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Aetna Student Health

Plan Design and Benefits Summary

Open Choice®
Preferred Provider Organization (PPO)

Western Washington University

Policy Year: 2020-2021
Policy Number: 686216
www.aetnastudenthealth.com
(877) 480-4161

This is a brief description of the Student Health Plan. The Plan is available for Western Washington University students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate of Coverage issued to you and may be viewed online at **www.aetnastudenthealth.com.** If there is a difference between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

Western Washington Student Health Center

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

Coverage Dates and Rates

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

	Fall	**Winter**	**Spring**	**Spring /Summer**	**Summer**
Coverage Start Date	**09/01/2020**	**01/01/2021**	**03/31/2021**	**03/31/2021**	**06/23/2021**
Coverage End Date	**12/31/2020**	**03/30/2021**	**06/22/2021**	**08/31/2021**	**08/31/2021**
Student	$1,018	$743	$701	$1,286	$585
Spouse	$1,018	$743	$701	$1,286	$585
Child	$1,018	$743	$701	$1,286	$585
Two or more Children	$2,036	$1,486	$1,402	$2,572	$1,170

Enrollment Deadlines
Fall – 11/01/2020
Winter – 02/28/2021
Spring – 05/31/2021
Spring/Summer – 05/31/2021
Summer – 07/31/2021

Student Coverage

Who is eligible?

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

Enrollment

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

• During the enrollment period

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

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

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

Dependent Coverage

Eligibility

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

Enrollment

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

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

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

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

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

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

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

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

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

Medicare Eligibility Notice

You are not eligible 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.

Termination and Refunds

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

Withdrawal from Classes – Other than Leave of Absence:
If you withdraw from classes other than under a school-approved leave of absence within 31 days after the policy effective date, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded. If the withdrawal is more than 31 days after

the policy effective date, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded. If you withdraw from classes to enter the armed forces of any country, coverage will terminate as of the effective date of such entry and a pro rata refund of premiums will be made if you submit a written request within 90 days of withdrawal from classes.

In-network Provider Network

Aetna'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 into your Aetna secure website at 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 may 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, covered benefits are paid at the in-network coverage level of benefits.

Precertification

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

Precertification for medical services and supplies

In-network care

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.

Out-of-network care

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, your benefits may be reduced, or the plan may not pay.

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.

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

We will 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.

What if you don't obtain the required precertification?
If you don't obtain the required precertification:
• Your benefits may be reduced, or 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 deductible or maximum out-of-pocket limit if there are any.

What types of services and supplies require precertification?

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

Inpatient services and supplies	Outpatient services and supplies
Gene-based, cellular and other innovative therapies (GCIT)	Applied behavior analysis
Stays in a **hospice** facility	Certain **prescription drugs** and devices*****
Stays in a **hospital**, except for stays due to involuntary commitment to a state **hospital**	Complex imaging
Stays in a **rehabilitation facility**	**Cosmetic** and reconstructive **surgery**
Stays in a **residential treatment facility** for	Non-emergency transportation by fixed-wing

treatment of **mental disorders** and **substance abuse**	airplane
Stays in a **skilled nursing facility**	Gene-based, cellular and other innovative therapies (GCIT)
	Home health care
	Hospice services
	Intensive outpatient program (IOP) – **mental disorder** and **substance abuse** diagnoses
	Kidney dialysis
	Knee **surgery**
	Medical **injectable drugs** (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, botox, hepatitis C medications)*****
	Outpatient back **surgery** not performed in a **physician's** office
	Partial hospitalization treatment – **mental disorder** and **substance abuse** diagnoses
	Private duty nursing services
	Psychological testing/neuropsychological testing
	Sleep studies
	Transcranial magnetic stimulation (TMS)
	Wrist **surgery**

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 onto the **Aetna** website at www.aetnastudenthealth.com.*

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).

Here's how COB works

- The primary plan pays first. When this is the primary plan, we will pay your claims first as if the other plan does not exist.
- The secondary plan pays after the primary plan. When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.

We will never pay an amount that, when combined with payments from your other coverage, add up to more than 100% of the allowable expenses.

For more information about the Coordination of Benefits provision, including determining which plan is primary and which is secondary, you may call the Member Services telephone number shown on your ID

card. A complete description of the Coordination of Benefits provision is contained in the Policy issued to Western Washington University and may be viewed online at www.aetnastudenthealth.com.

