

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-844-365-7373 (TTY: 711).

Smartphone or Tablet

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

Non-Discrimination

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

We provide free aids/services to people with disabilities and to people who need language assistance.

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

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Language Assistance

TTY:711

English To access language services at no cost to you, call the number on your ID card.

Spanish Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.

Vietnamese Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.

Korean 무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.

Chinese Traditional 如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼

Gujarati તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કોલ કરવો.

French Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.

Amharic የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎ ላይ ያለውን ቁጥር ይደውሉ።

Hindi बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।

French Creole

(Haitian) Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.

Russian Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.

Arabic للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.

Portuguese Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.

Persian Farsi برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.

German Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.

Japanese 無料の言語サービスは、IDカードにある番号にお電話ください。

Aetna Life Insurance Company



Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

This disclaimer provides a **brief summary** of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. The safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with the funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
 - \$500,000 in death benefits
 - \$200,000 in cash surrender or withdrawal values
- Accident and Health Insurance
 - \$500,000 for health benefit plans
 - \$500,000 in disability income insurance benefits
 - \$500,000 in long-term care insurance benefits
 - \$500,000 in other types of health insurance benefits
- Annuities
 - \$250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to health benefit plans.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, please visit the Association's website at www.ulhiga.org, or contact:
Utah Life and Health Insurance Guaranty Assoc. 32 West 200 South, #150
Salt Lake City, UT 84101 (801) 320-9955

Utah Insurance Department State Office Bldg., Rm. 3110 Salt Lake City, UT 84114 (801) 538-3800



Aetna Health of Utah Inc.

Health maintenance organization (HMO) policy

****SAMPLE – PLAN NAME WILL PRINT HERE****

This policy is by and between Aetna Health of Utah Inc. (Aetna®, we, us, or our) and the policyholder (you, your).

Coverage starts on your **effective date of coverage** and continues until it ends as described in this policy.

Your policy provides coverage for services and supplies that are **covered benefits**. It describes your coverage only. You may get health care services or **prescription drugs** that might not be **covered benefits** under your policy. Please read your policy and the schedule of benefits because they explain your benefits in detail.

This policy is underwritten by Aetna Health of Utah Inc. and is governed by federal law and the laws of Nevada. Aetna is part of the CVS Health family of companies.

Read your policy carefully

Your policy is a legal contract between you and us. We agree to cover you under this policy in return for your **premium** payments. We will pay eligible **covered benefits** while this policy is in force and after the policy conditions are met.

Right to examine the policy

You have 10 days after you receive this policy to read and review it. During that 10-day period, if you decide you don't want the policy, you may return it to us or to the agent who sold it to you. As soon as it is returned, this policy will be void from the beginning. **Premium** paid will be paid back.

Guaranteed renewable

You can renew this policy each year ("guaranteed renewable"). We decide the **premium** rates. But, we may decide not to renew the policy under certain conditions, which are explained in this policy, or when required by law. See the *When coverage ends* section of the policy for more information.

You may keep this policy in force by meeting the policy requirements and by paying the **premium** on time. See the *What does the policy cost you?* section of the policy for more information.

Your application

We relied on your answers to all questions in the application process when we issued the policy to you.

By applying for coverage under this policy, or accepting its benefits, you (or the person acting for you) represent that all information in your application and statements given as part of your application for this policy are true, correct and complete, to the best of your knowledge and belief; and you agree to all terms, conditions and provisions of the policy.

It is your responsibility to make sure the application that you submitted is accurate and complete. It is important that you notify us immediately of any mistakes that you find in your application.

If we learn that you defrauded us or you intentionally misrepresented material facts when you gave information and answers in the application, or in the application process, we may decide to cancel the policy. We may also report fraud to criminal authorities. Please read the *Honest mistakes and intentional deception* section of this policy for more information.

By:


Gregory S. Martino
Vice President

Welcome

Thank you for choosing us.

This is your policy. It is one of two documents that together describe the benefits you have and the terms of this policy.

This policy will tell you about your **covered benefits** – what they are and how you get them. 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 policy covers only a certain number of visits.

Sometimes, these documents have amendments, inserts or riders which we will send you. These change or add to the documents they're part of. When you receive these, they are considered part of your policy.

Where to next? Try the *Let's get started!* section. It gives you a summary of how your policy works. The more you understand, the more you can get out of your policy.

Welcome to Aetna.

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Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your policy works so you can get the most out of your coverage. But for all the details – this is very important – you need to read this entire policy 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 you as the policyholder and any covered dependents, if dependent coverage is available under the policy.
- When we say “us”, “we”, and “our”, we mean Aetna.
- Some words appear in **bold** type. We define them in the *Glossary* section.

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

What your policy does – providing covered benefits

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

How your policy works – starting and stopping coverage

Coverage under the policy has a start and an end. First, you complete the eligibility and application process. Then the policy is issued. Your coverage starts on the policyholder's **effective date of coverage**. Coverage is not provided for any services received before coverage starts or after coverage ends.

Dependent coverage starts on the policyholder's **effective date of coverage**, if the policyholder enrolled them at that time. See the *Effective date of coverage for your dependent* section for details.

Your coverage typically ends when you stop paying your **premium**. A covered dependent can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

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

How your policy works while you are covered

Your coverage:

- Helps you get and pay for a lot of – but not all – health care services. Benefits are provided for **eligible health services**.
- Generally will pay only when you get care from **network providers**.

1. Eligible health services

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

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

- They appear in the *Coverage and exclusions* section.
- They are not listed in the *General policy exclusions* section. (We will refer to this section as the “*Exclusions*” section in the rest of this policy.)
- They are not beyond any limits in the schedule of benefits.

2. Providers

Our network of doctors, **hospitals** and other health care **providers** is there to give you the care you need. You can find **network providers** and see important information about them most easily on our online **provider directory**.

Just log in to our website. See *the How to contact us for help* section.

You choose a **primary care physician** (we call that doctor your **PCP**) to oversee your care. Your **PCP** will provide your routine care, and send you to other **providers** when you need specialized care. You may also go directly to a network obstetrician (OB), gynecologist (GYN), or OB/GYN for **eligible health services**.

Until a **PCP** is selected, benefits will be limited to coverage for **emergency services, urgent conditions**, and transplants.

For more information about the network and the role of your **PCP**, see the *Who provides the care* section.

3. Service area

Your policy 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** and urgent care. See the *Who provides the care* section.

Important note:

If you have a dependent and they move outside of the **service area**, their coverage outside of the **service area** will be limited to emergency and **urgent conditions** for both medical and **pharmacy** services.

