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

Washington State University – Graduate Assistants

Policy Year: 2026–2027
Policy Number: 246865
www.aetnastudenthealth.com
(877) 480-4161

Disclaimer: These rates and benefits are pending approval by the Washington Department of Insurance and can change. If they change, we will update this information.

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

COUGAR HEALTH SERVICES

The University Health Services is the University's on-campus health facility. Staffed by medical doctors, nurse practitioners and physician assistants, it is open Monday, Tuesday, Thursday and Friday 8:00am to 5:00pm and Wednesday's open from 9:00am to 5:00pm during the Fall and Spring semesters. During the summer, hours are 8:20am-4:00pm. An after hours nurse line is available after hours, weekends and holidays. For more information, call the Health Services at 509-335-3575. In the event of an emergency, call 911.

Who is eligible?

Graduate Student Assistants

Graduate Student Assistants who are enrolled in 10 or more credit hours and who have an Assistantship stipend of at least 50% for an academic semester or more; and full time Research Fellows/Trainees who are paid a stipend of at least $800 per month who are engaged in research similar to that of a Research Assistant will be automatically enrolled in the Plan by the University. Non appointed Graduate Students in WSU Health Science Colleges, including Medicine, Nursing, Pharmacy and Veterinary Medicine, are eligible to be enrolled in this insurance plan unless covered by other insurance.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse or Domestic Partner and dependent children under 26 years of age. See the Definitions section of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

The Company maintains its right to investigate eligibility or student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

The eligibility date for Dependents of the Named Insured shall be determined in accordance with the following:

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
    a. On the date the Named Insured acquires a legal spouse or a Domestic Partner who meets the specific requirements set forth in the Definitions section of the Certificate.
    b. On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the Definitions section of the Certificate.

Dependent eligibility expires concurrently with that of the Named Insured.

Dependent Coverage Eligibility

Covered students may also enroll their:

- Legal spouse
- Domestic partner
- 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)
    - Grandchildren in your court-ordered custody
    - A grandchild whose parent is already covered as a dependent under this plan
    - Any other child with whom you have a parent-child relationship

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.

The rates below include premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as an administrative fee.

	Fall 08/16/2026 – 12/31/2026	Spring/Summer 01/01/2027 – 08/15/2027
Student	$1,622	$2,668
Spouse	$1,622	$2,668
Child	$1,622	$2,668
Two or More Children	$3,212	$5,286

Deadlines

Enrollment/Waiver Deadlines		
	Fall	**Spring/Summer**
Student and Dependents	**09/10/2026**	**01/28/2027**

Enrollment

Graduate Student Assistants who are enrolled in 10 or more credit hours and who have an Assistantship stipend of at least 50% for an academic semester or more; and full time Research Fellows/Trainees who are paid a stipend of at least $800 per month who are engaged in research similar to that of a Research Assistant will be automatically enrolled in the Plan by the University. Non appointed Graduate Students in WSU Health Science Colleges, including Medicine, Nursing, Pharmacy and Veterinary Medicine, are eligible to be enrolled in this insurance plan unless covered by other insurance.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse or Domestic Partner and dependent children under 26 years of age.

To enroll the dependent(s) of a covered student, please visit https://www.aetnastudenthealth.com , select Washington State University – Graduate and Health Sciences in the dropdown menu, and click "View Your School". Click on "Enroll/Waive" link and follow the instructions on the screen. If you have any questions, please contact Member Services at (877) 480-4161 for assistance.

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, call Member Services at (877) 480-4161.

Medicare Eligibility Notice

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

Termination and Refunds

Withdrawal from Classes – Leave of Absence

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

Withdrawal from Classes – Other than Leave of Absence

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

In-network Provider Network

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

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

Precertification

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

Precertification Call

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

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

We will provide a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 30 days as long as you remain enrolled in the plan.

