reasons listed above.

Why would we suspend paying claims or end coverage?

We may immediately end coverage if you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

Any statement made is considered a representation and not a warranty. We will only use a statement during a dispute if it is shared with you and your beneficiary, or the person making the claim.

On the date your coverage ends, we will refund to the **policyholder** any prepayments for periods after the date your coverage ended.

Special coverage options after your coverage ends

This section explains options you may have after your, or your dependents, coverage ends under this plan. Your individual situation will determine what options you will have.

Continuation of coverage

You can request an extension of coverage as we explain below**,** by calling us at the toll-free number in the *How to contact us for help* section.

How can you extend coverage when getting inpatient care when coverage ends?

Your coverage may be extended if you or a dependent are getting inpatient care in a **hospital** or **skilled nursing facility** when coverage ends.

Benefits are extended only for the condition that caused the **hospital** or **skilled nursing facility stay**. Benefits aren't extended for other medical conditions.

Benefits will be extended until the earliest of:

- When you are discharged
- When you no longer need inpatient care
- When you become covered by another health benefits plan
- 3 months of coverage

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend coverage for your disabled **covered dependent** child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of mental or physical disability
- Depends chiefly on you for support and maintenance

The right to coverage will continue only as long as a **health professional** certifies that your child still is disabled and your coverage under the **student policy** remains in effect.

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

General provisions – other things you should know

Entire student policy

The **student policy** consists of several documents taken together. These documents are:

- The **policyholder's** application
- Your enrollment form**,** if the **policyholder** requires one
- The **student policy**
- The certificate(s) of coverage
- The schedule of benefits
- Any riders, endorsement, inserts, attachments, and amendments to the **student policy**, the certificate of coverage, and the schedule of benefits

Administrative provisions

How you and we will interpret this certificate

We prepared this certificate of coverage according to federal laws and state laws that apply. You and we will interpret it according to these laws. Interpretation of this certificate of coverage is subject to the *When you disagree - claim decisions and appeal procedures section* when we administer your coverage.

How we administer this plan

We administer this plan to comply with all applicable laws and regulations. We also apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. They are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the **student policy**. This document may have endorsements too. Under certain circumstances, we or the **policyholder** or the law may change your plan. When an emergency or epidemic is declared, we may remove **precertification**, **prescription** quantity limits and/or your cost share if you are affected. Only **Aetna** may waive a requirement of your plan. No other person – including the **policyholder** or **provider** – can do this.

If your student status changes the amount of your coverage or benefit levels, the change will take effect on the date of the status change and the amount of coverage or benefit level will be changed to the new amount.

A retroactive change in your student status will not cause a retroactive change in your coverage.

If your dependent status changes the amount of your dependent coverage or benefit levels, the change will take effect on the date of the status change and the amount of coverage or benefit level will be changed to the new amount.

Physical examinations and evaluations

At our expense, we have the right to have a **health professional** of our choice examine you. This will be done at all reasonable times while certification or a claim for benefits is pending or under review.

Records of expenses
You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:
- Names of **providers** who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception
Honest mistakes
You or the **policyholder** may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception
If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious effects on your coverage. These include, but are not limited to:
- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

You have special rights if we rescind your coverage as follows:
- We will give you 30 days advanced written notice of any rescission of coverage
- You have the right to an **Aetna** appeal
- You have the right to a third-party review conducted by an independent external review organization

Some other money issues
Legal action
You must complete the internal appeal process before you take any legal action against us for any expense or bill. See the *When you disagree - claim decisions and appeals procedures* section. You cannot take any action until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Assignment of benefits
When you see a **network provider** they will usually bill us directly. When you see an **out-of-network provider,** we may choose to pay you or to pay the **provider** directly. To the extent allowed by law, we will not accept an assignment to an **out-of-network provider**.

Financial sanctions exclusions
If coverage provided under this **student policy** violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible health services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). Visit https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx to find out more.

Grace period
You will be allowed a grace period of 31 days after the due date for the payment of each contribution due after the first contribution payment. If contributions are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period.

Recovery of overpayments
We sometimes pay too much for **eligible health services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid – you or your **provider** – to return what we paid. If we don't do that, we have the right to reduce any future benefit payments by the amount we paid by mistake.

When you are injured
If someone else caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money. After you are fully compensated for your loss, we are entitled to that money, up to the amount we pay for your care. We have that right no matter who the money comes from – for example, the other driver, the **policyholder** or another insurance company.

