Student Health Insurance

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

Certificate of Coverage

Prepared exclusively for:

Policyholder:	Eastern Washington University
Policyholder number:	686215
Student policy effective date:	September 17, 2023
Plan effective date:	September 17, 2023
Plan issue date:	September 5, 2023

Underwritten by Aetna Life Insurance Company in the state of Washington

IMPORTANT NOTICES:

- **Notice of Non-Discrimination: Aetna Life Insurance Company** does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.
- **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). Visit https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx to find out more.

Welcome

Thank you for choosing **Aetna®**.

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

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

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

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

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

Welcome to your **Aetna** plan.

Table of contents

Let's get started!

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

Some notes on how we use words

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

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

What your plan does – providing covered benefits

Your plan provides **covered benefits**. Benefits are provided for **eligible health services**. Your plan has an obligation to pay for **eligible health services**.

How your plan works – starting and stopping coverage

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

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

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

Eligible health services

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

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

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

Paying for eligible health services– the general requirements

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

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

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

Paying for eligible health services– sharing the expense

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

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

Disagreements

We know that people sometimes see things differently.

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

For more information see the *When you disagree – claim decisions and appeal procedures* section.

How your plan works while you are covered in-network

Your in-network coverage helps you:

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

School health services

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

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

Routine care generally includes:

- preventive care
- office visits
- lab
- x-ray
- infusion therapy
- physical therapy
- mental health counseling and psychological services

Acupuncture and routine eye exams are not included.

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

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

Aetna's network of providers

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

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

Service area

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

The Washington service area is statewide without limitations.

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

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

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

Your out-of-network coverage:

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

You will find details on:

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

Surprise bill

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

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

How to contact us for help

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

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

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

Your ID card

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

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

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

We also mailed an ID card to you. You can show your ID card each time you get health care from a **provider** to help them bill us correctly and help us better process their claims.

Who the plan covers

You will find information in this section about:

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

Who is eligible

All International students, visiting faculty, and scholars maintaining a current passport and valid visa status (F-1, J-1 or M-1, etc.), engaged in educational activities at Eastern Washington University who are temporarily located outside of their home country and have not been granted permanent residency status, are automatically enrolled in this insurance plan at registration. The insurance can be waived if proof of valid comparable coverage is furnished.

All Domestic students who are taking 10 or more credit hours are eligible to enroll in this insurance plan. All Domestic students who are registered for the summer term must have 3 or more credit hours on-campus are eligible to enroll in this insurance plan.

Those enrolled in the Optional Practical Training program are eligible to enroll on a voluntary basis.

Medicare eligibility

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

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

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

When you can join the plan

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

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

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

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

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

- Your legal spouse
- Your domestic partner
- Your dependent children (your own or those of your spouse or domestic partner)
  - The children must be under 26 years of age, and they include your:
    - Biological children

- Stepchildren
- Legally adopted children, including any children placed with you for adoption
- Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
- 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

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

Adding new dependents

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

- A spouse – If you marry, you can put your spouse on your plan
  - We must receive your completed enrollment information not more than 60 days after the date of your marriage
  - The benefits for your spouse will begin the first day of the month following the date of marriage
- A domestic partner – If you enter a domestic partnership, you can put your domestic partner on your plan
  - We must receive your completed enrollment information not more than 60 days after the date of your domestic partnership
  - The benefits for your domestic partner will begin the first day of the month following the date of your domestic partnership
- A newborn child or grandchild – Your newborn child or grandchild is covered on your plan for the first 60 days after birth
  - When additional **premiums** are required, you must enroll the child within 60 days of birth to keep the newborn covered
  - If you miss this deadline, your newborn will not have benefits after the first 60 days
- An adopted child – You may put an adopted child on your plan on the date the child is placed for adoption
  - "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child
  - When additional **premiums** are required, you must enroll the child within 60 days of placement
  - Your adopted child's coverage will start from the date of placement
  - If you miss this deadline, your adopted child will not have benefits
- A stepchild – You may put a child of your spouse or domestic partner on your plan
  - You must enroll the child within 60 days of the date of your marriage or domestic partnership with your stepchild's parent
  - The benefits for your stepchild will begin the first day of the month following the date we receive your completed enrollment information

Inform us of any changes

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

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

Special times you and your dependents can join the plan

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

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

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

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

Effective date of coverage

Student coverage

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

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

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

Dependent coverage

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

Late enrollment

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

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

Medical necessity and precertification requirements

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

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

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

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

Medically necessary; medical necessity

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

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

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

Precertification

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

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

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

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

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

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

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

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

What if you don't obtain the required precertification?

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

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

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

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

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

What types of services require precertification?

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

Inpatient 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 treatment of **mental health disorders** and **substance related disorders***	Non-emergency transportation by airplane
Stays in a **skilled nursing facility**	Gene-based, cellular and other innovative therapies (GCIT)
Gender affirming treatment	Gender affirming treatment
	Home health care
	Hospice services
	Intensive outpatient program (IOP) – **mental health disorder** and **substance related disorders** treatment
	Kidney dialysis
	Knee **surgery**
	Medical **Injectables** (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 health disorder** and **substance related disorders** treatment
	Private duty nursing services
	Sleep studies
	Transcranial magnetic stimulation (TMS)
	Wrist **surgery**

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

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

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

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

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

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

Eligible health services under your plan

The information in this section is the first step to understanding your plan's **eligible health services**. If you have questions about this section, see the *How to contact us for help* section.

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

For example,

- **Physician** care generally is covered but **custodial care** is not covered. Custodial care is an exclusion.
- Home health care is generally covered but it is a **covered benefit** only up to a set number of visits a year. This is a limitation.