Coordination of Benefits (COB)

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

Description of Benefits

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

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

Policy year deductible	In-network coverage	Out-of-network coverage
Student	$300 per policy year	$300 per policy year
Spouse	$300 per policy year	$300 per policy year
Each child	$300 per policy year	$300 per policy year

Policy year deductible waiver

The policy year deductible is waived for all of the following covered services:

- In-network care and out-of-network care for *Preventive care and wellness, Outpatient Prescription Drugs, Ambulance and Adult Vision Exams and Supplies*
- In-network for *Pediatric Vision, Pediatric Type A Dental, Well-Newborn Nursery, Abortion*

Campus Clinics:
Benefits will be paid as specified below for services not covered by the student health fee when treatment is rendered at Cougar Health Services (CHS) on the Pullman campus, and Community Health of Central Washington for students attending the Yakima campus.

- All CHS locations: The Deductible and Copays will be waived for Covered Medical Expenses incurred when treatment is rendered at CHS.
- At CHS Pullman Campus location only: Benefits will be paid at 100% for Covered Medical Expenses subject to any benefit maximums, except as follows: Outpatient Physiotherapy will be paid at 80% for Covered Medical Expenses.
- Prescription Drugs will be paid at 100% after a $20 Copay for generic drugs and $40 Copay for brand-name drugs up to a 90-day supply.
- At Community Health of Central Washington location: Benefits will be paid at the Coinsurance and benefit maximums applicable to all other providers, except Outpatient Physiotherapy will be paid at 80% for Covered Medical Expenses incurred.
- Vision exams performed at CHS Pullman Campus will be covered at 100%.
- Chlamydia and Gonorrhea tests rendered at CHS Pullman Campus are covered at 100%, unless covered under the Preventive Care Services benefit.

Maximum out-of-pocket limit per policy year	
Student	$5,000 per policy year
Spouse	$5,000 per policy year
Each child	$5,000 per policy year
Family	$10,000 per policy year

Covered services	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a health professional's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit
Maximum age and visit limits per policy year through age 21	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.	
Maximum visits per policy year age 22 and over	1 visit	
The following are not covered under this benefit: • Services for diagnosis or treatment of a suspected or identified illness or injury • Exams given during your stay for medical care • Services not given by or under a health professional's direction • Psychiatric, psychological, personality or emotional testing or exams		
Preventive care immunizations		
Performed in a facility or at a health professional's office	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	100% (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.	
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment.		
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a health professional's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	

Covered services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (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 at age 45, or earlier if at increased risk due to health factors or family history • The comprehensive guidelines supported by the Health Resources and Services Administration For details, contact your health professional or Aetna by logging onto your Aetna website at www.aetnastudenthealth.com or calling the toll-free number in the *How to contact us for help* section.	
Lung cancer screening maximums	1 screenings every 12 months	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit
Lactation support and counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit
Breast pump supplies and accessories	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit

Covered services	In-network coverage	Out-of-network coverage
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit
Female contraceptive prescription drugs and devices	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit
Voluntary sterilization-Inpatient & Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	100% (of the recognized charge) per visit
The following are not preventive covered services: • The reversal of voluntary sterilization procedures, including any related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Contraception services received during an unrelated stay in a hospital or other facility for medical care		
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) includes telemedicine consultations)	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing & Allergy injections treatment including Allergy sera and extracts administered via injection performed at a health professional's or specialist's office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Physician and specialist - surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Covered services	In-network coverage	Out-of-network coverage
Outpatient surgery performed at a health professional's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • The services of any other physician who helps the operating physician, unless medically necessary • Services of another physician for the administration of a local anesthetic		
Alternatives to physician or other health professional office visits		
Walk-in clinic visits	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies Includes birthing center facility charges	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered services: • All services and supplies provided in: - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps		
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • A stay in a hospital. (A hospital stay is an inpatient hospital benefit. See the *Covered services under your plan* section.) • A separate facility charge for surgery performed in a physician's office. • Services of another physician for the administration of a local anesthetic		
Home health Care	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	130	