4. Paying for eligible health services– the general requirements

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

- The **eligible health service** is **medically necessary**
- You get your care from:
 - Your **PCP**
 - Another **network provider** after you get a **referral** from your **PCP**
- You or your **provider precertifies** the **eligible health service** when required

You will find details on **medical necessity, referral** and **precertification** requirements in the *Medical necessity, referral and precertification requirements* section. You will find the requirement to use a **network provider** and any exceptions in the *Who provides the care* section.

5. Paying for eligible health services— sharing the expense

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

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

6. Disagreements

We know that people sometimes see things differently.

The policy 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, may sometimes make the final decision for us.

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

How to contact us for help

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

- Logging in to our website at **Aetna.com**
 - Register for access to reliable health information, tools and resources that help you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness
 - Our website is available 24/7

You can also contact us by:

- Calling us at the number on your ID card
- Writing us at PO Box 981131 El Paso, TX 79998-1131

Your member ID card

Your member ID card tells doctors, **hospitals**, and other **providers** that you are covered by this contract. 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.

Remember, only you and your covered dependents can use your member ID card. If you misuse your card we may end your coverage.

To get your digital ID card, log in to our website. See *the How to contact us for help* section. You can print your ID card.

Tell us of any changes

It's important that you tell us of any changes that might affect your policy or the eligibility of anyone covered under the policy. This will help us effectively deliver your benefits. This may include changes in:

- Primary address
- Phone number
- Marital status or partnership changes
- Dependent status
- You or a covered dependent get health coverage through a job-based plan or a program like Medicare, Medicaid or the Children's Health Insurance Program (CHIP)

It's important that you tell us within 31 days of the date of any change. Your primary address is where you spend 6 months or more per **calendar year**. This may also be called your "home address".

See the *Special or limited enrollment periods* section for information on special or limited enrollment periods.

What does the policy cost you?

Premium payment

This policy requires you to make **premium** payments. We will not pay benefits under this policy for services obtained after coverage ends if **premium** payments are not made by the end of the grace period. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree – claim decisions and appeal procedures* section of this policy.

The first **premium** payment is due on or before your **effective date of coverage**. When we calculate the **premium** you owe, we use our records to determine who is covered under the policy. You owe **premium** for each person covered under the policy starting with the first **premium** due date on or after the day the person's coverage starts. You stop paying **premium** as of the first **premium** due date on or after the day the person's coverage ends.

After your first **premium** payment is made, **premium** payments are due on the 1st or 15th of each month based on your **effective date of coverage**. Each **premium** payment is to be paid to us on or before the due date. Your **premium** becomes overdue after the last day of the **premium** period.

We provide this policy to you and you pay **premium** to us. We may choose not to accept **premium** that is paid for you by someone else unless we are required to by **applicable law**.

Grace period

You have a grace period of 31 days after the due date for the payment of each **premium** due after the first **premium** payment. If **premiums** are not paid by the end of the grace period, your coverage will automatically terminate at the last date for which premium was paid, or as of the date required by **applicable law**.

We have the right to require the return of any payments for claims paid during the grace period for which **premium** was not received.

Reinstatement

We can end this policy because you have not paid your **premium**. If this happens, we can reactivate ("reinstatement") the policy without a break in coverage. You must ask us to do so within 30 days of the policy end date. But, for us to do this, you must pay us the total **premium** you already owe plus the new **premium**. We can decide not to reinstate the policy.

Premium agreement

Your **premium** rate will not change during the policy term as long as there are no changes to this policy. Changes include things like the area you live in, the benefit plan or adding dependents to the policy.

Your **premium** rate is based on factors such as:

- The plan in which you are enrolled
- Your age and the ages of covered dependents
- The number of covered persons
- Tobacco use
- Where you live (primary address)

Each **premium** will be based on the rates that apply on that **premium** due date. If premium increases, we will give you written notice 60 days prior to the increase.

In the event of any changes in **premium** rates, payment of the **premium** by you means that you accept the **premium** changes.

SAMPLE

Who the policy covers

You will find information in this section about:

- Who is eligible
- Who can be on your policy (who can be your dependent)
- Special or limited enrollment periods
- Adding new dependents
- **Effective date of coverage** for your dependent

Who is eligible

You are eligible as the policyholder when you are:

- A legal resident of Nevada
- Age 19 or older
- Not enrolled in Medicare at the time of application
- Listed as the applicant on the application
- Approved by us

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

You can enroll the following family members on your policy. They are your “dependents”:

- Your legal spouse
- Your domestic partner who meets eligibility requirements under **applicable law**.
- 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 children placed with you for adoption
- Foster children
- 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

You can enroll your dependent:

- At initial enrollment
- At other special times during the year as listed below

A dependent must live in the state where the policy was issued and be approved by us.

Special or limited enrollment periods

Federal law allows you and your dependents to enroll in a new policy under some circumstances. These are called special or limited enrollment periods. You can enroll in these situations when:

- You have added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section (below) for more information.
- You or your dependent are enrolled in any non-**calendar year** group health plan or individual health insurance coverage.
- You did not enroll a dependent in this policy before because they had other coverage and now that other coverage has ended.
- A court orders you to cover a current spouse, domestic partner or a child on your health policy.

- You or your dependent are eligible for new plans because you have moved to a new permanent location.
- You or your dependent 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.
- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan.

We must receive the completed enrollment information from you within 31 days of the event or the date on which you or your dependent no longer has the other coverage mentioned above. But, the completed enrollment form may be submitted within 60 days of the event when:

- You or your dependent are enrolled in any non-**calendar year** group health plan or individual health insurance coverage
- You or your dependent have access to new plans because you have moved to a new permanent location and either:
 - Had minimum essential coverage for at least one day during the 60 days before the date of the move
 - Lived outside the U.S. or a U.S. territory at the time of the move

Adding new dependents

You can add the following new dependents to your policy:

- A spouse - If you marry, you can put your spouse on your policy:
 - We must receive your completed enrollment information and additional **premium** not more than 60 days after the date of your marriage
 - Coverage will be effective on the first day of the month following plan selection
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your policy:
 - We must receive your completed enrollment information and additional **premium** not more than 60 days after the date you file a Declaration of Domestic Partnership
 - Coverage will be effective on the first day of the month following plan selection
- A newborn child - Your newborn child is covered on your policy for the first 31 days after birth:
 - To keep your newborn covered, we must receive your completed enrollment information and additional **premium** within 31 days of birth
 - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** for the covered dependent
 - If you miss this deadline, your newborn will not have benefits after the first 31 days
- An adopted child – You may put an adopted child on your policy when the adoption is complete or the date the child is placed for adoption as certified by the public or private agency making the placement . “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:
 - We must receive your completed enrollment information and additional **premium** within 31 days after the date of the adoption or the date the child was placed for adoption
 - Benefits for your adopted child will begin on the date of the adoption (or placement) or the first day of the month following adoption (or placement)
 - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
 - Coverage will end at the time a public or private agency certifies that the adoption proceeding has ended.