You can find out about exclusions in the *Exclusions* section and about limitations in the schedule of benefits.

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

1. Preventive care and wellness

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

Important notes:

1. You will see references to the following recommendations and guidelines in this section:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
   - United States Preventive Services Task Force
   - Health Resources and Services Administration
   - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

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

2. Diagnostic testing is not covered under the preventive care benefit. You will pay the cost sharing specific to **eligible health services** for diagnostic testing.

3. Gender-specific preventive care benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. **Eligible health services** include screening for physical, mental, sexual, and reproductive health care needs as well as **medically necessary** services and **prescription** medications for the treatment of physical, mental, sexual, and reproductive health care needs that arise from a sexual assault.

5. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **health professional** or see the *How to contact us for help* section. This information can also be found at the www.healthcare.gov website.

Routine physical exams

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

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

The following are not covered under this benefit:

- Services for diagnosis or treatment of a suspected or identified **illness** or **injury**
- Exams given during your **stay** for medical care
- Services not given by or under a **physician's** direction
- Psychiatric, psychological, personality or emotional testing or exams

Preventive care immunizations

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

Your plan does not cover immunizations that are not considered preventive care.

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **health professional**, such as an obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes Pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **health professional** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.

Preventive screening and counseling services

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

Obesity and/or healthy diet counseling

Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:

- Preventive counseling visits and/or risk factor reduction intervention
- Nutritional counseling
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

Misuse of alcohol and/or drugs

Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:

- Preventive counseling visits
- Risk factor reduction intervention
- A structured assessment

Use of tobacco products

Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:

- Preventive counseling visits
- Treatment visits
- Class visits

Tobacco product means a substance containing tobacco or nicotine such as:

- Cigarettes
- Cigars
- Smoking tobacco
- Snuff
- Smokeless tobacco
- Candy-like products that contain tobacco

Sexually transmitted infection counseling

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

Genetic risk counseling for breast and ovarian cancer

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

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms, including 3-D mammograms (tomosynthesis)
- Prostate specific antigen (PSA) tests
- Digital rectal exams

- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies (includes:
  - Bowel preparation medications
  - Anesthesia
  - Removal of polyps performed during a screening procedure
  - Pathology exam on any removed polyps)
- Lung cancer screenings

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

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

Prenatal care

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

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

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

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

Comprehensive lactation support and counseling services

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

Breast feeding durable medical equipment

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

Breast pump

Eligible health services include:

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

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

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

Breast pump supplies and accessories

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

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

Family planning services

Eligible health services include family planning services such as:

Counseling services

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

Devices

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

Voluntary sterilization

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

The following are not covered under this benefit:

- The reversal of voluntary sterilization procedures, including any related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Contraception services received during an unrelated **stay** in a **hospital** or other facility for medical care

Important note: See the following sections for more information.

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

2. Physicians and other health professionals

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

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

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

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

Allergy testing and treatment

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

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

Physician and specialist – inpatient surgical services

Eligible health services include the services of:

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

Anesthetist

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

Surgical assistant

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

Physician and specialist – outpatient surgical services

Eligible health services include the services of:

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

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

Anesthetist

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

Surgical assistant

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

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

In-hospital non-surgical health professional services

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

Consultant services (non-surgical and non-preventive)

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

Covered benefits include treatment by the consultant. The consultation by your **health professional** may happen by way of **telemedicine.**

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

Alternatives to physician or other health professional office visits

Walk-in clinic

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

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

3. Hospital and other facility care

Hospital care (facility charges)

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

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

- **Room and board** charges up to the **hospital's semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition)
- Services of **health professionals** employed by the **hospital**, including services for inpatient respite care
- Operating and recovery rooms
- **Intensive care units** of a **hospital**
- Administration of blood and blood derivatives
- Dialysis services
- Radiation therapy
- Inhalation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a **hospital**

Preadmission testing

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

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

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

Alternatives to hospital stays

Outpatient surgery (facility charges)

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

The following are not covered under this benefit:

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

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

Home health care

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

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

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

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

The following are not covered under this benefit:

- Nursing and **home health aide** services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Homemaker or housekeeper services
- Food or home delivered services
- Maintenance therapy

Hospice care

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

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

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

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

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

The following are not covered under this benefit:

- Funeral arrangements
- Pastoral counseling
- Bereavement counseling
- Financial or legal counseling, 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

Outpatient private duty nursing

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

Skilled nursing facility

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

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

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

For your **stay** in a **skilled nursing facility** to be eligible for coverage, the following conditions must be met:

- The **skilled nursing facility** admission will take the place of:
  - An admission to a **hospital** or sub-acute facility
  - A continued **stay** in a **hospital** or sub-acute facility
- There is a reasonable expectation that your condition will improve enough to go home within a reasonable amount of time
- The **illness** or **injury** is severe enough to require constant or frequent skilled nursing care on a 24-hour basis

4. Emergency services and urgent care

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

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

- An **ambulance**
- The emergency room facilities
- The emergency room staff **health professional** services

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

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

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

For follow-up care, you are covered when:

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

In case of a medical emergency

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

Non-emergency condition

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

In case of an urgent condition

Urgent condition

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

Non-urgent care

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

Examples of non-urgent care are:

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

The following are not covered under this benefit:

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

5. Pediatric dental care

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

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

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

Orthodontic treatment

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

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

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

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

Not covered under this benefit are:

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

Replacements

The plan’s “replacement rule” applies to:

- Crowns
- Inlays
- Onlays
- Veneers

- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

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

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

When does your plan cover missing teeth that are not replaced?