To help us get paid back, you are doing four things now:

- Agreeing to repay us from money you receive because of your **injury** after you are fully compensated for your loss.
- Giving us the right to seek money in your name, from any person who causes you **injury** and from your own insurance. We can seek money only up to the amount we paid for your care.
- Agreeing to cooperate with us so we can get paid back in full. For example, you'll tell us within 30 days of when you seek money for your **injury** or **illness**. You'll hold any money you receive until we are paid in full. And you'll give us the right to money you get, ahead of everyone else.
- Agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money.

If you incur reasonable attorney's fees and costs to recover money and we share in that recovery, then to the extent that we benefit from your attorney's efforts, we will share the attorney's fees and costs related to our subrogation claim that were necessary to generate the recovery.

Your health information
We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your policy.

You can get a free copy of our Notice of Privacy Practices. Just contact us.

When you accept coverage under this group policy, you agree to let your **providers** share information with us. We need information about your physical and mental condition and care.

Glossary

Accident or accidental
An **injury** to you that is not planned or anticipated. An **illness** does not cause or contribute to an **accident**.

Aetna®
Aetna Life Insurance Company, an affiliate, or a third-party vendor under contract with **Aetna**.

Behavioral health provider
An individual professional that is licensed or certified to provide diagnostic and/or therapeutic services for **mental health disorders** and **substance related disorders** under the laws of the jurisdiction where the individual practices.

Biosimilar prescription drug
A biological **prescription drug** that is highly similar to a U.S. Food and Drug Administration (FDA) – licensed reference biological **prescription drug** , even though there may be minor differences in clinically inactive components, and for which there are no clinically meaningful differences between the highly similar biological **prescription drug** and the reference biological **prescription drug** in terms of the safety, purity, and potency of the drug. As defined in accordance with U.S. Food and Drug Administration (FDA) regulations.

Brand-name prescription drug
An FDA-approved **prescription drug** marketed with a specific name or trademark name by the company that manufactures it, usually by the company which develops and patents it.

Calendar year
A period of 12 months beginning January 1st and ending on December 31st.

Coinsurance
Coinsurance is both the percentage of **eligible health services** that the plan pays and what you pay. The specific percentage that we have to pay for **eligible health services** is listed in the schedule of benefits.

Copayments
The specific dollar amount you have to pay for a health care service listed in the schedule of benefits.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible health services that meet the requirements for coverage under the terms of this plan.

Covered dependent
A person who is insured under the **student policy** as a dependent of a **covered student**.

Covered person
A **covered student** or a **covered dependent** of a **covered student** for whom all of the following applies:
- The person is eligible for coverage as defined in the certificate of coverage
- The person has enrolled for coverage and paid any required **premium** contribution
- The person's coverage has not ended

Covered student
A student who is insured under the **student policy**.

Custodial care
Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be **custodial care** even if it prescribed by a **physician** or given by trained medical personnel.

Deductible
For plans that include a **deductible**, this is the amount you pay for **eligible health services** per year before your plan starts to pay as listed in the schedule of benefits.

Dental emergency
Any dental condition that:
- Occurs unexpectedly
- Requires immediate diagnosis and treatment in order to stabilize the condition, and
- Is characterized by symptoms such as severe pain and bleeding

Dental emergency services
Services and supplies given by a **dental provider** to treat a **dental emergency**.

Dental provider
Any individual legally qualified to provide dental services or supplies, including a denturist.

Dentist
A legally qualified **dentist** licensed to do the dental work he or she performs.

Detoxification
The process of getting alcohol or other drugs out of an addicted person's system and getting them physically stable.

Directory
The list of **network providers** for your plan. The most up-to-date **directory** for your plan appears at https://www.aetnastudenthealth.com. When searching from our online **provider directory**, you need to make sure that you are searching for **providers** that participate in your specific plan. **Network providers** may only be considered for certain **Aetna** plans. When searching for **network dental providers**, you need to make sure you are searching under the dental plan.

Distant site
The site at which a **physician** or other licensed **provider**, delivering a professional service, is physically located at the time the service is provided through **telemedicine**.

Drug guide
A list of **prescription** and over-the-counter (OTC) drugs and devices established by **Aetna** or an affiliate. It does not include all **prescription** and OTC drugs and devices. This list can be reviewed and changed by **Aetna** or an affiliate. A copy of the **drug guide** is available at your request. You can also find it on the **Aetna** website at https://www.aetnastudenthealth.com.