- A foster child – You may put a foster child on your policy when you have obtained legal responsibility as a foster parent. A foster child is a child whose care, comfort, education and upbringing is left to persons other than the natural parents:
 - We must receive your completed enrollment information and additional **premium** within 31 days after the date the child is placed with you.
 - Benefits for your foster child will begin on the date you legally become a foster parent or the first day of the month following this event.
- A stepchild - You may put a child of your spouse, or domestic partner on your policy:
 - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or , Declaration of Domestic Partnership with your stepchild’s parent along with the additional **premium** required
- Court order – You can put a child you are responsible for under a qualified medical support order or court-order on your policy:
 - You must complete your enrollment information and send it to us within 31 days after the date of the court order

Effective date of coverage for your dependent

Your dependent’s coverage will start on your **effective date of coverage**, if you enrolled them at that time, otherwise:

- As shown above under the *Adding new dependents* section
- No later than the first day of the following month if completed enrollment information is received by the 15th of the month
- No later than the first day of the second month if completed enrollment information is received between the 16th and the last day of the month
- In accordance with the effective date of a court order
- An appropriate date based on the circumstances of the special enrollment period

Medical necessity, referral and precertification requirements

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

Your policy 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 get your care from:
 - Your **PCP**
 - Another **network provider** after you get a **referral** from your **PCP**
- You or your **provider** **precertifies** the **eligible health service** when required

This section addresses the **medical necessity**, **referral** and **precertification** requirements. You will find the requirement to use a **network provider** and any exceptions to this 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 **eligible health services** under this policy.

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**.

Referrals

You need a **referral** from your **PCP** for most **eligible health services**. If you do not have a **referral** when required, we won't pay the **provider**. You will have to pay for services if your **PCP** fails to ask us for the **referral**. Refer to the *What the policy pays and what you pay* section.

Precertification

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

Your **physician** or **PCP** is responsible for obtaining any necessary **precertification** before you get the care.

For precertification of outpatient **prescription drugs**, see *Coverage and exclusions– Outpatient prescription drugs – What precertification requirements apply*. If your **physician** or **PCP** 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 **physician** or **PCP** fails to ask us for **precertification**. If your **physician** or **PCP** requests **precertification** and we refuse it, you can still get the care but the policy won't pay for it. You will find details on requirements in the *What the policy pays and what you pay - Important note – when you pay all* section.

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**.

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 www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

SAMPLE

Coverage and exclusions

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

Your policy 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 **physician** care for **cosmetic surgery** is never covered. This is an exclusion.
- Skilled nursing facility care is generally covered but it is a **covered benefit** only up to a set number of days a year. This is a limitation.

You can find out about general policy exclusions in the *General 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.

Important note:

Sex-specific **eligible health services** are covered when medically appropriate, regardless of identified gender.

1. Preventive care and wellness

This section describes the **eligible health services** and supplies available under your policy 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 policy. The updates will be effective on the first day of the 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. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or us. See the *How to contact us for help* section. This information can also be found at [Healthcare.gov](https://www.healthcare.gov).

Routine physical exams

Eligible health services include office visits to your **physician**, **PCP** or other **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 **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and it 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 infections
 - Human Immune Deficiency Virus (HIV) infections
 - 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.

Preventive care immunizations

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

The following is not covered under this benefit:

- Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel.

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **physician, PCP, OB, GYN or OB/GYN**. This includes Pap smears. Your policy 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 **physician** 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 policy will cover the services you get in an individual or group setting. Here is more detail about those benefits.

- **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
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure and a pathology exam on any removed polyp
- 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 includes the initial and subsequent physical exam services such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height
- Anemia screening
- Chlamydia infection screening
- Hepatitis B screening
- Rh incompatibility screening

You can get this care at your **physician's, PCP's, OB's, GYN's, or OB/GYN's** office.

Important note:

You should review the benefit under the *Coverage and exclusions- Maternity and related newborn care* section of this contract for more information on coverage for pregnancy expenses under this policy.

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 policy will cover this when you get it in an individual or group setting. Your policy 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 policy will cover this cost once every 12 months.
 - A manual breast pump. Your policy 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 – female contraceptives counseling, devices and voluntary sterilization

Eligible health services include family planning services such as:

Counseling services

Eligible health services include counseling services provided by a **physician, PCP, 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 **physician** during an office visit.

Voluntary sterilization

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

The following are not covered under this benefit:

- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA
- Contraception services during a **stay** in a **hospital** or other facility for medical care
- Male contraceptive methods, sterilization procedures or devices

2. Physicians and other health professionals

Physician services

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

- At the **physician’s** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine**

Important note:

Your plan covers **telemedicine** only when you get your consult through a **provider** that has contracted with **us** to offer these services.

All in-person office visits covered with a **behavioral health provider** are also covered if you use **telemedicine** instead.

Telemedicine may have different cost sharing. See the schedule of benefits for more information.

Other services and supplies that your **physician** may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Physician surgical services

Eligible health services include the services of:

- The surgeon who performs your **surgery**
- Your surgeon who you visit before and after the **surgery**
- Another surgeon you go to for a second opinion before the **surgery**

The following are not covered under this benefit:

- The services of any other **physician** who helps the operating **physician**.
- A **stay** in a **hospital**. See the *Coverage and exclusions – Hospital and other facility care* section.
- A separate facility charge for **surgery** performed in a **physician's** office.
- Service of another **physician** for the administration of a local anesthetic.

Alternatives to physician office visits

Walk-in clinic

Eligible health services include, but are not limited to, health care services provided through a **walk-in clinic** 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
- Telemedicine consultation
- Preventive screening and counseling services that will help you:
 - With obesity or healthy diet
 - To stop using tobacco products

3. Hospital and other facility care

Hospital care

Eligible health services include inpatient and outpatient **hospital** care.

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 policy will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians** employed by the **hospital**.
- Operating and recovery rooms.
- Intensive or special care units of a **hospital**.
- Administration of blood and blood derivatives.
- Radiation 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**.

Anesthesia for certain dental procedures

Eligible health services include services for general anesthesia and associated **hospital** care in connection with dental care for your dependent children. A dentist may refer your child to the **hospital** or similar facility for general anesthesia and associated care because in the dentist's opinion, the child has:

- A physical, mental, or medically compromising condition
- Dental needs for which local anesthesia will be ineffective
- Anxiety, is extremely uncooperative or unmanageable
- Sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation

You will need the same authorization for the general anesthesia and hospitalization here, as for any other disease or covered conditions.