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

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

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

An advance claim review

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

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

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

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

When to get an advance claim review

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

1. Ask your **dental provider** to write down a full description of the treatment you need. To do this, they must use an **Aetna** claim form or an American Dental Association (ADA) approved claim form.
2. Your **dental provider** should send the form to us before treating you.
3. We may request supporting images and other dental records.

4. Once we have received all the information we need, we will review your **dental provider's** plan. We will give you and your **dental provider** a statement of the benefits payable.
5. You and your **dental provider** can then decide how to proceed.

What is a course of dental treatment?

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

Exclusions

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

- Any instruction for diet, plaque control and oral hygiene for those age 9 and older.
- **Cosmetic** services and supplies including:
  - Plastic surgery, reconstructive surgery, **cosmetic** surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth, except to the extent coverage is specifically provided in the *Eligible health services under your plan* section
  - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be **medically necessary**), mouth guards and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic **surgery**, and treatment of malocclusion or devices to alter bite or alignment, except as specifically covered in this section
- Orthodontic treatment except as covered above and in the *Eligible health services under your plan – Pediatric dental care* section
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically described in the *Eligible health services under your plan – Pediatric dental care* section
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a **dental provider**

6. Specific conditions

Birthing center

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

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

Eligible health services also include charges made by:

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

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

Diabetic equipment, supplies and education

Eligible health services include:

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

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

Temporomandibular joint dysfunction treatment (TMJ)

Eligible health services include the:

- Diagnostic or therapeutic services including treatment of associated myofascial pain
- Medical and dental surgical treatment
- Medical and dental non-surgical treatment including prosthesis placed directly on the teeth

for TMJ by a **provider**

The following are not covered under this benefit:

- Dental implants

Impacted wisdom teeth

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

Accidental injury to sound natural teeth

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

The following are not covered under this benefit:

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

Dermatological treatment

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

The following are not covered under this benefit:

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

Maternity and related newborn care

Eligible health services include:

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

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

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

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

Gender affirming treatment

Eligible health services include certain services and supplies for gender reassignment (sometimes called sex reassignment) treatment.

Eligible health services under this benefit include:

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

The following are not covered under this benefit:

- **Cosmetic** services and supplies, unless they are **medically necessary** for treatment of gender identity disorder or gender dysphoria. Services include, but are not limited to the following:
  - Rhinoplasty
  - Face-lifting
  - Lip enhancement
  - Facial bone reduction
  - Blepharoplasty
  - Liposuction of the waist (body contouring)
  - Reduction thyroid chondroplasty (tracheal shave)
  - Hair removal (including electrolysis of face and neck)
  - Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing
  - Chin implants, nose implants, and lip reduction

Important note: As a reminder, gender affirming treatment requires **precertification** by **Aetna**. Your **network provider** is responsible for obtaining **precertification**. You are responsible for making sure that **precertification** is obtained if you are using an **out-of-network provider**. **Precertification** can be requested by either you or your **out-of-network provider**. Visit https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html for detailed information about this **covered benefit,** including eligibility requirements. You can also call *Member Services* at the toll-free number 1-877-480-4161.

Autism spectrum disorder

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

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

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

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

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

Behavioral health

Mental health treatment

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

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

Substance related disorders treatment

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

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

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

Reconstructive surgery and supplies

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

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

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

Transplant services

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

This includes the following transplant types:

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

Network of transplant facilities

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

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

Important note:

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

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

Travel and lodging expenses

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

The following are not covered under this benefit:

- Services and supplies furnished to a donor when the recipient is not a **covered person**
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing **illness**
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing **illness**

Treatment of infertility

Basic infertility services

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

- To diagnose and evaluate the underlying medical cause of **infertility**.
- To do **surgery** to treat the underlying medical cause of **infertility**. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.

The following are not covered under this benefit:

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

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

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

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

Diagnostic lab work and radiological services

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

Genetic and prenatal testing

Eligible health services include:

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

Outpatient therapies

Chemotherapy

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

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

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

Key Terms

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

Gene

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

Molecular

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

Therapeutic

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

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

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

Eligible health services for GCIT include:

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

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

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

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 and precertification requirements* section.

Outpatient infusion therapy

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

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

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

Infusion therapy is the administration of prescribed medications or solutions through an IV.

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

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

The following are not covered under this benefit:

- Enteral nutrition
- Blood transfusions and blood products

Outpatient radiation therapy

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

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

Specialty prescription drugs

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

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

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

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

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

Outpatient respiratory therapy

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

Transfusion or kidney dialysis of blood

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

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

Cardiac and pulmonary rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

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

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

Rehabilitation, habilitation and neurodevelopmental therapy

Rehabilitation therapy services

Rehabilitation therapy services help you restore or develop skills and functioning for daily living. **Eligible health services** include rehabilitation therapy services your **health professional** prescribes. The services have to be provided by a:

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

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

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Cognitive rehabilitation therapy associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function
- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute **illness**, **injury** or **surgical procedure**
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness**, **injury** or **surgical procedure**

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

Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

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

Habilitation therapy services

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

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

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

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

Outpatient aural, physical, occupational, and speech habilitation therapy

Eligible health services include:

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

Neurodevelopmental therapy services

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

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

Chiropractic services

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

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

Diagnostic testing for learning disabilities

Eligible health services include diagnostic testing for:

- Attention deficit disorder
- Attention deficit hyperactive disorder
- Dyslexia

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

8. Other services

Abortion

Eligible health services include services and supplies for an abortion. This is the voluntary termination of pregnancy performed by a **health professional**. An abortion is also covered when the pregnancy is the result of rape or incest, or if it places the woman's life in serious danger.