Durable medical equipment (DME)
Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an **illness** or **injury**
- Suited for use in the home
- Not normally used by people who do not have an **illness** or **injury**
- Not for altering air quality or temperature
- Not for exercise or training

Effective date of coverage
The date your and your dependent's coverage, if your plan includes coverage for dependents, begins under this certificate of coverage as noted in **Aetna's** records.

Eligible health services
The health care services and supplies and outpatient **prescription drugs** listed in the *Eligible health services and exclusions* section and not carved out or limited in the *General exclusions* section of this certificate of coverage or in the schedule of benefits.

Emergency admission
An admission to a **hospital** or treatment facility ordered by a **health professional** within 24 hours after you receive **emergency services**.

Emergency medical condition
An acute, severe medical condition that would lead a prudent layperson to reasonably believe that the condition, **illness**, or **injury** is of a severe nature. And that if you don't get immediate medical care it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus
- In the case of a pregnant woman:
  - Serious jeopardy to the health of the fetus
  - One who is having contractions and there is inadequate time to effect a safe transfer to another **hospital** before delivery or
  - A transfer may pose a threat to the health or safety of the woman or unborn child

Emergency services
Treatment given in an ambulance and a **hospital**'s emergency room or an independent freestanding emergency department. This includes evaluation of and treatment to stabilize the **emergency medical condition**. An "independent freestanding emergency department" means a health care facility that is geographically separate, distinct and licensed separately from a **hospital** and provides **emergency services**.

Established relationship

The **provider** providing audio-only **telemedicine** has access to sufficient health records to ensure safe, effective, and appropriate care services. And, for behavioral health treatment, you:

- Have had at least one in-person appointment or one real-time interactive appointment using both audio and video technology within the last 3 years with the same **provider**, or
- Were referred to the **provider** providing audio-only **telemedicine** by another **provider** who has:
  - Had at least one in-person appointment, or at least one real-time interactive appointment with you using both audio and video technology within the last 3 years
  - Supplied relevant medical information to the **provider** providing audio-only **telemedicine**

And, for any other health care service, you:

- Have had at least one in-person appointment, or until July 1, 2024, at least one real-time interactive appointment using both audio and video technology within the last 2 years with the same **provider**, or
- Were referred to the **provider** providing audio-only **telemedicine** by another **provider** who has:
  - Had at least one in-person appointment, or, until July 1, 2024, at least one real-time interactive appointment with you using both audio and video technology within the last 2 years
  - Supplied relevant medical information to the **provider** providing audio-only **telemedicine**

Experimental, investigational, or unproven

A drug, device, procedure, supply, treatment, test, or technology is considered by us to be **experimental, investigational, or unproven** if any of the following apply:

- It hasn't been shown through well-conducted clinical trials or cohort studies published in peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which it's meant.
  - A well-conducted clinical trial means a randomized, controlled trial where the experimental intervention is compared to a control group receiving care according to best practice and study participants are randomly assigned to the experimental or control group.
  - A well-conducted cohort study means a prospective cohort study from more than one institution where the experimental intervention is compared to a group of subjects receiving care according to best practice and where the comparison group is well matched to the experimental intervention group.
- There isn't FDA approval or clearance to market it for the proposed use.
- A national medical society, dental society, or regulatory agency has written that it's **experimental, investigational, or unproven**, or mainly for research purposes.
- It's the subject of a Phase I, Phase II, or the experimental or research arm of a Phase III clinical trial. The FDA and Department of Health and Human Services define these.
- Written procedures or consent form used by a facility **provider** says it's **experimental, investigational, or unproven**

Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product. It is considered to be as effective as the brand-name product and offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional
A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, **physicians**, nurses, licensed nurse midwife, massage therapists, **dental providers**, vision care **providers**, and physical therapists.

Home health aide
A **health professional** that provides services through a **home health care agency.** The services that they provide are not required to be performed by an **R.N.**, **L.P.N.**, or **L.V.N**. A **home health aide** primarily aids you in performing the normal activities of daily living while you recover from an **injury** or **illness**.

Home health care agency
An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

Home health care plan
A plan of services prescribed by a **health professional** to be provided in the home setting. These services are usually provided after your discharge from a **hospital** or if you are **homebound**.

Homebound
This means that you are confined to your home because:

- Your **health professional** has ordered that you stay at home because of an **illness** or **injury**
- The act of transport would be a serious risk to your life or health

You are not **homebound** if:

- You do not often travel from home because you are feeble or insecure about leaving your home
- You are confined to a wheelchair but you can be transported by a vehicle that can safely transport you in a wheelchair

Hospice care
Supportive care given to people in the final phase of a **terminal illness** with a focus on comfort and quality of life, rather than cure.