Alternatives to hospital stays

Outpatient surgery

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

Important note:

Some **surgeries** are done safely in a **physician's** office. For those **surgeries**, your policy will pay only for **physician** services and not for a separate fee for facilities.

The following are not covered under this benefit:

- The services of any other **physician** who helps the operating **physician**.
- A **stay** in a **hospital**. A **hospital stay** is an inpatient **hospital** benefit. See the *Coverage and exclusions – Hospital and other facility care* section.
- A separate facility charge for **surgery** performed in a **physician's** office.
- Service of another **physician** for the administration of a local anesthetic.

Home health care

Eligible health services include home health care services provided by a **home health agency** 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 **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
- Medical social services are provided by or supervised by a **physician** or social worker

If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.

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

The following are not covered under this benefit:

- **Custodial care**
- 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

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**
- Psychological and dietary counseling
- Pain management and symptom control

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** 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

The following are not covered under this benefit:

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

Private duty nursing

Eligible health services include private duty nursing care provided by an **R.N.** or **L.P.N.** for inpatient and non-hospitalized acute **illness** or **injury**. in a **hospital, surgery center, skilled nursing facility** or **hospice care** facility. Non-hospitalized services are **eligible health services** only at an ambulatory surgical facility or as part of home health careif:

- Your condition requires skilled nursing care
- 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**

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**.

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** and urgent care from **out-of-network providers** ends when the attending **physician** and we determine that you are medically able to travel or to be transported to a **network provider** if you need more care.

Follow-up care must be provided by your **physician, PCP**. Follow-up care from a **physician** other than your **PCP**, like a **specialist**, may require a **referral**. See the *Medical necessity, referral and precertification requirements* section for more information.

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 **physician**, but only if a delay will not harm your health.

Non-emergency condition

See the schedule of benefits and the *Glossary* section for specific policy information.

The following is not covered under this benefit:

- **Non-emergency medical condition** care in a **hospital** emergency room facility

In case of an urgent condition

Urgent condition within the service area

If you need care for an **urgent condition** while within the **service area**, you should first seek care through your **physician, PCP**. If your **physician, PCP** is not reasonably available to provide services, you may access urgent care from an **urgent care facility** within the **service area**.

Urgent condition outside the service area

You are covered for urgent care obtained from a facility outside of the **service area** if you are temporarily absent from the **service area** and getting the health care service cannot be delayed until you return to the **service area**.

Non-urgent care

See the *Exclusions* section and the schedule of benefits for specific plan details.

The following is not covered under this benefit:

- Non-urgent condition care in an **urgent care facility** or at a non-**hospital** freestanding facility

5. Specific conditions

Autism spectrum disorder

Autism spectrum disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Eligible health services include the services and supplies provided by a **physician** or **behavioral health provider** for the screening, diagnosis and treatment of autism spectrum disorder. We will only cover this treatment if a **physician** or **behavioral health provider** 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

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 – blood glucose, ketone and urine
 - Injection aids for the blind
 - Blood glucose calibration liquid
 - Lancet devices and kits
 - Alcohol swabs
- Equipment
 - External insulin pumps and pump supplies
 - Blood glucose monitors without special features, unless required due to blindness
- Education
 - Self-management training provided by a health care **provider** certified in diabetes self-management training, including nutritional counseling

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**.

Family planning services – other

Eligible health services include certain family planning services provided by your **physician** such as:

- Voluntary sterilization for males
- Abortion to the extent the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

The following are not covered under this benefit:

- Reversal of voluntary sterilization procedures included related follow-up care
- Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

Gender affirming treatment

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

Important note:

Visit <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html> for detailed information about this benefit, including eligibility and **medical necessity** requirements. You can also call the telephone number on your ID card.

Jaw joint disorder treatment

Eligible health services include the diagnosis and surgical treatment of **jaw joint disorder** by a **provider** which includes:

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- Involving the relationship between the jaw joint and related muscles and nerves such as myofascial pain dysfunction (MPD)

The following are not covered under this benefit:

- Treatment of Jaw joint disorder that is recognized as a dental procedure, including but not limited to, extraction of teeth and the application of orthodontic devices and splints

Maternity and related newborn care

Eligible health services include prenatal and postpartum care and obstetrical services. 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 **physician**, with the consent of the mother, discharges the mother or newborn earlier

Coverage also includes the services and supplies needed for circumcision by a **provider**.

The following is not covered under this benefit:

- Newborn care for a child when you are acting as a gestational carrier

Behavioral health

Mental health treatment

Eligible health services include the treatment of **mental health disorders** provided by a **hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate** (the policy will cover the extra expense of a private room when appropriate because of your medical condition), and 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 **physician or behavioral health provider** such as a **psychiatrist, psychologist, social worker, or licensed professional counselor** (includes **telemedicine** consultation).
 - 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**.
 - **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**.
 - 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 to avoid placing you at risk for serious complications.
 - Electro-convulsive therapy (ECT).
 - Transcranial magnetic stimulation (TMS).
 - Psychological testing.
 - Neuropsychological testing.
 - Observation.
 - Peer counseling support by a peer support specialist. A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. 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, physician or behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate** (the policy will cover the extra expense of a private room when appropriate because of your medical condition) and 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 **physician or behavioral health provider** such as a **psychiatrist, psychologist, social worker or licensed professional counselor** (includes **telemedicine** consultation).
 - 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**.
 - **Intensive outpatient program** provided in a facility or program for **substance related disorders** treatment provided under the direction of a **physician**.
 - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other **substance related disorders**, including administration of medications.
 - Treatment of withdrawal symptoms.
 - Observation.
 - Peer counseling support by a peer support specialist. A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

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
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T-cell receptor therapy for FDA approved treatments
- Thymus tissue, for FDA-approved treatment

Network of transplant facilities

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

You must get transplant services from the Exchange IOE facility we designate to perform the transplant you need. Transplant services received from an Exchange IOE facility are subject to the network **copayment, coinsurance, deductible**, maximum out of pocket and limits, unless stated differently in this certificate and schedule of benefits.

Important note:

- If there are no Exchange IOE facilities for your transplant type in your network, the National Medical Excellence® (NME) program will arrange for and coordinate your care at an Exchange IOE facility in another **provider** network. If you don't get your transplant services at the facility we designate, they will not be **eligible health services**.
- Many pre and post transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant is being coordinated by the National Medical Excellence® (NME) program, all medical services must be managed through NME so that you receive the highest level of benefits at an appropriate facility. This is true even if the **eligible health service** is not directly related to your transplant.