Description of Benefits

The Plan excludes coverage for certain services (referred to as exceptions in the certificate of coverage) and has limitations on the amounts it will pay. While this Plan Design and Benefit Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Certificate of Coverage issued to you, go to **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

How your plan works while you are covered for in-network coverage
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 an in-network provider

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

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**
Policy year deductible waiver		
The **policy year deductible** is waived for all of the following **eligible health services:** • In-network care for: – *Preventive care and wellness* services – *Pediatric dental care - Type A* services – *Pediatric vision care* services • 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**.		

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 secure website at 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 secure website at 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	

Eligible health services	In-network coverage	Out-of-network coverage
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
Maximum visits per **policy year** (This maximum applies only to **covered persons** age 22 and older)	26 visits* (you may use up to 10 of these 26 visits for healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)	
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one 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
Maximum visits per **policy year**	5 visits*	
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one 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
Maximum visits per **policy year**	8 visits*	
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one 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
Maximum visits per **policy year**	1 visit*	
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one 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
Maximum visits per **policy year**	2 visits*	
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		

Eligible health services	In-network coverage	Out-of-network coverage
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	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 • The comprehensive guidelines supported by the Health Resources and Services Administration • Colorectal cancer screenings as recommended by your **health professional** if you are less than 50 years of age and at high risk For details, contact your **health professional** or **Aetna** by logging onto your Aetna secure website at 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.		

Eligible health services	In-network coverage	Out-of-network coverage
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
Lactation counseling services maximum visits per **policy year**, in either a group or individual setting	6 visits	
Important note: Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section.		
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
Contraceptive counseling services maximum visits per **policy year** either in a group or individual setting	2 visits	
Important note: Any visits that exceed the contraceptive counseling services maximum are covered under *Physician services* office visits.		
Contraceptives (prescription drugs and devices)		
Contraceptive **prescription drugs** and devices provided, administered, or removed, by a **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

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

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

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

Eligible health services	In-network coverage	Out-of-network coverage
4. Emergency services and urgent care		
Emergency services		
Hospital emergency room	$100 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	Paid the same as in-network coverage
Important note: • As **out-of-network providers** do not have a contract with us, the **provider** may not accept payment of your cost share (**copayment** and **coinsurance**) as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, or call Member Services for an address at 1-877-480-4161 and we will resolve any payment dispute with the **provider** over that amount. Make sure the ID card number is on the bill. • A separate **hospital** emergency room **copayment** will apply for each visit to an emergency room. If you are admitted to a **hospital** as an inpatient right after a visit to an emergency room, your emergency room **copayment** will be waived and your inpatient **copayment** will apply. • **Covered benefits** that are applied to the **hospital** emergency room **copayment** cannot be applied to any other **copayment** under the plan. Likewise, a **copayment** that applies to other **covered benefits** under the plan cannot be applied to the **hospital** emergency room **copayment.** • Separate **copayment** amounts may apply for certain services given to you in the **hospital** emergency room that are not part of the **hospital** emergency room benefit. These **copayment** amounts may be different from the **hospital** emergency room **copayment**. They are based on the specific service given to you. • Services given to you in the **hospital** emergency room that are not part of the **hospital** emergency room benefit may be subject to **copayment** or **coinsurance** amounts.		
Non-emergency care in a **hospital** emergency room	Not covered	Not covered
Urgent care		
Urgent medical care provided by an **urgent care provider**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Non-urgent use of **urgent care provider**	Not covered	Not covered

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

Diagnostic and preventive care (type A services)

Visits and images

- Office visits during regular office hours, for oral examination, beginning before age 1 (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
- Emergency palliative treatment, per visit
- Limited oral evaluations to evaluate the member for a specific dental problem or oral health complaint, dental emergency or referral for other treatment
- 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
- Routine comprehensive or recall examination (limited to 2 visits per year)
- 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 (limited to: 1 application every 3 years for permanent bicuspids and molars only)
- Sealant repair
- Bitewing images (limited to: 2 sets per year)
- Periapical images
- Cephalometric radiographic image (limited to: 1 in a 2 year period)
- Complete image series, including bitewings if **medically necessary** (limited to: 1 set every 3 years)
- Panoramic radiographic image (limited to 1 set every 3 years)
- Vertical bitewing images (limited to 1 set every 3 years)
- Intra-oral, occlusal radiographic image
- Photographic images, when **medically necessary**
- Diagnostic casts