Hospice care agency
An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**. These services may be available in your home or inpatient setting.

Hospice care program
A program prescribed by a **health professional** to provide **hospice care** and support to a person with a terminal illness and their families.

Hospice facility
An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**.

Hospital
An institution licensed as a **hospital** by applicable law and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can stay overnight for care. Or than can be treated and leave the same day. All **hospitals** must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

Hospital stay
This is your **stay** of 18 or more hours in a row as a resident bed patient in a **hospital**.

Illness or illnesses
Poor health resulting from disease of the body or mind.

Injectable drug(s)
These are **prescription drugs** when an oral alternative drug is not available.

Injury or injuries
Physical damage done to a person or part of their body.

Intensive care unit
A ward, unit, or area in a **hospital** which is set aside to provide continuous specialized or intensive care services to your because your **illness** or **injury** is severe enough to require such care.

Jaw joint disorder
This is:

- A **Temporomandibular Joint (TMJ)** dysfunction or any similar disorder of the jaw joint
- A Myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

L.P.N.
A licensed practical nurse or a licensed vocational nurse.

Mail order pharmacy
A **pharmacy** where **prescription drugs** are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit
This is the most you will pay per year in **copayments**, **coinsurance** and any **policy year deductible**, if one applies, for **eligible health services** as listed in the schedule of benefits.

Medically necessary/Medical necessity
Health care services or supplies that prevent, evaluate, diagnose or treat an **illness**, **injury**, disease or its symptoms, and that are all of the following:

- In accordance with "generally accepted standards of medical practice"
- Clinically appropriate, in terms of type, frequency, extent, site, place of service, duration, and considered effective for your **illness**, **injury** or disease
- Not primarily for your convenience, the convenience of your **physician**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce the same benefits or diagnostic results as to the diagnosis or treatment of your **illness**, **injury** or disease

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and
- Following the standards set forth in our clinical policies and applying clinical judgment

Important note:
We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **medically necessary, experimental, investigational, or unproven**. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact us. See the *How to contact us for help* section.

Medicare

As used in this plan, **Medicare** means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of **Medicare.**

Mental health disorder

A **mental health disorder** is, in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of **mental health disorder** is in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

Negotiated charge

Health coverage

This is either:

- The amount **network provider** has agreed to accept
- The amount we agree to pay directly to a **network provider** or third-party vendor (including any administrative fee in the amount paid)

for providing services, **prescription drugs** or supplies to **covered persons** in the plan. This does not include **prescription drug** services from a **network pharmacy**.

For surprise billing, calculations will be made based on the median contracted rate.

We may enter into arrangements with **in-network providers** or others related to:

- The coordination of care for **covered persons**
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing

These arrangements will not change the **negotiated charge** under this plan.

Prescription drug coverage from a network pharmacy

The amount we established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts we agreed to pay directly to the **network pharmacy** or to a third-party vendor for the **prescription drug**, and may include a rebate, an additional service or risk charge set by us.

We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may change the **negotiated charge** under this plan.

Network pharmacy
A **retail**, **mail order** or **specialty pharmacy** that has contracted with **Aetna**, an affiliate, or a third-party vendor, to provide outpatient **prescription drugs** to you.

Network provider
A **provider** listed as an Open Choice® **network provider** in the **directory** for your plan.

Out-of-network pharmacy
A **pharmacy** that is not a **network pharmacy**.

Out-of-network provider
A **provider** who is not a **network provider**.

Pharmacy
An establishment where **prescription drugs** are legally dispensed. This can be a **retail**, **mail order** and **specialty pharmacy**.

Physician
A skilled **health professional** trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Policy year
This is the period of time from anniversary date to anniversary date of the **student policy** except in the first year when it is the period of time from the effective date to the first anniversary date.

Policyholder
The school named on the front page of the **student policy** and your certificate of coverage and schedule of benefits for the purpose of coverage under the **student policy**.

Precertification, precertify
A requirement that you or your **health professional** contact **Aetna** before you receive coverage for certain services. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage.

Preferred drug
A **prescription drug** or device that may have a lower out-of-pocket cost than a **non-preferred drug**.

Premium
The amount you or the **policyholder** are required to pay to **Aetna**.