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.

Comprehensive infertility services

You are eligible for **infertility** services if:

- You are covered under this policy as the policyholder or as a covered dependent who is the policyholder’s legal spouse, or domestic partner, referred to as “your partner”.
- There exists a condition that:
 - Is demonstrated to cause the disease of **infertility**.
 - Has been identified by your **physician** or **infertility specialist** and documented in your or your partner’s medical records.
- You or your partner have not had a voluntary sterilization, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- You or your partner do not have **infertility** that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this policy.
- You have met the requirement for the number of months trying to conceive and your unmedicated day 3 Follicle Stimulating Hormone (FSH) level meets the following criteria:

You are:	Number of months of unprotected timed sexual intercourse:	Number of donor artificial insemination cycles:	You need to have an unmedicated day 3 FSH test done within the past:	The results of your unmedicated day 3 FSH test:
A female under 35 years of age with a male partner	A. 12 months or more  or	B. At least 12 cycles of donor insemination	12 months	Must be less than 19 mIU/mL in your most recent lab test
A female under 35 years of age without a male partner	Does not apply	At least 12 cycles of donor insemination	12 months	Must be less than 19 mIU/mL in your most recent lab test
A female 35 years of age or older with a male partner	A. 6 months or more  or	B. At least 6 cycles of donor insemination	6 months	If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40

You are:	Number of months of unprotected timed sexual intercourse:	Number of donor artificial insemination cycles:	You need to have an unmedicated day 3 FSH test done within the past:	The results of your unmedicated day 3 FSH test:
A female 35 years of age or older without a male partner	Does not apply	At least 6 cycles of donor insemination	6 months	<p>If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test</p> <p>If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40</p>
A male of any age with a female partner under 35 years of age	12 months or more	Does not apply	Does not apply	Does not apply
A male of any age with a female partner 35 years of age or older	6 months or more	Does not apply	Does not apply	Does not apply

You can find a network infertility specialist and facility in several ways:

- See the *How to contact us for help* section.
- From our National Infertility Unit (NIU). Our NIU can provide you with information about our Institutes of Excellence™ infertility facilities.

The first step to using your comprehensive **infertility** health care services is enrolling with our NIU. To enroll you can reach our dedicated NIU at 1-800-575-5999. Our NIU is here to help you. It's staffed by a dedicated team of registered nurses and **infertility** coordinators with expertise in all areas of **infertility** who can help with enrollment, **precertification** and eligibility.

Your **provider** will request approval from us in advance for your **infertility** services. We will cover charges made by a network **infertility specialist** for the following **infertility** services:

- Ovulation induction with menotropins
- Intrauterine insemination

The following are not covered under the *Basic and Comprehensive infertility services* benefits:

- 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) of eggs, embryos or sperm.
 - Storage of eggs, embryos or sperm.
 - Thawing of cryopreserved (frozen) eggs, embryos or sperm.
 - 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.
 - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
- Home ovulation prediction kits or home pregnancy tests.
- Injectable **infertility** medication, including but not limited to menotropins, hCG and GnRH agonists.
- The purchase of donor embryos, donor oocytes or donor sperm.
- Reversal of voluntary sterilizations, including follow-up care.
- Any charges associated with obtaining sperm from a person not covered under this plan for ART services.
- 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).

6. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

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

- 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
- Other outpatient diagnostic imaging service where the billed charge exceeds \$500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Eligible health services include diagnostic lab services, and pathology and other tests, but only when you get them from a licensed lab.

Diagnostic radiological services

Eligible health services include radiological services (other than diagnostic complex imaging) but only when you get them from a licensed radiological facility.

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.”

GCIT **eligible health services** 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-based 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**.

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**.

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 **physician's** 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 for the website 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 **physician's** office
 - A home care **provider** in your home
- Listed on our **specialty prescription drug** list as covered under this policy

Certain infused medications may be covered under the outpatient **prescription drug** section.

See the *How to contact us for help* section to:

- Access the list of **specialty prescription drugs**
- Determine if coverage for a **specialty prescription drug** 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.

Short-term 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 physician's office**, but only if those services are part of a treatment plan determined by your risk level and ordered by your **physician**.

Pulmonary rehabilitation

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

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

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

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living.

Eligible health services include short-term rehabilitation services your **physician** prescribes. The services have to be performed by a:

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

Short-term rehabilitation services have to follow a specific treatment plan ordered by your **physician**.

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the *Short-term rehabilitation services* section in the schedule of benefits.

Outpatient cognitive rehabilitation, physical, occupational and speech therapy

Eligible health services include:

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

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

- Cognitive rehabilitation 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.

Spinal manipulation

Eligible health services include spinal manipulation 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.

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 **physician** 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**

Habilitation therapy services have to follow a specific treatment plan ordered by your **physician**.

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- 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.

7. Other services

Acupuncture

Eligible health services include manual or electro acupuncture.

The following is not covered under this benefit:

- Acupressure

Ambulance service

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

- To the first **hospital** to provide **emergency services**
- From one **hospital** to another **hospital**, if the first **hospital** cannot provide the **emergency services** needed
- 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
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment

Your policy 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 travelling from one **hospital** to another and
 - The first **hospital** cannot provide the **emergency services** you need, and
 - 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
- Fixed wing air **ambulance** transportation by an **out-of-network provider**

Clinical trial therapies (experimental or investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an "approved clinical trial" only when you have cancer or **terminal illnesses** and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- We determine based on published, peer-reviewed scientific evidence that you may benefit from the treatment.

Eligible health services include Phase II, III, and IV clinical trials for the treatment for chronic fatigue syndrome.

An "approved clinical trial" is a clinical trial that meets all of these criteria:

- 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 clinical trial is approved by an Institutional Review Board that will oversee the investigation.

- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial 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.

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, or chronic fatigue syndrome, as those terms are defined in the federal Public Health Service Act, Section 2709.

As it applies to in-network services, coverage is limited to benefits for routine patient services provided within the network.

The following are not covered under this benefit:

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising **experimental or investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with our claim policies)

Durable medical equipment (DME)

Eligible health services include the expense of renting or buying **DME** and accessories you need to operate the item from a **DME** supplier. Your policy 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.

When we **precertify** it, we cover the instruction and appropriate services needed for a member to learn how to properly use the item.

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.

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

All maintenance and repairs that result from misuse or abuse are your responsibility.