<table>
<tr><th>Covered services</th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td colspan="3">The following are not covered under this benefit:
• Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
• Transportation
• Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
• Homemaker or housekeeper services
• Food or home delivered services
• Maintenance therapy</td></tr>
<tr><td>Hospice-Inpatient</td><td>80% (of the negotiated charge) per visit</td><td>60% (of the recognized charge) per visit</td></tr>
<tr><td>Hospice-Outpatient</td><td>80% (of the negotiated charge) per visit</td><td>60% (of the recognized charge) per visit</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
• Funeral arrangements
• Pastoral counseling
• Bereavement counseling
• Financial or legal counseling, including estate planning and the drafting of a will
• Homemaker or caretaker services, which are services not solely related to your care and may include:
– Sitter or companion services for either you or other family members
– Transportation
– Maintenance of the house</td></tr>
<tr><td>Outpatient private duty nursing</td><td>80% (of the negotiated charge) per visit</td><td>60% (of the recognized charge) per visit</td></tr>
<tr><td>Skilled nursing facility-Inpatient</td><td>80% (of the negotiated charge) per visit</td><td>60% (of the recognized charge) per visit</td></tr>
<tr><td>Emergency room</td><td>$200 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit</td><td>Paid the same as in-network coverage</td></tr>
<tr><td>Non-emergency care in an emergency room</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td colspan="3">Important note:
• If you get emergency services from an out-of-network provider or hospital, the most the provider or hospital may bill you is your plan’s in-network cost-sharing amount. You can’t be balance billed for these emergency services. See Your Rights and Protections Against Surprise Medical Bills and Balance Billing in Washington State in the certificate of coverage for more information.
• A separate emergency room copayment will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment will be waived and your inpatient copayment will apply.
• Covered benefits that are applied to the emergency room copayment cannot be applied to any other copayment under the plan. Likewise, a copayment that applies to other covered benefits under the plan cannot be applied to the emergency room copayment.
• Separate copayment amounts may apply for certain services given to you in the hospital emergency room that are not part of the l emergency room benefit. These copayment amounts may be different from the hospital emergency room copayment. They are based on the specific service given to you.
• Services given to you in the emergency room that are not part of the emergency room benefit may be subject to copayment or coinsurance amounts.</td></tr>
</table>

<table>
<tr><th>Covered services</th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td>Urgent Care</td><td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</td><td>$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit</td></tr>
<tr><td>Non-urgent use of urgent care provider</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
Non-emergency services in an emergency room facility
Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)</td></tr>
<tr><td colspan="3">Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)</td></tr>
<tr><td>Type A services</td><td>100% (of the negotiated charge) per visit

No copayment or deductible applies</td><td>75% (of the recognized charge) per visit</td></tr>
<tr><td>Type B services</td><td>80% (of the negotiated charge) per visit</td><td>75% (of the recognized charge) per visit</td></tr>
<tr><td>Type C services</td><td>50% (of the negotiated charge) per visit</td><td>50% (of the recognized charge) per visit</td></tr>
<tr><td>Orthodontic services</td><td>50% (of the negotiated charge) per visit</td><td>50% (of the recognized charge) per visit</td></tr>
<tr><td>Dental emergency treatment</td><td>Covered according to the type of benefit and the place where the service is received.</td><td>Covered according to the type of benefit and the place where the service is received.</td></tr>
<tr><td colspan="3">Pediatric dental care exclusions
The following are not covered under this benefit:
Any instruction for diet, plaque control and oral hygiene for those age 9 and older.
Asynchronous dental treatment
Cosmetic services and supplies including:
Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance
Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the Covered 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
Mouth guards, and other devices to protect, replace or reposition teeth
Dental implants except when part of an approved treatment plan for a covered service described in Covered</td></tr>
</table>

services and exclusions - Reconstructive surgery and supplies

- 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 dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Covered services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another covered service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs
- 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 provided in the *Pediatric dental care* section of the schedule of benefits
- 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
-