Prescription
As to hearing care:
A written order for the dispensing of **prescription** electronic hearing aids by otolaryngologist, otologist or audiologist.

*As to **prescription drugs**:*
A written order for the dispensing of a **prescription drug** or device by a **provider**. If it is a verbal order, it must promptly be put in writing by the **network pharmacy**.

As to vision care:
A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

Prescription drug
An FDA approved drug or biological which can only be dispensed by **prescription.**

Provider(s)
A **physician**, other **health professional**, **hospital**, **skilled nursing facility**, **home health care agency, pharmacy,** or other entity or person licensed or certified under applicable state and federal law to provide health care services to you, and practicing within the scope of that license. If state law does not specifically provide for licensure or certification, the entity must meet all **Medicare** accreditation standards (even if it does not participate in **Medicare**).

Psychiatric hospital
An institution licensed or certified as a **psychiatric hospital** by applicable laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse or **mental health disorders** (including **substance related disorders**).

Recognized charge
The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The **recognized charge** depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Service or supply	Recognized charge is based on:
Professional services and other services or supplies not mentioned below	105% of the **Medicare** allowed rate
Services of **hospitals** and other facilities	105% of the **Medicare** allowed rate
Prescription drugs	100% of the average wholesale price (AWP)
Dental expenses	80% of the prevailing charge rate
Ambulance service**s**	80% of the prevailing charge rate

Important note:
If the **provider** bills less than the amount calculated using the method above, the **recognized charge** is what the **provider** bills.

Recognized charge does not apply to involuntary services.

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

- Involuntary services are services or supplies that are one of the following:
  - Performed at a **network** facility by an **out-of-network provider,** unless that **out-of- network provider** is an assistant surgeon for your **surgery**
  - Not available from a **network provider**
  - **Emergency services**

  We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**.
- **Medicare** allowed rates are the rates CMS establishes for services and supplies provided to **Medicare** enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If **Medicare** does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set **Medicare** rates
  - What other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply
- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.

Our reimbursement policies

We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the **recognized charge**. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided

Our reimbursement policies are based on our review of:

- The Centers for **Medicare** and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and **dentists** practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits

We have online tools to help you decide whether to get care and if so, where. Log in to your **Aetna** website at https://www.aetnastudenthealth.com. The website contains additional information that can help you determine the cost of a service or supply.

R.N.

A registered nurse.

Residential treatment facility

A facility that provides **mental health disorder** services or **substance related disorder** services and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed **physician** for the level of care provided
- Maintains a written treatment plan prepared by a licensed **behavioral health provider** (**R.N.** or master's level) requiring full-time residence and participation
- Has a licensed **behavioral health provider** (**R.N.** or master's level) on-site 24 hours per day 7 days per week
- And is:
  - Credentialed by us, or
  - Certified by **Medicare**, or
  - Accredited by The Joint Commission (TJC); The Committee on Accreditation of Rehabilitation Facilities (CARF); The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP); or The Council on Accreditation (COA)

For residential treatment programs treating **substance related disorders**:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a **physician**
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For **detoxification** programs within a residential setting:

- An **R.N.** must be onsite 24 hours/day for 7 days/week within a residential setting
- Residential care must be provided under the direct supervision of a **physician**

Respite care

This is care provided to you when you have a **terminal illness** for the sole purpose of providing temporary relief to your family (or other care givers) from the daily demands of caring for you**.**

Retail pharmacy

A community **pharmacy** that dispenses outpatient **prescription drugs**.

Room and board

A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

School health services

The **policyholder's** or school's student health center or a **provider** or organization that is identified as a **school health services provider**.

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, **Aetna** will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility

A facility that provides skilled nursing care and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed **physician** for the level of care provided
- Maintains a written treatment plan prepared by a licensed **provider** (**R.N.** or master's level) requiring full-time residence and participation
- Has a licensed **provider** (**R.N.** or master's level) on-site 24 hours per day 7 days per week
- And is:
  - Credentialed by us, or
  - Certified by **Medicare**, or
  - Accredited by The Joint Commission (TJC) or The Committee on Accreditation of Rehabilitation Facilities (CARF)

Skilled nursing facilities also include rehabilitation **hospital**s, and portions of a rehabilitation **hospital** and a **hospital** designated for skilled or rehabilitation therapy services.

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of **mental health disorders** or **substance related disorders**.

Skilled nursing services

Services provided by an **R**.**N**. or **L.P.N.** within the scope of his or her license.