The following are not covered under this benefit:

- Whirlpools
- Portable whirlpool pumps
- Massage table
- Sauna baths
- Message devices (personal voice recorder)
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

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 or make up for impaired hearing
- Parts, attachments or accessories

Hearing aid services are:

- Audiometric hearing visit 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

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 36 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist
- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**
- Any tests, appliances and devices to:
 - Improve your hearing, including hearing aid batteries and auxiliary equipment
 - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Nutritional support

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

For purposes of this benefit, “low protein modified food product” means foods specifically formulated to have less than one gram of protein per serving and intended to be used under the direction of a **physician** 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 items, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if they are the sole source of nutrition

Obesity (bariatric) surgery

Eligible health services include the treatment of **morbid obesity** and include one bariatric **surgical procedure** including related outpatient services within a two-year period, beginning with the date of the first bariatric **surgical procedure**, unless a multi-stage procedure is planned.

The following are not covered under this benefit:

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

Prosthetic devices

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

Prosthetic device means:

- A medical device which replaces all or part of an internal body organ or an external body part lost or impaired as the result of disease, congenital defect or **injury**

Coverage includes:

- 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

- Instruction and other services (such as attachment or insertion) so you can properly use the device

The following are not covered under this benefit:

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of, or to prevent complications of, diabetes or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Vision care

Pediatric vision care

Routine vision exams

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

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

Eligible health services include:

- 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
- Eye exams for contact lenses or their fitting
- Acuity tests
- Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

8. Outpatient prescription drugs

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**
- **Eligible health services** under your policy
- 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 drugs** may not be covered or coverage may be limited. This does not keep you from getting **prescription drugs** 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 policy provides standard safety checks to, 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

How to find a network pharmacy

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

You may go to any of our **network pharmacies**. If you do not get your **prescriptions** at a **network pharmacy**, your **prescriptions** will not be covered as **eligible health services** under the policy. **Pharmacies** include network **retail**, **mail order** and **specialty pharmacies**.

If the pharmacy you have been using leaves the network

Sometimes a **pharmacy** might leave the network. If this happens, you will have to get your **prescriptions** filled at another **network pharmacy**. You can use your **provider directory** or call the number on your ID card to find another **network pharmacy** in your area.

Eligible health services under your policy

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

- They are listed in the *Coverage and exclusions* 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 policy's general rules:

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

We base your **prescription** drug plan on drugs listed in the **drug guide**. We exclude **prescription** drugs not in the **drug guide** unless we approve a medical exception. If it is **medically necessary** for you to use a **prescription** drug that is not on this **drug guide**, you or your **provider** must request a medical exception. See the *Requesting a medical exception* section for more information.

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 drugs 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 **network 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**.

Early refill of eye drops

The plan may cover a **prescription** refilled early by a pharmacy for liquid eye drops. This is because you may have difficulty with wastage that you cannot avoid. If you have a valid **prescription**, we will refill the **prescription** when 70% of the initial days supply is remaining.

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.

After you obtain your first refill at a network **retail pharmacy**, you must tell us whether you want to use your network **mail order pharmacy** benefit, a CVS pharmacy or continue to use your **retail pharmacy**. See the *Contact us* section for how. If you don't tell us your choice, the next **prescription** refill and any other refills at a network **retail pharmacy** will not be covered. You can tell us at any time that you intend to use a network **retail pharmacy** for future **prescription** refills.

Specialty pharmacy

Specialty prescription drugs are covered when dispensed through a network **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.

All **specialty prescription drug** fills the initial fill must be filled at a network **specialty pharmacy** unless it is an urgent situation.

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.

Some **specialty prescription drugs** may qualify for third-party **copayment** assistance programs that could lower your out-of-pocket costs. Any manufacturer coupon or rebate assistance amount received through one of these programs will not apply towards your **deductible** or **maximum out-of-pocket limit**.

Other services

Preventive contraceptives

For females who are able to become pregnant, 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. At least one form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive drugs. See the *How to contact us for help* section for how.

We cover over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA at no cost share. 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 at no 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**:

- Diabetic needles, syringes and pens
- Test strips – blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs
- Continuous glucose monitors
- Insulin infusion disposable pumps

See the *Coverage and exclusions - Specific conditions - Diabetic equipment, supplies and education* section for coverage of blood glucose meters and insulin pumps and for diabetic supplies that you can get from other **providers**.

Immunizations

Eligible health services include preventive immunizations as required by the ACA guidelines when administered at a **network pharmacy**. Call the pharmacy for vaccine availability, as not all pharmacies will stock all available vaccines.

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.

Preventive care drugs and supplements

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

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.

The following are not covered under this benefit:

- Abortion drugs
- Allergy serum and extracts administered by injection
- Any services related to the dispensing, injection or application of a drug
- Biological liquids and fluids unless specified on the **drug guide**
- **Cosmetic** drugs
 - Medications or preparations used for **cosmetic** purposes
- Compound **prescriptions** containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA), including compounded bioidentical hormones
- 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 **applicable law**, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written, except where stated above
 - That is 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 includes 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 except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
- Implantable drugs and associated devices except where stated above
- **Infertility**
 - **Prescription drugs** used primarily for the treatment of **infertility** except where stated in the *Coverage and exclusions – 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 exception does not apply to Depo Provera and other injectable drugs used for contraception.

- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription drugs:**
 - 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 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 cessation drug unless recommended by the United States Preventive Services Task Force (USPSTF). See the *Coverage and exclusions – Tobacco cessation prescription and over-the-counter drugs- Outpatient prescription drugs* section.
- Test agents except diabetic test agents
- A manufacturer’s product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan’s **drug guide**
- Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan’s **drug guide**

How you get an emergency prescription filled

You may not have access to a **network pharmacy** in an emergency or urgent care situation, or you may be traveling outside of the policy’s **service area**. If you must fill a **prescription** in either situation, we will reimburse you as shown in the table below.

Type of pharmacy	Your cost share
Network pharmacy	<ul style="list-style-type: none"> • You pay the copayment.
Out-of-network pharmacy	<ul style="list-style-type: none"> • 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 policy.

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

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

The policy may, in certain circumstances, make some **preferred brand-name prescription drugs** available to members at the generic **copayment** level.

What precertification requirements apply

Why 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.

There is another type of **precertification** for **prescription drugs**, and that is **step therapy**. 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 to request a medical exception

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

- Call us or contact us through our website. For details, see the *Contact us for help* section.
- Submit your 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.

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.

General exclusions

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

In this section we tell you about the exclusions that apply to your policy.

And just a reminder, you'll find benefit and coverage limitations in the schedule of benefits.

The following are not **eligible health services** under your policy except as described in the *Coverage and exclusions* section of this policy or by a rider or amendment included with this policy:

Behavioral health treatment

Services for the following 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 dementias or amnesia without a behavioral disturbance 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
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions - Preventive screening and counseling services* section
- Pathological gambling, kleptomania, and pyromania

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of blood to the **hospital**, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis

For autologous blood donations, only administration and processing expenses are covered.