Space maintainers

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

Basic restorative care (type B services)

Visits and images

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

Images and pathology

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

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 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 per quadrant
    - Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces per quadrant
    - Vestibulopasty
    - Excision of hyperplastic tissue
    - Removal of exostosis
    - Removal of torus palatinus
    - Removal of torus mandibularis
    - Crown exposure to aid eruption
    - Removal of foreign body from soft tissue
    - Frenulectomy/frenulopasty

Periodontics

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

Endodontics

- Pulp capping (direct and indirect)
- Pulpal therapy, resorbable filling
- Pulpal regeneration
- Pulpotomy (therapeutic)
- Pulpal debridement
- Pulp vitality test

- Apexification/recalcification
- Apicoectomy
- Retrograde filling, per root
- Root amputation, per root
- Hemisection
- Root canal therapy, including **medically necessary** images, for:
  - Anterior
  - Bicuspid
  - Molar (excluding teeth 1, 16, 17 and 32)
- Retreatment of previous root canal therapy for:
  - Anterior
  - Bicuspid
  - Molar

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
- Protective restoration
- 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
  - Crown
  - Fixed partial dentures (bridge)

General anesthesia and intravenous sedation when medically necessary (15 minute increments)

- Evaluation – deep anesthesia or general anesthesia
- Drugs or medicaments when used with parenteral conscious sedation or general anesthesia
- Local anesthesia:
  - Regional block anesthesia including office-based oral anesthesia
  - Parenteral conscious sedation
  - 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
    - Titanium
- 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 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 every 5 years)
- Complete dentures
    - Fees for dentures include relines, rebases and adjustments within 6 months after installation
- Resin partial dentures (limited to 1 every 3 years)
    - Fees for partial dentures include relines, rebases and adjustments within 6 months after installation
- Office reline (more than 6 months after installation)
- Laboratory reline (more than 6 months after installation)
- Special tissue conditioning, per denture (more than 6 months after installation)
- Rebase, per denture (more than 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 in a 5 year period
- 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
    - Removal of appliance
    - Construction of retainer
    - Placement of retainer

Eligible health services	In-network coverage	Out-of-network coverage
6. Specific conditions		
Birthing center		
Inpatient (room and board and other services and supplies	Paid at the same cost-sharing as **hospital** care	Paid at the same cost-sharing as **hospital** care
Diabetic equipment, supplies and education		
Diabetic equipment, supplies and education	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Temporomandibular joint dysfunction (TMJ)		
TMJ treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Impacted wisdom teeth		
Impacted wisdom teeth	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Accidental injury to sound natural teeth		
Accidental i**njury** to **sound natural teeth**	80% (of the **negotiated charge**)	80% (of the **recognized charge**)
Dermatological treatment		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maternity care		
Maternity care (includes delivery and postpartum care services in a **hospital** or **birthing center**)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Gender reassignment (sex change) 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

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

Eligible health services	In-network coverage	Out-of-network coverage
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
Transplant services		
Inpatient	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Outpatient	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Physician 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	
Treatment of infertility		
Basic infertility services		
Basic **infertility**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage	Out-of-network coverage
7. Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services		
Performed in the outpatient department of a **hospital** or other facility	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Diagnostic lab work and radiological services		
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)***	**GCIT non-designated facility/provider and Out-of-network coverage***
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

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

Eligible health services	In-network coverage	Out-of-network coverage
Neurodevelopmental therapy services		
Neurodevelopmental therapy	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	Unlimited	
Chiropractic services		
Chiropractic services	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	35*	
*Note: A visit is equal to no more than 1 hour of therapy.		
Diagnostic testing for learning disabilities		
Diagnostic testing for learning disabilities	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage	Out-of-network coverage
8. Other services and supplies		
Abortion		
Inpatient (**room and board**) and other services and supplies	80% (of the **negotiated charge**) per admission	60% (of the r**ecognized charge**) per admission
Outpatient	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
Acupuncture		
Acupuncture	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
Ambulance service		
Emergency use of **ambulance** (air, ground and water)	80% (of the **negotiated charge**) per trip	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
Enteral formulas and nutritional support		
Enteral formulas and 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 and exams		
Hearing aid exams	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Hearing aid exam maximum	One hearing exam every **policy year**	