Sound natural teeth

These are natural teeth. If there is a filling in a tooth, the major portion of the tooth must be present. A tooth cannot be decayed, abscessed, or defective. **Sound natural teeth** are not capped teeth, implants, crowns, bridges, or dentures.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty and is board-certified.

Specialty pharmacy

A **pharmacy** that fills **prescriptions** for specialty drugs.

Specialty prescription drug

An FDA-approved **prescription drug** that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:

- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

Stay
A full-time inpatient confinement for which a **room and board** charge is made.

Step therapy
A form of **precertification** where you must try one or more required drug(s) before a **step therapy** drug is covered. The required drugs have FDA approval, may cost less and treat the same condition. If you don't try the appropriate required drug first, you may need to pay full cost for the **step therapy** drug.

Store and forward technology
This means that your medical information is shared with a **provider**, but not in real time. But, there are some rules:

- You must have already had a related office visit with the referring **provider**
- We must have an existing agreement with the **provider** to pay for the service
- You and the **provider** must be in different locations
- The **provider** must use the information to diagnose or manage your medical condition

Store and forward technology does not include:
- Telephone calls (audio only)
- Faxes
- Emails

Student policy
The **student policy** consists of several documents taken together. The list of documents can be found in the *General provisions – other things you should know* section of this certificate of coverage.

Substance related disorder
The use of drugs, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association, that directly affect the brain's reward system in an amount or frequency that causes problems with normal activities.

Surgery center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all **Medicare** accreditation standards (even if it does not participate in **Medicare**).

Surgery, surgeries or surgical procedures
The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy

- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution or
- Otherwise physically changing body tissues and organs

Telemedicine

Health care services provided to you by a **physician**, **specialist**, **behavioral health provider** , or **telemedicine provider** at a **distant site** using interactive audio and video technology, or audio only, if you have an **established relationship** with the provider. This means that you and the **provider** are in different locations but are communicating in real time. The provider must be diagnosing, consulting or treating your medical or behavioral health condition. .

Telemedicine does not include:

- Faxes
- Emails

Temporomandibular joint dysfunction (TMJ)

This is a disorder of the jaw joint.

Terminal illness

A medical prognosis that you are not likely to live more than 12 months.

Urgent admission

This is an admission to the **hospital** due to an **illness** or **injury** that is severe enough to require a **stay** in a **hospital** within 2 weeks from the date the need for the **stay** becomes apparent.

Urgent care facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition.**

Urgent condition

An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

Walk-in clinic

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near, or within a:

- Drug store
- **Pharmacy**
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- **Hospital**
- Outpatient department of a **hospital**
- **Physician's** office
- **Urgent care facility**

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
1-800-648-7817, 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	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ፡፡
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
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 aidentifikasion.
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
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
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.
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.
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	လၢနတၢ်ကမၤန့ၢ်ကျိာ်တၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ် လၢတအိၣ်ဒီးအပ့ၢ်လၢနကဘၣ်ဟ့ၣ်အီၤအဂ့ၤကီးဘၣ်လီၤတဲစိနီၣ်ဂံၢ်လၢအအိၣ်လၢနခိၣ်ဂီၤ ဖ (၍) အလိၤ့ၣ်တက့ၢ်၍
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈໍາຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó naaltsoos bee atah nílįįgo nanitinígíí bee nééhó'dólzinígíí béésh bee hane'í biká'ígíí áajj' hólne'.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному 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 los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	[illegible]
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.

Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขทีแสดงอยู่บนบัตรประจำตัวของท่าน
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.

Out-of-network benefits disclosure

Your health plan's out-of-network benefits

Not all health coverage plans provide out-of-network benefits. Please refer to your schedule of benefits for a description of your health plan's out-of-network benefits.

Notice of consumer rights

Washington State has developed a notice of consumer rights. You can find this in your certificate of coverage.

Out-of-network costs

You may choose a doctor in our network. You may choose to visit an out-of-network doctor. We cover the cost of care based on whether the provider, a doctor or hospital, is "in network" or "out of network." We want to help you understand how much we will pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care.

"In network" means we have a contract with that doctor. Doctors agree to how much they will charge you for covered services. That amount is often less than what they would charge you if they were not in our network. Most of the time, it costs you less to use doctors in our network. Doctors also agree to not bill you for any amount over their contract rate. All you have to pay is your coinsurance, copayments, and deductible that applies. Your network doctor will handle any precertification your plan requires.