Acupuncture

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

Administration of blood and blood products

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

Ambulance service

Eligible health services include transport by professional ground **ambulance** services.

For **emergency services**:

- To the first **hospital** to provide **emergency services**
- From one **hospital** to another **hospital** if the first **hospital** cannot provide the **emergency services** you need

For non-**emergency** services:

- From **hospital** to your home or to another facility if an **ambulance** is the only safe way to transport you
- From your home to a **hospital** if an **ambulance** is the only safe way to transport you

Your plan also covers transportation to a **hospital** by professional air or water **ambulance** when:

- Professional ground **ambulance** transportation is not available
- Your condition is unstable, and requires medical supervision and rapid transport
- You are traveling from one **hospital** to another and
  - The first **hospital** cannot provide the **emergency services** you need
  - The two conditions above are met

The following are not covered under this benefit:

- **Ambulance** services, for routine transportation to receive outpatient or inpatient services

Clinical trials (routine patient costs)

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

An approved clinical trial must satisfy one of the following:

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

The following are not covered under this benefit:

- Services and supplies related to data collection and analysis needs and are not used in your direct clinical management
- Services and supplies provided by the trial sponsor without charge to you
- The experimental item, device, or service itself
- Services and supplies that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

Durable medical equipment (DME)

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

Coverage includes:

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

We:

- Assume no responsibility
- Make no express or implied warranties

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

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

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

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

The following are not covered under this benefit:

- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems
- Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a **health professional**

Nutritional support

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

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

The following are not covered under this benefit:

- Any food item, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in this section

Experimental or investigational therapies

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

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

Prosthetic devices

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

Prosthetic device means:

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

Coverage includes:

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

The following 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

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

Hearing aid means:

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

Hearing aid services are:

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

Hearing aids alternate treatment rule

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

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

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

The following are not covered under this benefit:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 12 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- Cochlear implants
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam if the services are not within the health care provider's permitted scope of practice

Hearing exams

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

The following are not covered under this benefit:

- Any ear or hearing exam if the services are not within the health care provider's permitted scope of practice
- Hearing exams given during a stay in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital** stay

Podiatric (foot care) treatment

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

Non-routine treatment means:

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

The following are not covered under this benefit:

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

Telemedicine

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

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

Travel and lodging expenses

We will reimburse you for travel and lodging expenses when you need to travel at least 100 miles to access **eligible health services** because a law or regulation where you are located prohibits those **eligible health services**. The following are covered travel and lodging expenses:

- U.S. domestic travel expenses for the **covered person** and the **covered person's** travel companion in the 48 contiguous states (coach class air, bus, train or shuttle fares, taxi or ride share fares for local travel)
- Mileage costs, not to exceed amounts permitted by Internal Revenue Service guidelines
- Parking and tolls
- Lodging costs of up to $50 per night, per **covered person** or $100 per night, total, for the **covered person** and the **covered person's** travel companion, not to exceed amounts permitted by Internal Revenue Service guidelines

You must submit a travel and lodging claim form to be reimbursed. You will need to confirm travel was necessary because no **provider** within 100 miles of where you are located was available to provide the **eligible health services** when you submit your travel and lodging claim form.

Call the toll-free number on your ID card. Contact us to:

- Obtain a travel and lodging claim form
- Get assistance in locating a **provider**
- Get information about these **eligible health services** including specific eligibility requirements and limitations

We will reimburse your covered travel and lodging expenses as described in the schedule of benefits.

The following are not covered travel and lodging expenses:

- Expenses for more than one travel companion
- Gasoline/fuel costs
- Car rentals
- Meals, groceries, hotel room service, alcohol/tobacco products
- Personal care/convenience items, (e.g. shampoo, clothing, deodorant)
- Entertainment/souvenir expenses
- Telephone calls
- Taxes
- Tips, gratuities
- Childcare expenses
- Lost wages

Vision care - Pediatric vision care

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

Comprehensive vision exams

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

Low vision evaluations and services

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

Vision care supplies

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

Eligible health services include:

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

In any one year, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.

The following are not covered under this benefit:

- Special supplies such as non-**prescription** sunglasses
- Non-**prescription** eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your **stay** in a **hospital** or other facility for health care
- Acuity tests
- Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

9. Outpatient prescription drugs

Your prescription drug rights

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

What you need to know about your outpatient prescription drug covered benefits

Read this section carefully so that you know:

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

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

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

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

A **pharmacy** may refuse to fill a **prescription** order or refill when in the professional judgment of the pharmacist the **prescription** should not be filled.

Your plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication's FDA-approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

How to access network pharmacies

You can find a **network pharmacy** online or by phone. See the *How to contact us for help* section for details.

How the drug guide works

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

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

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

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

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

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

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

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

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

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

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

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

Eligible health services under your plan

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

- They are listed in the *Eligible health services under your plan* section
- They are not listed in the *Exclusions* section
- They are not beyond any limits in the schedule of benefits

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

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

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

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

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

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

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

Prescription drug synchronization

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

Retail pharmacy

Generally, **retail pharmacies** may be used for up to a 30 day supply of **prescription drugs**. You should show your ID card to the **network pharmacy** every time you get a **prescription** filled. The **network pharmacy** will submit your claim. You will pay any cost sharing directly to the **network pharmacy**.

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

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

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

Mail order pharmacy

Generally, the drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition.

Outpatient **prescription drugs** are covered when dispensed by a network **mail order pharmacy.** Each **prescription** is limited to a maximum 90 day supply. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a network **mail order pharmacy**.

Specialty pharmacy

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

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

Specialty prescription drugs may fall under various drug tiers regardless of their names. See the schedule of benefits for details on supply limits and cost sharing.