Covered services	**In-network coverage**	**Out-of-network coverage**
Specific Conditions		
Diabetic services, Supplies and education	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Impacted wisdom teeth	80% (of the negotiated charge)	60% (of the recognized charge)
Temporomandibular joint dysfunction treatment (TMJ)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Dental implants		
Accidental injury to sound natural teeth	80% (of the negotiated charge)	60% (of the recognized charge)

<table>
<tr><th>Covered services</th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td colspan="3">The following are not covered 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
</td></tr>
<tr><td>Obesity Surgery</td><td>Covered according to the type of benefit and the place where the service is received.</td><td>Covered according to the type of benefit and the place where the service is received.</td></tr>
<tr><td colspan="3">The following are not covered services:

Weight management treatment.
Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate.
Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:

Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
Hypnosis, or other forms of therapy]

Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.
</td></tr>
<tr><td>Dermatological treatment</td><td>Covered according to the type of benefit and the place where the service is received</td><td>Covered according to the type of benefit and the place where the service is received</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:

Acne treatment
Cosmetic treatment and procedures
</td></tr>
<tr><td colspan="3">Maternity care</td></tr>
<tr><td>Maternity care (includes delivery and postpartum care services in a hospital or birthing center)</td><td>Covered according to the type of benefit and the place where the service is received.</td><td>Covered according to the type of benefit and the place where the service is received.</td></tr>
<tr><td>Well newborn nursery care in a hospital or birthing center</td><td>80% (of the negotiated charge)

No policy year deductible applies</td><td>60% (of the recognized charge)

No policy year deductible applies</td></tr>
<tr><td colspan="3">Family planning services – other</td></tr>
<tr><td>Abortion-Inpatient</td><td>100% (of the negotiated charge)

No policy year deductible applies</td><td>60% (of the recognized charge)</td></tr>
</table>

Covered services	In-network coverage	Out-of-network coverage
Abortion- Outpatient	100% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge)
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Cosmetic services and supplies unless they are 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, which are used in feminization – Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic		
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Behavioral Health **Mental Health & Substance Abuse Treatment**		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient office visits (includes telemedicine consultations)	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

<table>
<tr><th>Covered services</th><th>In-network coverage (IOE facility)</th><th>Out-of-network coverage
(Includes providers who are otherwise part of Aetna’s network but are non-IOE providers)</th></tr>
<tr><td>Inpatient</td><td>80% per transplant</td><td>60% per transplant</td></tr>
<tr><td>Outpatient</td><td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</td><td>$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit</td></tr>
<tr><td>Physician and specialist services</td><td>Covered according to the type of benefit and the place where the service is received</td><td>Covered according to the type of benefit and the place where the service is received</td></tr>
<tr><td colspan="3">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</td></tr>
<tr><td>Basic infertility services</td><td>Covered according to the type of benefit and the place where the service is received.</td><td>Covered according to the type of benefit and the place where the service is received.</td></tr>
<tr><td colspan="3">Infertility services exclusions
The following are not covered under the infertility services benefit:
All infertility services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
Infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
Intrauterine (IUI)/intracervical insemination (ICI) services. Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
The donor’s care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
A gestational carrier’s care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
Home ovulation prediction kits or home pregnancy tests.
The purchase of donor embryos, donor eggs or donor sperm.
Obtaining sperm from a person not covered under this plan.
Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
Infertility treatment when infertility is due to a natural physiologic process such as age-related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna’s infertility clinical policy.</td></tr>
</table>

Covered services	In-network coverage	Out-of-network coverage
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) per visit	60% (of the recognized charge) per visit
Diagnostic lab work and radiological services performed in a health professional's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
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 infusion therapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Enteral nutrition • Blood transfusions and blood products		
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient aural, physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Neurodevelopmental therapy services – Outpatient physical, occupational, speech and cognitive therapies. Combined for rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Acupuncture therapy	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit
Chiropractic services	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit

<table>
<tr><th>Covered services</th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td>Maximum visits per policy year</td><td colspan="2">35</td></tr>
<tr><td colspan="3">Other services and supplies</td></tr>
<tr><td>Emergency ground, air, and water ambulance</td><td>$200 copayment then the plan pays 100% (of the balance of the negotiated charge) per trip</td><td>Paid the same as in-network coverage</td></tr>
<tr><td>Non-emergency ground, air, and water ambulance</td><td>$200 copayment then the plan pays 100% (of the balance of the negotiated charge) per trip</td><td>Paid the same as in-network coverage</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
• Ambulance services, for routine transportation to receive outpatient or inpatient services</td></tr>
<tr><td colspan="3">Clinical trials</td></tr>
<tr><td>Routine patient costs</td><td>Covered according to the type of benefit and the place where the service is received.</td><td>Covered according to the type of benefit and the place where the service is received.</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
• Services and supplies related to data collection and analysis needs and are not used in your direct clinical management
• Services and supplies provided by the trial sponsor for free
• The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)</td></tr>
<tr><td>Durable medical and surgical equipment</td><td>80% (of the negotiated charge) per item</td><td>60% (of the recognized charge) per item</td></tr>
<tr><td colspan="3">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</td></tr>
<tr><td>Nutritional support</td><td>Covered according to the type of benefit and the place where the service is received.</td><td>Covered according to the type of benefit and the place where the service is received.</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
• Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in this section</td></tr>
</table>

Covered services	In-network coverage	Out-of-network coverage
Prosthetic Devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item	80% (of the actual charge) per item
The following is not covered under this benefit: • Services covered under any other benefit • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft		
Hearing aids and exams		
Hearing exams	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit
Hearing exam maximum	One hearing exam every policy year	
The following are not covered under this benefit: • Any ear or hearing exam if the services are not within the health care provider's permitted scope of practice • Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay		
Hearing aids	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aid maximum per ear	One hearing aid per ear every 3 years	
The following are not covered under this benefit: • A replacement of: – A hearing aid that is lost, stolen or broken – A hearing aid installed within the prior 12 month period • Replacement parts or repairs for a hearing aid • Batteries or cords • Cochlear implants • A hearing aid that does not meet the specifications prescribed for correction of hearing loss • Any ear or hearing exam if the services are not within the health care provider's permitted scope of practice • Any tests, appliances and devices to: – Improve your hearing, including hearing aid batteries, amplifiers, and auxiliary equipment – Enhance other forms of communication to make up for hearing loss or devices that simulate speech		
Podiatric (foot care) treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Covered services	In-network coverage	Out-of-network coverage
The following are not covered under this benefit: • Services and supplies for: – The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches – The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes – Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet		
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the recognized charge) per visit]
Maximum visits per policy year	1 visit	
Pediatric comprehensive vision exams (including refraction)	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the recognized charge) per visit]
Maximum visits per policy year	1 visit	
Pediatric low vision evaluations and services		
Performed by a legally qualified ophthalmologist or optometrist, including optical devices, services, training and instructions	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maximum	1 visit every 5 policy years	
Pediatric vision care services and supplies		
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the recognized charge) per visit]
Maximum	1 visit	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the recognized charge) per visit]
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses	 One set of eyeglass frames One pair of prescription lenses One year supply	

Covered services	In-network coverage	Out-of-network coverage
The following are not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		
Vision Care-Limited to covered persons age 19 and over		
Adult routine vision exams (including refraction) Performed by a legally qualified ophthalmologist or optometrist	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year Maximum per policy year	1 visit $100	
Note: The maximum does not apply when services are rendered at the CHS student health center		
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	100% (of the actual charge) per item No policy year deductible applies
Maximum per policy year eyeglass frames, prescription lenses or prescription contact lenses	$200	
*__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.		