"Out of network" means we do not have a contract for discounted rates with that doctor. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna® health plan may pay some of that doctor's bill. Most of the time, you will pay more money out of your own pocket if you choose to use an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that the plan doesn't recognize. You'll also pay higher copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket limits. This means you are fully responsible for paying everything above the amount the plan allows for a service or procedure

How to use the transparency tool

Aetna provides online tools to help you determine the cost of health care services and your potential share of those expenses. After logging in to our member website, you can search for procedures and providers to see estimated costs.

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Search our network for doctors, hospitals and other health care providers

Use our online provider search tool for the most up-to-date list of health care professionals and facilities. You can get a list of available doctors by ZIP code or enter a specific doctor's name in the search field.

Visit **Aetna.com** and log in. From your secure member website home page, select "Find Care" from the menu bar and start your search.

Our online search tool is more than just a list of doctors' names and addresses. It also includes information about:

- Where the doctor went to medical school
- Board certification status
- Language spoken
- Hospital affiliations
- Gender
- Driving directions

Obtain an estimated range of the out-of-pocket costs for an out-of-network benefit

Contact member services at the number on your ID card for help estimating your out-of-pocket cost for an out-of-network benefit. Out-of-network providers do not have a contracted rate with Aetna. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. However, your out-of-pocket costs may be much higher compared to the costs of using a network provider. Your out-of-pocket costs for an out-of-network benefit, if included in your plan, consists of your
out-of-network deductible plus your plan coinsurance. To estimate your coinsurance amount, subtract the remaining plan deductible from the provider's billed charge. Then multiply the balance by your coinsurance percentage.

Policies and plans are insured and/or administered by Aetna Life Insurance Company or its affiliates (Aetna). Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Refer to **Aetna.com** for more information about Aetna® plans.

Estimated costs are not available in all markets. The tool gives you an estimate of what you would owe for a particular service based on your plan at that point in time. Actual costs may differ from the estimate if, for example, claims for other services are processed after you get your estimate but before the claim for this service is submitted, or if the doctor or facility performs a different service at the time of your visit.

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Aetna Life Insurance Company

Endorsement

This endorsement is added to your booklet-certificate. It describes your benefits for coverage of services related to coronavirus disease. The emergency orders and proclamation noted below are ordered by the State of Washington, Office of the Insurance Commissioner (OIC) and Office of the Governor and can be found at https://www.insurance.wa.gov/coronavirus-and-health-insurance.

Corona Virus Physician Evaluation and Testing

If you meet the Centers for Disease Control and Prevention (CDC) criteria for testing, as determined by your health care **provider**, we will, by OIC Emergency Order 20-01 dated March 5, 2020, cover:

- health care **provider** visits and
- U.S. Food and Drug Administration (FDA) authorized coronavirus disease 2019 testing

No **deductible** or other cost sharing applies.

This Order is in force from March 5, 2020 through May 4, 2020, unless extended.

When testing is determined **medically necessary** by your health care **provider** and billed in conjunction with a COVID-19 related diagnosis code, we will, by OIC Emergency Order 20-02 dated March 24, 2020, cover:

- diagnostic test panels for influenza A & B,
- norovirus and other coronaviruses, and
- respiratory syncytial virus (RSV)

No **deductible** or other cost sharing applies.

This Order is in force from March 24, 2020 through May 23, 2020, unless extended.

Alternate Site Testing:

We will, by OIC Emergency Order 20-02 dated March 24, 2020, cover as a "**provider** visit":

- the services of a health care **provider** to assess symptoms, and
- obtain biological samples for you at a drive through site established for testing and assessment of COVID19

Testing performed during such visit is covered so long as testing is:

- approved by the FDA or Washington Department of health,
- is performed by in-network **providers**, and
- provided as ordered by your health care **provider**.

This Order is in force from March 24, 2020 through May 23, 2020, unless extended.

Prescription Drug Refills

You may, by OIC Emergency Order 20-01 dated March 5, 2020, obtain a one-time refill of your covered **prescription drugs** between refills so that you can maintain an adequate supply of necessary medication. Any waiting period is waived.

This Order is in force from March 5, 2020 through May 4, 2020, unless extended.

Suspension of Prior authorization
We will not, by OIC Emergency Order 20-01 dated March 5, 2020, require **precertification** of:

- diagnostic testing and
- treatment of corona virus disease 2019.

This Order is in force from March 5, 2020 through May 4, 2020, unless extended.