Other services

Preventive contraceptives

Your outpatient **prescription drug** plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. Your outpatient **prescription drug** plan also covers related services and supplies needed to administer covered devices. You can access the list of contraceptive drugs. See the *How to contact us for help* section for how.

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

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

You may be able to receive your covered contraceptive at your **provider's** office.

We cover over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA. Visit https://www.fda.gov/media/135111/download for more information. Note that not all drugs or devices in each contraceptive method are covered. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drugs** or devices for that method for the same cost share.

> **Important note:** You may qualify for a medical exception if your provider determines that the contraceptives covered standardly as preventive are not medically appropriate. Your **prescriber** may request a medical exception and submit the exception to us.

Diabetic supplies

Eligible health services include but are not limited to the following diabetic supplies upon **prescription** by a **prescriber**:

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

See the *Diabetic equipment, supplies and education* section for medical **eligible health services**.

Off-label use

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

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

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

Orally administered anti-cancer drugs, including chemotherapy drugs

Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

Over-the-counter drugs

Eligible health services include certain over-the-counter medications, as determined by the plan. Coverage of the selected over-the-counter medications requires a **prescription**, except for FDA-approved over-the-counter contraceptives. You can access the list by logging onto your Aetna member website at https://www.aetnastudenthealth.com.

Preventive care drugs and supplements

Eligible health services include the following preventive care drugs and supplements (including over-the-counter drugs and supplements) when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing:

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

Risk reducing breast cancer prescription drugs

Eligible health services include **prescription drugs** used to treat people who are at:

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

Tobacco cessation prescription and over-the-counter drugs

Eligible health services include FDA approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

How you get an emergency prescription filled

You may not have access to a **network pharmacy** in an emergency or urgent care situation. This may occur when the **network pharmacy** contacts us after business hours for preauthorization, when we can't reach your **provider** for consultation, or when you are traveling outside of the United States and require emergency care. If you must fill a **prescription** in these situations, we will reimburse you as shown in the table below.

Type of pharmacy	Your cost share
Network pharmacy	• You pay the **copayment**.
Out-of-network pharmacy	• You pay the **pharmacy** directly for the cost of the **prescription**. Then you fill out and send a **prescription drug** refund form to us, including all itemized **pharmacy** receipts. • Coverage is limited to items obtained in connection with covered emergency and out-of-area urgent care services. • Submission of a claim doesn't guarantee payment. If your claim is approved, you will be reimbursed the cost of your **prescription** less your **network copayment/ coinsurance**.

Where your schedule of benefits fits in

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

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

- The type of **prescription** you use
- Where you fill your **prescription**

The plan may, in certain circumstances make some **preferred brand-name prescription drugs** available to members at the generic **copayment** level. For example, an over-the-counter (OTC) branded product could be covered at the generic **copayment** level or when a generic version of a **brand-name prescription drug** becomes available, we may cover the brand-name at the generic **copayment** level.

What precertification requirements apply

Why do some drugs need precertification?

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

Step therapy

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

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

How can I request a medical exception?

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

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

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

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

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

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

Prescribing units

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

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

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

Exclusions

The following are not covered under this benefit:

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

- For which the cost is covered by a federal, state or government agency (for example: Medicaid or Veterans Administration)
- Not approved by the FDA or not proven to be safe and effective.
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies

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

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 generally an **eligible health service** but **custodial care** is not 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**.

Behavioral health treatment

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

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

Beyond legal authority

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

Cosmetic services and plastic surgery

- Any treatment, **surgery** (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, except as covered in the *Eligible health services under your plan* section.

Court-ordered testing

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

Custodial care

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

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

Dental care for adults

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

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

Educational services

Examples of these services are:

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

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Facility charges

For care, services or supplies provided in:

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

Felony

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

Genetic care

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

Growth/Height care

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

Incidental surgeries

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

Jaw joint disorder

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

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

Maintenance care

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

Sports

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

Store and forward technology

- Services for which there is no related office visit with the **provider**.
- Services using:
  - Faxes
  - Emails

Strength and performance

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

Students in mental health field

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

Telemedicine

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

Therapies and tests

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

Tobacco cessation

Except where described in this certificate of coverage:

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

Treatment in a federal, state, or governmental entity

Except where required by law:

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

Vision care for adults

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

Wilderness treatment programs

See *Educational services* within this section

Work related illness or injuries

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

Who provides the care

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

School health services

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

In-network providers

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

- **Emergency services** and urgent care – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section
- Transplants – see the description of transplant services in the *Eligible health services under your plan* section

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

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

Out-of-network providers

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

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

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

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

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

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

If this situation applies to you, contact us for details. As long as the **provider** did not leave the network based on fraud, lack of quality standards, or our termination of the **provide**r, you'll be able to receive transitional care from your **provider** for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

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

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

What the plan pays and what you pay

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

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

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

The general rule

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

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

And then

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

And then

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

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

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

Important note – when your plan pays all

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

Important note – when you pay all

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

- When you get a health care service or supply that is not **medically necessary.** See the *Medical necessity and precertification requirements* section.
- When your plan requires **precertification**, it was requested and we refused it, or you get an **eligible health service** without **precertification**. See the *Medical necessity and precertification requirements* section.

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

Special financial responsibility

You are responsible for the entire expense of cancelled or missed appointments.