Clinical trial therapies (experimental or investigational)

- Your policy does not cover clinical trial therapies (**experimental or investigational**), except where described in the *Coverage and exclusions - Clinical trial therapies (experimental or investigational)* section.

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 where described in the *Coverage and exclusions* section

Court-ordered testing

- Court-ordered testing or care unless **medically necessary**

Custodial care

Examples are:

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

Dental care

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

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

Educational services

Examples of those services are:

- Any service or supply for education, training or retraining services or testing. This includes:
 - Special education
 - Remedial education
 - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
 - Job training
 - Job hardening programs.

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

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, 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 clinical trial therapies (**experimental or investigational**) or covered under clinical trials (routine patient costs)

Facility charges

For care, services or supplies provided in:

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

Foot care

- Services and supplies for:
 - The treatment of calluses, bunions, toenails, 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
 - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies

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

The following are not **eligible health services** unless you receive prior written approval from us:

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**.
- All associated services when GCIT services are not covered. Examples include:
 - Infusion
 - Laboratory
 - Radiology
 - Anesthesia
 - Nursing services

See the *Medical necessity, referral and precertification requirements* section.

Growth/Height care

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

Maintenance care

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

Medical supplies – outpatient disposable

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

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer

Personal care, comfort or convenience items

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

Private duty nursing, except where described in the *Coverage and exclusions– Outpatient private duty nursing* section.

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

Services, supplies and drugs received outside of the United States

- Non-emergency medical services, 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 policy.

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
 - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services

Strength and performance

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

Telemedicine

- Services given by **providers** that are not contracted with Aetna® as **telemedicine providers**
- Services given when you are not present at the same time as the **provider**
- Services including:
 - Telephone calls
 - Telemedicine kiosks
 - Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

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

Tobacco cessation

Except where described in this policy:

- 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 *Coverage and exclusions – Preventive care and wellness* section
 - Hypnosis and other therapies
 - Medications, except where stated in the *Coverage and exclusions– Outpatient prescription drugs* section
 - Nicotine patches
 - Gum

Treatment in a federal, state, or governmental entity

Except where required by **applicable law**:

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

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* in this section.

Work related illness or injuries

- Coverage available to you under workers' compensation or under a similar program under **applicable 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 **applicable 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 policy 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 providers**.

Network providers

We have contracted with **providers** in the **service area** to provide **eligible health services** to you. These **providers** make up the network for your policy.

For you to receive the network level of benefits, you must use **network providers** for **eligible health services**. There are some exceptions:

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Coverage and exclusions* section.
- **Network provider not reasonably available** – You can get **eligible health services** under your policy that are provided by an **out-of-network provider** if an appropriate **network provider** is not reasonably available. You must ask to use the **out-of-network provider** in advance and we must agree. See the *How to contact us for help* section for how.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section

You may select a **network provider** from the **directory** through our website. See the *How to contact us for help* section. 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 policy owes.

Your PCP

For you to receive the network level of benefits, **eligible health services** must be accessed through your **PCP's** office. They will provide you with primary care.

A **PCP** can be any of the following **providers** available under your policy:

- General practitioner
- Family **physician**
- Internist
- Pediatrician
- OB, GYN, and OB/GYN

How to choose your PCP

You can choose a **PCP** from the list of **PCPs** in our **directory**.

Each covered family member is required to select a **PCP**. You may each select a different **PCP**. You must select a **PCP** for your covered dependent if they are a minor or cannot choose a **PCP** on their own.

What your PCP will do for you

Your **PCP** will coordinate your medical care or may provide treatment. They may send you to other **network providers**.

Your **PCP** can also:

- Order lab tests and radiological services
- Prescribe medicine or therapy
- Arrange a **hospital stay** or a **stay** in another facility

Your **PCP** will give you a written or electronic **referral** to see other **network providers**.

How to change your PCP

You may change your **PCP** at any time. You can call us at the number on your ID card or log in to our website. See the *How to contact us for help* section to make a change.

What happens if you don't select a PCP

Because having a **PCP** is so important, we may choose one for you. We will notify you of the **PCP's** name, address and telephone number.

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

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

- The **provider** you have now is not in the network
- You are already a member of Aetna 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 you are a new enrollee and your provider is an out-of-network provider	When your provider stops participation with us
Request for approval	You need to complete a Transition of Coverage Request form and send it to us. You can get this form by calling the number on your ID card.	You or your provider should call us for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. This date is based on the date the provider terminated their participation with us.

	If you are a new enrollee and your provider is not contracted with us
Request for approval	You need to complete a Transition of Coverage Request form and send it to us. You can get this form by calling the number on your ID card.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.
How claim is paid	Your claim will be paid at the network provider cost sharing level.

If you are pregnant and in your second trimester, the transitional period will include the time required for postpartum care directly related to the delivery and up to 45 days after delivery or from 120 days the provider contract was ended, whichever comes first..

We will authorize coverage for the transitional period only if the **provider** agrees to our usual terms and conditions for contracting **providers**.

SAMPLE

What the policy pays and what you pay

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

- Your **deductible**
- Your **copayments/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 your policy 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 **deductible** limit, when a **deductible** applies.
- Then, the policy and you share the expense up to any **maximum out-of-pocket limit**. Your share is called a **copayment** or **coinsurance**.
- Then, the policy 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**. See the *Glossary* section for what this term means.

Important note – when your policy pays all

Your policy pays the entire expense for all **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, referral and precertification requirements* section.
- When your policy requires **precertification**, it was requested, we refused it, and you get an **eligible health service** without **precertification**. See the *Medical necessity, referral and precertification requirements* section.
- When you get an **eligible health service** without a **referral** when your policy requires a **referral**. See the *Medical necessity, referral and precertification requirements* section.
- Usually, when you get an **eligible health service** from someone who is not a **network provider**. See the *Who provides the care* section.

In all these cases, the **provider** may require you to pay the entire charge. And any amount you pay will not count towards your **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, expenses or costs in excess of the **negotiated charge** for **covered benefits**.

Where your schedule of benefits fits in

The schedule of benefits shows any benefit limitations that apply to your policy. 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 **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 policy.

SAMPLE

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	<ul style="list-style-type: none"> 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 forms. 	<ul style="list-style-type: none"> You must send us notice and proof as soon as reasonably possible. If you are unable to complete a claim form, you must send us: <ul style="list-style-type: none"> A description of services Bill of charges Any medical documentation you received from your provider
Proof of loss (a 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.	<ul style="list-style-type: none"> A completed claim form and any additional information required by us. 	<ul style="list-style-type: none"> You or your provider must send us notice and proof within 12 months of the date you received services, unless you are legally unable to notify us.
Benefit payment	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of claims and communicating our claim decisions

Your **network provider** will send us a claim on your behalf. We will review that claim for payment to the **provider**.