Eligible health services	In-network coverage	Out-of-network coverage
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	
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
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 (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		
Performed by a legally qualified ophthalmologist or optometrist	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	
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	

Eligible health services	In-network coverage	Out-of-network coverage
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.		
All other outpatient services and supplies		
All other outpatient services and supplies for which cost-sharing is not otherwise shown in this schedule of benefits	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
9. Outpatient prescription drugs		
Plan features		
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 31 day supply filled at a **retail 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 31 day supply filled at a **retail 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 31 day supply filled at a **retail 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 **retail pharmacy** or **mail order pharmacy**.		
Diabetic prescription drugs, supplies and insulin		
For each fill up to a 31 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the *schedule of benefits* above	Paid according to the type of drug per the *schedule of benefits* above

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

Limitations:	Coverage is limited to two, 90-day treatment programs only. Any additional treatment programs will be paid according to the tier of drug per the schedule of benefits, above. Coverage only includes **generic drug** when there is also a brand-name drug available. Coverage is subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, see the *How to contact us for help* section.

Dispense as written (DAW)

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

The cost difference related to a **prescription drug** that is not specified as "DAW" is not applied towards your **policy year deductible** or **maximum out-of-pocket limit**.

What your plan doesn't cover – eligible health service exclusions

We already told you about the many health care services and supplies that are eligible for coverage under your plan in the *Eligible health services under your plan* section. In that section we also told you that some health care services and supplies are not covered at all (exclusions). For example, **physician** care is an **eligible health service** but **physician** care for **cosmetic** surgery is never covered. This is an exclusion.

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

Exclusions

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

Alternative health care

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

Armed forces

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

Beyond legal authority

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

Cosmetic services and plastic surgery

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

Court-ordered services and supplies

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

Custodial care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- **Respite care**, except where stated in the *Eligible health services under your plan-Hospital and other facility care* section
- Adult (or child) day care, or convalescent care
- Institutional care (including **room and board** for rest cures, adult day care and convalescent care)
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service performed by a person without any medical or paramedical training

Dental care for adults

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

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

Educational services

Examples of these services are:

- Any service or supply for education, training or retraining services or testing, except where described in the Eligible health services under your plan – *Diabetic equipment, supplies and education* section. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment program (whether or not the program is part of a residential treatment facility or otherwise licensed institution)

  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Elective treatment or elective surgery

- **Elective treatment** or elective surgery except as specifically covered under the **student policy** and provided while the **student policy** is in effect.

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Facility charges

For care, services or supplies provided in:

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

Felony

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

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

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, laboratory, radiology, anesthesia, and nursing services.

Please refer to the *Medical necessity precertification requirements* section.

Genetic care

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

Growth/Height care

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

Incidental surgeries

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

Jaw joint disorder

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

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

Maintenance care

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

Medical supplies – outpatient disposable

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

Medicare

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

Non-medically necessary services and supplies

- Services and supplies which are not **medically necessary** for the diagnosis, care, or treatment of an **illness** or **injury** or the restoration of physiological functions.

Non-U.S .citizen

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

Obesity (bariatric) surgery

Organ removal

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

Personal care, comfort or convenience items

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

Riot

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

School health services

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

Services provided by a family member

- Services provided by a spouse, domestic partner, parent, child, 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**, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- **Surgery**, **prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ, provided however, this exclusion does not apply to services for treatment of gender identity disorder or gender dysphoria
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Sinus surgery

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

Sleep apnea

- Any services or supplies given by **providers** for the treatment of obstructive sleep apnea and sleep disorders.

Sports

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

Store and forward technology

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

Strength and performance

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

Students in mental health field

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

Telemedicine

- Services given by **providers** that are not contracted with **Aetna** as **telemedicine providers**.
- Services that are not provided in real time.
- Services that are not interactive, including:
  - Telephone calls that are audio only
  - Faxes
  - Emails
  - **Telemedicine** kiosks

- Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

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

Tobacco cessation

Except where described in this certificate of coverage:

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

Treatment in a federal, state, or governmental entity

Except where required by law:

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

Vision care for adults

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

Wilderness treatment programs

See *Educational services* within this section

Work related illness or injuries

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

The Western Washington University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

Sanctioned Countries

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). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).