Neither you nor we are responsible for:

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

Where your schedule of benefits fits in

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

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

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

When you disagree - claim decisions and appeal procedures

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

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

Claim procedures

For claims involving **out-of-network providers**:

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from us • The claim form will provide instructions on how to complete and where to send the form(s)	• If you are unable to complete a claim form, you must send us: – A description of services – Bill of charges – Any medical documentation you received from your **provider**
Proof of loss (claim) When you have received a service from an eligible provider, you will be charged. The information you receive for that service is your proof of loss.	• A completed claim form and any additional information required by us	• You must send us notice and proof as soon as reasonably possible
Benefit payment	• Written proof must be provided for all benefits • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss	• Benefits will be paid as soon as the necessary proof to support the claim is received

Types of claims and communicating our claim decisions

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

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

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

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

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

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

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

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

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

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

The chart below shows the different types of claims and how much time we have to tell you about our decision. We may need to tell your **health professional** about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the **hospital.**

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

*We have to receive the request at least 24 hours before the previously approved health care services end.

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** with a **network provider** and the **recognized charge** with an **out-of-network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we don't pay at all. Any time we don't pay even part of the claim that is an "adverse benefit determination" or "adverse decision".

It is also an "adverse benefit determination" if we rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

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

The difference between a grievance and an appeal

A grievance

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

An appeal

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

Appeals of adverse benefit determinations

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

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

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

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

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

Urgent care or pre-service claim appeals

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

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

Timeframes for deciding an appeal

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

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

Exhaustion of appeal process

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

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

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

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

External review

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

You have a right to external review if:

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

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

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

You must submit the Request for External Review Form:

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

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

Aetna will contact the ERO that will conduct the review of your claim.

The ERO will:

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

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

How long will it take to get an ERO decision?

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

Sometimes you can get a faster external review decision. Your **provider** must call us or send us a Request for External Review Form. There are two scenarios when you may be able to get a faster external review:

For an initial adverse determination

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

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

For a final adverse determination

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

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

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

Recordkeeping

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

Fees and expenses

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

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms

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

Allowable expense means:

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

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

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

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

Here's how COB works

- The primary plan pays first. When this is 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.

Determining who pays

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

If you are:	Primary plan	Secondary plan
Covered under the plan as a student or dependent	The plan covering you as a student	The plan covering you as a dependent
COB rules for dependent children		
Child of: • Parents who are married or living together	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the **calendar year**. *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*. *Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together and there is a court-order	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then their spouse's plan is primary.	The plan of the other parent. But if that parent has no coverage, then their spouse's plan is primary.
Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
Child of: • Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parent pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
Child covered by: • Individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination. See *Child of* content above.	
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?	
Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.

How COB works with Medicare

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

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

- Age
- Disability
- ALS / Lou Gehrig's disease
- End stage renal disease

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

How are benefits paid?		
If you have Medicare because of:	**Primary plan**	**Secondary plan**
Age	**Medicare**	This plan
Disability	**Medicare**	This plan
ALS / Lou Gehrig's disease	**Medicare**	This plan
End stage renal disease (ESRD)*****	This plan will pay first for the first 3 months unless you take a self-dialysis course, there is no **Medicare** waiting period and **Medicare** becomes primary payer on the first month of dialysis. Also, if a transplant takes place within the 3-month waiting period, **Medicare** becomes primary payer on the first of the month in which the transplant takes place.	**Medicare**
*Note regarding ESRD: If you have **Medicare** due to age and then later have it due to ESRD, **Medicare** will remain your primary plan and this plan will be secondary.		

This plan is secondary to **Medicare** in all other circumstances.

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

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

Other health coverage updates – contact information

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

Right to receive and release needed information

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

Right to pay another carrier

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

Right of recovery

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

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

Notice to covered persons

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

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

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

When coverage ends

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

When will your coverage end?

Your coverage under this plan will end when:

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

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

Withdrawal from classes – other than leave of absence

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

When will coverage end for any dependents?

Coverage for your dependent will end if:

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

Why would we suspend paying claims or end coverage?

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

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

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

Special coverage options after your coverage ends

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

Continuation of coverage

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

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

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

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

Benefits will be extended until the earliest of:

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

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

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

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

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

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

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

General provisions – other things you should know

Entire student policy

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

- The **policyholder's** application
- Your enrollment form, if the **policyholder** requires one
- The **student policy**
- The certificates of coverage
- The schedules of benefits
- Any endorsements to the **student policy**, the certificate of coverage, and the schedule of benefits

Administrative provisions

How you and we will interpret this certificate of coverage

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

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

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

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

Coverage and services

Your coverage can change

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

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

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

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

Legal action

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

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

Physical examinations and evaluations

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

Records of expenses

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

Things that would be important to keep are:

- Names of **providers** who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

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

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious effects on your coverage. These include, but are not limited to:

- Loss of coverage, starting at some time in the past
- Loss of coverage going forward
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to criminal authorities.

You have special rights if we rescind your coverage:

- We will give you 30 days advanced written notice of any rescission of coverage
- You have the right to an **Aetna** appeal
- You have the right to a third party review conducted by an independent external review organization

Some other money issues

Assignment of benefits

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

Grace period

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

Recovery of overpayments

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

When you are injured

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

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

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

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

Your health information

We will protect your health information. We use and share it to help us process your claims and manage your policy. You can get a free copy of our Notice of Privacy Practices. Just call us at the toll-free number in the *How to contact us for help* section. When you accept coverage under this group policy, you agree to let your **providers** share your information with us. We will need information about your physical and mental condition and care.

Glossary

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

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

Ambulance
A vehicle staffed by medical personnel and equipped to transport an **ill** or **injured** person.

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

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

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

Calendar year
A period of 12 months that begins on January 1st and ends on December 31st.