We will not, by OIC Emergency Order 20-02 dated March 24, 2020, require **precertification** for:

- treatment at a long-term care facility, or
- home health care services

following discharge from a **hospital**.

This Order is in force from March 24, 2020 through May 23, 2020, unless extended.

Telehealth, Telemedicine
We will not, by Proclamation by the Governor 20-29 dated March 25, 2020, do any of the following:

- Reimburse in-network **providers** for **telemedicine** claims for **medically necessary** covered services at a rate lower than the contracted rate that would be paid if the services had been delivered through traditional (in-person) methods.
- Deny a **telemedicine** claim from an in-network **provider** for a **medically necessary** covered service due to an existing **provider** contract term with that **provider** that denies reimbursement for services provided through **telemedicine**.
- Establish requirements for the payment of **telemedicine** services that are inconsistent with the emergency orders, rules or technical advisories issued by the OIC.

We will, by OIC Emergency Order 20-02 dated March 24, 2020, allow in-network **providers** to use non-HIPAA compliant communication platforms to provide patient care.

We will cover audio-only telephone services as **telemedicine**.

This Order is in force from March 24, 2020 through May 23, 2020, unless extended.

Premium Payment Grace Period:
We will, by OIC Emergency Order 20-02 dated March 24, 2020 and expanded and clarified by OIC Emergency Order 20-04 dated April 3, 2020, allow group policyholders (i.e. your employer or plan sponsor) a premium payment grace period of no less than 60 days.

We will pay all claims for services that are rendered to you during the first thirty days of the grace period, that are covered under:

- the terms of your plan, and
- current law then in effect, including:
  - any emergency orders issued by any branch or instrumentality of the State of Washington, or
  - the federal government.

We may delay adjudicating claims for services rendered to you during the remainder of the grace period.

You are obligated to pay your applicable contribution to the cost of group health coverage or potentially be subject to billing from health care **providers** for unpaid claims for services rendered to you after the first thirty days of the grace period as a result of cancellation due to non-payment of premium.

This Order is in force from March 24, 2020 through May 23, 2020, unless extended.

You can contact us for help
To help get you through this, we've opened crisis response lines for all members, call us at 1-833-327-AETNA (2386) (TTY: 711).

All Aetna® and CVS Caremark® members also have access to the Aetna nurse medical line at 1-800-556-1555 (TTY: 711).

You can find information about coronavirus, by logging onto your **Aetna** member website at www.aetna.com www.aetnainternational.com www.aetnastudenthealth.com.

You can also contact us by:

- Calling **us** at the number on your ID card, or at 800-297-7145 , or at 877-480-4161
- Calling your **Aetna** Concierge at the number on your ID card from 8:00 a.m. to 6:00 p.m., Monday through Friday
- Writing us at:
  Aetna Life Insurance Company
  Attn: Aetna International
  151 Farmington Ave
  Hartford, CT 06156

If you have not already, register for our secure Internet access to reliable health information, tools and resources that can make it easier for you to make informed health care decisions, view claims, research care and treatment options and access information on health and wellness.

Your Rights and Protections Against Surprise Medical Bills and Balance Billing in Washington state

Effective January 1, 2025

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. These costs are called cost-sharing. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of- pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you take an ambulance ride, have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you, via their websites or if you ask, which providers, hospitals, and facilities are in their networks. Hospitals, surgical facilities, providers, behavioral health emergency services providers and ground ambulance providers must tell you which provider networks they participate in on their website or if you ask.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition, mental health or substance use disorder condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes ground or air ambulance rides, and care you receive in a hospital or in facilities that provide crisis services to people experiencing a mental health or substance use disorder emergency. You can't be balance billed for these emergency services, including services you may get after you're in a stable condition.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most these providers may bill you is your plan's in- network cost-sharing amount.

You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When can you be asked to waive your protections from balance billing:

Health care providers, including hospitals, emergency behavioral health services providers, and ground or air ambulance providers, can never require you to give up your protections from balance billing.

If you have coverage through a self-funded group health plan, in some limited situations, a provider can ask you to consent to waive your balance billing protections, but you are never required to give your consent. Please contact your employer or health plan for more information.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in- network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may file a complaint with the federal government at https://www.cms.gov/nosurprises/consumers or by calling 1-800-985-3059; and/or file a complaint with the Washington state Office of the Insurance Commissioner at their website or by calling 1-800-562- 6900.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Visit the Washington state Office of the Insurance Commissioner's website for more information about your rights under Washington state law.