

Appendix 1 (Healthcare)

All benefit and cost-sharing terms of 2023/24 graduate student assistant insurance program not listed below shall be continued. The insurance carrier for the 2024/2025 plan shall be selected based on their ability to provide these terms.

The preferred provider network will be expanded

Deductible Preferred Provider ~~\$300~~ \$500 (Per Insured Person, Per Policy Year)

Deductible Out-of-Network ~~\$300~~ \$1,000 (per Insured Person, Per Policy Year)

Coinsurance Preferred Provider ~~90%~~ 80% except as noted below

Coinsurance Out-of-Network ~~80%~~ 60% except as noted below

Out-of-Pocket Maximum ~~\$1,000~~ \$5,000 (Per Insured Person, Per Policy Year)

Out-of-Pocket Maximum ~~\$2,000~~ \$10,000 (For all Insureds in a Family, Per Policy Year)

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| Physician's Visits | 95% 80% of Preferred Allowance after Deductible | 95%-60% of Usual and Customary Charges after Deductible |
| Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. | 95% 80% of Preferred Allowance after Deductible | 95%-60% of Usual and Customary Charges after Deductible |
| Diagnostic X-ray Services | 95% 80% of Preferred Allowance after Deductible | 95%-60% of Usual and Customary Charges after Deductible |
| Laboratory Procedures <u>Lab work billed or referred by CHS Pullman Campus, Multicare Rockwood Clinic, Community Health of Central Washington and CHS Vancouver Clinic will be covered at 100%.</u> | 95% 80% of Preferred Allowance after Deductible | 95%-60% of Usual and Customary Charges after Deductible |

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| <p>Tests & Procedures</p> | <p><u>95%</u> 80% of Preferred Allowance after Deductible</p> | <p><u>95%</u> 60% of Usual and Customary Charges after Deductible</p> |
| <p>Mental Illness Treatment See Benefits for Mental Disorders and Substance Use Disorders</p> | <p>Inpatient: <u>100%</u> 80% of Preferred Allowance after Deductible Outpatient office visits: \$25 Copay per visit <u>100%</u> 80% of Preferred Allowance after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: <u>100%</u> 80% of Preferred Allowance after Deductible</p> | <p>Inpatient: <u>100%</u> 60% of Usual and Customary Charges after Deductible Outpatient office visits: \$25 Copay per visit <u>100%</u> 60% of Usual and Customary Charges after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: <u>100%</u> 60% of Usual and Customary Charges after Deductible</p> |
| <p>Maternity</p> | <p><u>95%</u> 80% of Preferred Allowance \$25 Copay per visit for Outpatient Physician's Visits after Deductible <u>95%</u> 80% of Preferred Allowance for other covered services after Deductible</p> | <p><u>95%</u> 60% of Usual and Customary Charges \$25 Copay per visit for Outpatient Physician's Visits after Deductible <u>95%</u> 60% of Usual and Customary Charges for other covered services after Deductible</p> |
| <p>Substance Use Disorder Treatment See Benefits for Mental Disorders and Substance Use Disorders</p> | <p>Inpatient: <u>95%</u> 80% of Preferred Allowance after Deductible Outpatient office visits: \$25 Copay per visit <u>95%</u> 80% of Preferred Allowance after Deductible All other outpatient services, except Medical Emergency Expenses</p> | <p>Inpatient: <u>95%</u> 60% of Usual and Customary Charges after Deductible Outpatient office visits: \$25 Copay per visit <u>95%</u> 60% of Usual and Customary Charges after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: <u>95%</u> 60% of Usual and</p> |

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| | and Prescription Drugs: 95% 80% of Preferred Allowance after Deductible | Customary Charges after Deductible |
| Vision Care Supplies Covered Students age 19 and older only. There is a combined maximum of \$350 \$200 for Lenses and Frames, including contact lenses. | 100% of Preferred Allowance not subject to Deductible | 100% of billed charges not subject to Deductible |
| Routine Eye Exam Covered Students age 19 and older only. Limited to one per Policy Year.; up to a \$100 maximum. The maximum does not apply when services are rendered at the CHS. | 100% of Preferred Allowance not subject to Deductible | 100% of billed charges not subject to Deductible |
| STD Screening Not otherwise covered under Preventive Care, the physician office visit and laboratory tests are covered including a urinalysis and the comprehensive metabolic panel. | 100% 80% of Preferred Allowance after Deductible | 95% 60% of Usual and Customary Charges after Deductible |
| <u>Gender Affirming Care</u> <ul style="list-style-type: none"> ● <u>Office visits</u> ● <u>Inpatient Facility Fees</u> ● <u>Other Professional Services</u> <p>The following are examples of covered services:</p> <ul style="list-style-type: none"> ● <u>Breast/chest affirmation surgery</u> ● <u>Genital affirmation surgery</u> ● <u>Rhinoplasty or nose implants</u> ● <u>Face-lifts</u> ● <u>Lip enhancement or reduction</u> ● <u>Facial bone reduction or</u> | <u>100%</u> of Preferred Allowance after Deductible | <u>95%</u> of Usual and Customary Charges after Deductible |

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| <p><u>enhancement</u></p> <ul style="list-style-type: none">• <u>Blepharoplasty</u>• <u>Breast augmentation to any size</u>• <u>Liposuction of the waist (body contouring)</u>• <u>Reduction thyroid chondroplasty</u>• <u>Hair removal</u>• <u>Voice modification surgery (laryngoplasty or shortening of the vocal cords)</u>• <u>Skin resurfacing</u> | | |
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