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

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

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

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

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

Covered person
A **covered student** or a **covered dependent** of a **covered student** for whom all of the following applies:

- The person is eligible for coverage as defined in the certificate of coverage
- The person has enrolled for coverage and paid any required premium contribution
- The person's coverage has not ended

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

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

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

Dental emergency
Any dental condition that:

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

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

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

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

Detoxification
The process where an alcohol or drug intoxicated or dependent person is assisted through the period needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This can be done by metabolic or other means determined by a **health professional** working within the scope of their license. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

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

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

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

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

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

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

Eligible health services
The health care services and supplies listed in the *Eligible health services under your plan* section and not listed or limited in the *Exclusions* section or in the schedule of benefits**.**

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

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

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus

- In the case of a pregnant woman:
  - Serious jeopardy to the health of the fetus
  - One who is having contractions and there is inadequate time to effect a safe transfer to another **hospital** before delivery or
  - A transfer may pose a threat to the health or safety of the woman or unborn child

Emergency services

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

Established relationship

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

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

And, for any other health care service, you:

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

Experimental or investigational

A drug, device, procedure, or treatment that we find is **experimental or investigational** because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness** or **injury** involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational.**
- It is provided or performed in a special setting for research purposes.

Generic prescription drug

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

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional

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

Home health aide

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

Home health care agency

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

Home health care plan

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

Homebound

This means that you are confined to your home because:

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

You are not homebound if:

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

Hospice care

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

Hospice care agency

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

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

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

Hospital
An institution licensed as a **hospital** by applicable state and federal laws, and accredited as a **hospital** by The Joint Commission (TJC).

Hospital does not include a:
- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility** for **substance related disorders**
- **Residential treatment facility** for **mental health disorders**
- Extended care facility
- Intermediate care facility
- Skilled nursing facility

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

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

Infertile, infertility
A disease defined by the failure to become pregnant:
- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart

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

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

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

Intensive outpatient program (IOP)
Clinical treatment provided must be no more than 5 days per week, no more than 19 hours per week and a minimum of 2 hours each treatment day. Services must be **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental health disorder** or **substance related disorder** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder
This is:

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

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

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

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

Medically necessary, medical necessity
Health care services or supplies that prevent, evaluate, diagnose or treat an **illness**, **injury** or disease, or its symptoms, and that are all of the following, as determined by us within our discretion:

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

Generally accepted standards of medical practice means:

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

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

Medicare

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

Mental health disorder

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

Negotiated charge

For health coverage, this is either:

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

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

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

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

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

Some of these arrangements are called:

- Value-based contracting
- Risk sharing

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

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

We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may not change the **negotiated charge** under this plan.

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

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

Non-preferred drug
A **prescription drug** or device that may have a higher out-of-pocket cost than a **preferred drug**.

Out-of-network pharmacy
A **pharmacy** that is not a **network pharmacy**.

Out-of-network provider
A **provider** who is not a **network provider.**

Partial hospitalization treatment
Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. Services must be **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental health disorder** or **substance related disorder** issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Care is delivered according to accepted medical practice for the condition of the person.

Pharmacy
An establishment where **prescription drugs** are legally dispensed. This can be a **retail**, **mail order** and **specialty pharmacy**.

Physician
A skilled **health professional** trained and licensed to practice medicine under the laws of the state where they practice; for example, doctors of medicine or osteopathy.

Policyholder
The school named on the front page of the **student policy**, your certificate of coverage and schedule of benefits for the purpose of coverage under the **student policy**.

Policy year
This is the period of time from anniversary date to anniversary date of the **student policy** except in the first year when it is the period of time from the effective date to the first anniversary date.

Precertification, precertify
A requirement that you or your **health professional** contact **Aetna** before you receive coverage for certain services. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage.

Preferred drug
A **prescription drug** or device that may have a lower out-of-pocket cost than a **non-preferred drug**.

Premium
The amount you or the **policyholder** are required to pay to **Aetna** for your coverage.

Prescriber
Any **provider** acting within the scope of their license, who has the legal authority to write an order for outpatient **prescription drugs**.

Prescription
As to hearing care:
A written order for the dispensing of **prescription** electronic hearing aids by otolaryngologist, otologist or audiologist.

*As to **prescription drugs**:*
A written order for the dispensing of a **prescription drug** or device by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **network pharmacy**.

As to vision care:
A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

Prescription drug
An FDA approved drug or biological which can only be dispensed by **prescription.**

Provider
A **physician**, other **health professional**, **hospital**, **skilled nursing facility**, **home health care agency, pharmacy,** or other entity or person licensed or certified under applicable state and federal law to provide health care services to you, and practicing within the scope of that license. If state law does not specifically provide for licensure or certification, the entity must meet all **Medicare** accreditation standards (even if it does not participate in **Medicare**).

Psychiatric hospital
An institution specifically licensed or certified as a **psychiatric hospital** by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, **mental health disorders** (including **substance related disorders**) or mental **illnesses**.

Psychiatrist
A **psychiatrist** generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

Recognized charge

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The **recognized charge** depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Service or supply	**Recognized charge**
Professional services and other services or supplies not mentioned below	105% of the Medicare allowed rate
Services of **hospitals** and other facilities	105% of the Medicare allowed rate
Prescription drugs	100% of the average wholesale price (AWP)
Dental expenses	80% of the prevailing charge rate
Ambulance services	80% of the prevailing charge rate
Important note: if the **provider** bills less than the amount calculated using the method above, the **recognized charge** is what the **provider** bills.	

Recognized charge does not apply to involuntary services.

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Involuntary services are services or supplies that are one of the following:
  - Performed at a **network** facility by an **out-of-network provider,** unless that **out-of- network provider** is an assistant surgeon for your **surgery**
  - Not available from a **network provider**
  - **Emergency services**

  We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply

  When the **recognized charge** is based on a percentage of the **Medicare** allowed rate, it is not affected by adjustments or incentives given to **providers** under **Medicare** programs.
- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the Fair Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.