Covered services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs		
Preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy or **specialty pharmacy**	$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	80% (of the recognized charge) No policy year deductible applies
More than a 31 day supply but less than a 90 day supply filled at a mail order pharmacy]	$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	80% (of the recognized charge) No policy year deductible applies
Preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy or **specialty pharmacy**	$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	70% (of the recognized charge) No policy year deductible applies
More than a 31 day supply but less than a 90 day supply filled at a mail order pharmacy]	$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	70% (of the recognized charge) No policy year deductible applies
Non-preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy or **specialty pharmacy**	$80 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	70% (of the recognized charge) No policy year deductible applies
More than a 31 day supply but less than a 90 day supply filled at a mail order pharmacy	$200 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	70% (of the recognized charge) No policy year deductible applies
Non-preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy or specialty pharmacy	$80 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	70% (of the recognized charge) No policy year deductible applies
More than a 31 day supply but less than a 90 day supply filled at a mail order pharmacy	$200 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	70% (of the recognized charge) No policy year deductible applies

Covered services	In-network coverage	Out-of-network coverage
Diabetic insulin important note: Your cost share per 30 day supply of a covered diabetic **prescription** filled at an **in-network pharmacy** will not exceed: • $25 for preferred **prescription** insulin No **deductible** applies for insulin and any cost share will apply toward your **deductible**.		
Orally administered anti-cancer prescription drugs- For each fill up to a 30 day supply filled at a retail or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Preventive care drugs and supplements filled at a retail or mail order pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy (preventative care) For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	

Outpatient prescription drug exclusions

The following are not covered services:

- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- 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 covered 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 covered service
  - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications 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 covered 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
- 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

General Exclusions

Cosmetic services and plastic surgery

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

Court-ordered testing

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

Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs.
Examples of these are:

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

Dental care for adults

- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolectomy
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth

- Prosthetic restoration of dental implants
- Dental implants except when part of an approved treatment plan for a **covered service** described in the *Covered services and exclusions – Reconstructive surgery and supplies* section.

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

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs, whether or not the program is part of a residential treatment **f**acility or otherwise licensed institution
  - Job training
  - Job hardening programs
- Any services that are schooling related or similar programs
- Therapeutic programs within a school, vocational, work, or recreational setting

Examinations

Any health or dental examinations needed:

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

Experimental, investigational, or unproven

- Experimental, investigational, or unproven drugs, devices, treatments or procedures unless otherwise covered under clinical trials

Growth/Height care

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

Jaw joint disorder

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

This exclusion does not apply to covered services for treatment of TMJ as described in the Covered services and exclusions –Temporomandibular joint dysfunction (TMJ)section.

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services.

Medical supplies – outpatient disposable

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

Non-U.S .citizen

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

Obesity surgery and services

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

Personal care, comfort or convenience items

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

Routine exams and preventive services and supplies

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the Covered services and exclusions section

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. Emergency **prescription drugs** received outside of the United States are covered.

Sexual dysfunction and enhancement

- Except where described in the Covered services and exclusions section, any treatment, prescription drug, 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

Sports

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

Store and forward technology

- Services for which there is no related office visit with the **provider**
- Services using emails

Strength and performance

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

Students in mental health field

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

Telemedicine

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

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Tobacco cessation

Except where described in this certificate of coverage:

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

Treatment in a federal, state, or governmental entity

Except where required by law:

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

Wilderness treatment programs

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

Work related illness or injuries

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

Important note:

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

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

Sanctioned Countries

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

Assistive Technology

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

Smartphone or Tablet

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

Non-discrimination notice

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

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

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

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

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

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

You can also file a civil rights complaint with:

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

  U.S. Department of Health and Human Services

  200 Independence Avenue, SW Room 509F, HHH Building

  Washington, D.C. 20201

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

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

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