Our reimbursement policies
We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the **recognized charge**. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of, or related to, the primary service provided

Our reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice and
- The views of **physicians** and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits: We have online tools to help decide whether to get care and, if so, where. Use the "Estimate the Cost of Care" tool on the Aetna website. **Aetna's** member website at https://www.aetna.com may contain additional information that can help you determine the cost of a service or supply. Log on to the Aetna website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools.

R.N.

A registered nurse.

Residential treatment facility (mental health disorders)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by **Aetna** or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for residential treatment programs treating **mental health disorders**:

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week
- The patient must be treated by a **psychiatrist** at least once per week
- The medical director must be a **psychiatrist**
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

Residential treatment facility (substance related disorders)

An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for **substance related disorder** residential treatment programs. And is credentialed by **Aetna** or accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Chemical Dependence Residential Treatment Programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a **physician**
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

In addition to the above requirements, for Chemical Dependence **Detoxification** Programs within a residential setting:

- An **R.N.** must be onsite 24 hours per day for 7 days a week within a residential setting
- Residential care must be provided under the direct supervision of a **physician**

Respite care

This is care provided to you when you have a **terminal illness** for the sole purpose of providing temporary relief to your family (or other care givers) from the daily demands of caring for you**.**

Retail pharmacy

A community **pharmacy** that dispenses outpatient **prescription drugs** at retail prices.

Room and board

A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

School health services

The **policyholder's** or school's student health center or a **provider** or organization that is identified as a **school health services provider**.

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, **Aetna** will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation **hospital**s, and portions of a rehabilitation **hospital** and a **hospital** designated for skilled or rehabilitation therapy services.

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of **mental health disorders** or **substance related disorders**.

Skilled nursing services

Services provided by an **R**.**N**. or **L.P.N.** within the scope of their license.

Sound natural teeth

These are natural teeth. If there is a filling in a tooth, the major portion of the tooth must be present. A tooth cannot be decayed, abscessed, or defective. Sound natural teeth are not capped teeth, implants, crowns, bridges, or dentures.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty pharmacy

A **pharmacy** that fills **prescriptions** for specialty drugs.

Specialty prescription drugs

An FDA-approved **prescription drug** that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:

- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

Stay

A full-time inpatient confinement for which a **room and board** charge is made.

Step therapy

A form of **precertification** where you must try one or more required drug(s) before a **step therapy** drug is covered. The required drugs have FDA approval, may cost less and treat the same condition. If you don't try the appropriate required drug first, you may need to pay full cost for the **step therapy** drug.

Store and forward technology

This means that your medical information is shared with a **provider**, but not in real time. But, there are some rules:

- You must have already had a related office visit with the referring **provider**
- We must have an existing agreement with the **provider** to pay for the service
- You and the **provider** must be in different locations
- The **provider** must use the information to diagnose or manage your medical condition

Store and forward technology does not include:

- Telephone calls (audio only)
- Faxes
- Emails

Student policy

The **student policy** consists of several documents taken together. The list of documents can be found in the *General provisions – other things you should know* section of this certificate of coverage.

Substance related disorder

A **substance related disorder**, addictive disorder, or both, as defined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association.

Surgery center

A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all **Medicare** accreditation standards (even if it does not participate in **Medicare**).

Surgery, surgeries, surgical procedures

The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means. This includes:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution
- Physically changing body tissues and organs

Telemedicine

Health care services provided to you by a **provider** at a **distant site** using interactive audio and video technology, or audio only, if you have an **established relationship** with the **provider**. This means that you and the **provider** are in different locations, but are communicating in real time. The **provider** must be diagnosing, consulting or treating your medical or behavioral health condition.

Telemedicine does not include:

- Faxes
- Emails

Terminal illness
A medical prognosis that you are not likely to live more than 12 months.

Urgent admission
This is an admission to the **hospital** due to an **illness** or **injury** that is severe enough to require a **stay** in a **hospital** within 2 weeks from the date the need for the **stay** becomes apparent.

Urgent care facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition.**

Urgent condition
An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

Walk-in clinic
A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near, or within a:

- Drug store
- **Pharmacy**
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgery center
- Emergency room
- Hospital
- Outpatient department of a **hospital**
- Physician's office
- Urgent care facility

Your Rights and Protections Against Surprise Medical Bills and Balance Billing in Washington State

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.
"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of- pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you, via their websites or on request, which providers, hospitals, and facilities are in their networks. Hospitals, surgical facilities, and providers must tell you which provider networks they participate in on their website or on request.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition, mental health or substance use disorder condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes care you receive in a hospital and in facilities that provide crisis services to people experiencing a mental health or substance use disorder emergency. You can't be balance billed for these emergency services, including services you may get after you're in stable condition.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most these providers may bill you is your plan's in- network cost-sharing amount.

You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When can you be asked to waive your protections from balance billing:

Health care providers, including hospitals and air ambulance providers, can **never** require you to give up your protections from balance billing.

If you have coverage through a self-funded group health plan, in some limited situations, a provider can ask you to consent to waive your balance billing protections, but you are **never** required to give your consent. Please contact your employer or health plan for more information.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may file a complaint with the federal government at https://www.cms.gov/nosurprises/consumers or by calling 1-800-985-3059; and/or file a complaint with the Washington State Office of the Insurance Commissioner at their website or by calling 1-800-562- 6900.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Visit the Office of the Insurance Commissioner Balance Billing Protection Act website for more information about your rights under Washington state law.