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 doctor treating you decides 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. Or it could 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 if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as **copayments/coinsurance** and **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 **physician** 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	72 hours	15 days	30 days	24 hours for urgent request, or 72 hours if clinical information is required and received more than 24 hours after request^ 15 days for non-urgent request
Extensions	Not applicable	15 days	15 days	
If we request more information	Not applicable	15 days	15 days	
Time you have to send us additional information	48 hours	45 days	45 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**, 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 within 10 business days of our decision. The notice will include information on your right to appeal our decision.

The difference between a complaint and an appeal

A complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call the number on your ID card or write us. See the *How to contact us for help* section. Your complaint 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 complaint. 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 the number on your ID card. You need to include:

- The member'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 (see the *How to contact us for help* section), or by calling the number on your ID card. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

You can appeal one time under this policy.

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 final decision. This decision is called the final adverse benefit determination. You can respond to this information before we tell you our final decision.

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)	36 hours	15 days	30 days	As appropriate to type of claim
Extensions	None	None	None	

Exhaustion of appeals process

In most situations, you must complete the one level of appeal with us before you can take these other actions:

- Contact the Nevada Office of Consumer Health Assistance to request an investigation of a complaint or appeal.
- File a complaint or appeal with the Nevada Office of Consumer Health Assistance.
- Appeal through an external review process.
- Pursue arbitration, litigation or other type of administrative proceeding.

Sometimes you do not have to complete the one level appeals process before you may take other actions. These are when:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.
- We did not follow all of the claim determination and appeal requirements of the State or Federal Department of Health and Human Services. But, you will not be able to proceed directly to external review if the:
 - Rule violation was minor and not likely to influence a decision or harm you
 - Violation was for a good cause or beyond our control
 - Violation was part of an ongoing, good faith exchange between you and us.

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 only 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

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also 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 the Nevada Office of Consumer Health Assistance
- Within 4 months 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.

The Nevada Office of Consumer Health Assistance 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
- 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

The Nevada Office of Consumer Health Assistance will notify you, your representative and us that they have received the request for external review within 5 days after they receive the request.

Once the Nevada Office of Consumer Health Assistance notifies us of the assigned ERO, we will provide to them all of the necessary information relating to the determination, within 5 days.

After the ERO receives the required documentation from us, they will notify you or your representative if they need additional information to conduct the review. The additional information must be submitted within 5 days after the request is received. The ERO will forward the information to us within 1 business day after they receive it.

The ERO shall make its determination to approve, modify or reverse the adverse determination within 15 days after it receives all the information it needs to make the determination.

The ERO will submit a copy of its determination, including the reasoning of the decision, to:

- You
- Your **physician**
- Your authorized representative, if any
- Us

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

Nevada Office for Consumer Health Assistance
555 E. Washington Ave., Suite 4800
Las Vegas, NV 89101
Hours: Monday – Friday 8:00 am to 5:00 pm
Phone: (702) 486-3587 or Toll Free 1-888-333-1597
Fax: (702) 486-3586
Email: cha@govcha.state.nv.us

How long will it take to get an ERO decision?

The ERO will provide their determination to you in a timely manner according to the timeframe necessary to obtain the required information.

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:

Initial adverse determinations

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

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

Final adverse determinations

- Your **provider** tells us that a delay in your receiving health care services would:
 - Jeopardize your life, health or ability to regain maximum function
 - Be much less effective if not started right away (**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 requires an expedited external review, you may submit that request to the Nevada Office of Consumer Health Assistance. They will approve or deny the request, within 72 hours after they receive it.

If approved, the request will be submitted to the ERO no later than 1 business day from the approval.

We will submit all relevant medical documentation and information used to establish the adverse determination within 24 hours after we receive the notice from the Nevada Office of Consumer Health Assistance.

The ERO will complete the expedited review within 48 hours after they are assigned the case unless you, your representative, if any, and we agree to a longer period of time.

The ERO will send notification of its decision within 24 hours after completing its review to:

- You
- Your **physician**
- Your representative, if any
- Us

The ERO will submit a written copy of its determination within 48 hours to the parties listed.

Recordkeeping

We will keep the records of all complaints 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 complaint or appeal.

Coordination of benefits (COB)

This policy does not coordinate benefits with any other policies. That means that this policy pays benefits regardless of whatever other coverage you might have.

SAMPLE

When coverage ends

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

When your coverage will end

Your coverage under this policy will end if:

- This policy is discontinued
- You voluntarily stop your coverage by notifying us in writing 31 days before the date you want your coverage to end
- You are no longer eligible for coverage including moving out of the **service area**
- You do not pay the required **premium** payment by the end of the grace period
- This product is discontinued in the state, if approved by the insurance department of the state where this policy was issued
- We withdraw from the individual market in the state, if approved by the insurance department of the state where this policy was issued
- We rescind your coverage, as permitted under this policy

When coverage will end for any dependents

Dependent coverage will end if:

- They no longer eligible for coverage
- The required **premium** contribution toward the cost of dependents' coverage is not made
- Your coverage ends for any of the reasons listed above

In addition, coverage for a domestic partner will end on the earlier of:

- The date this policy no longer allows coverage for domestic partners.
- The date the domestic partnership ends. For a domestic partnership, you should provide a completed and signed Declaration of Termination of Domestic Partnership to us.

Notice of coverage ending

- We will send you notice if your coverage is ending. This notice will tell you the date that coverage ends. Coverage will end immediately on the next **premium** contribution due date following the date on which you no longer meet the eligibility requirements.

When we would end coverage

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

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

Special coverage options after your coverage ends

This section explains options you may have after your, or your dependent's, coverage ends under this policy. Your individual situation will determine what options you will have.

To request an extension of coverage, call the number on your ID card.

Extending coverage for your disabled child beyond the policy age limits

You have the right to extend coverage for your dependent **child** beyond the policy age limits if your disabled **child**:

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly (more than 50% of income) on you for support

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled and your 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 end coverage for your dependent child.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this policy

We prepared this policy according to federal and state laws as applicable. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this policy when we administer your coverage, so long as we use reasonable discretion.

How we administer this policy

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

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

Sometimes things happen outside of our control. These are things such as natural disasters, epidemics, fire, and riots. We will try hard to get you access to the **eligible health services** that you need even if these things happen.

Your coverage is defined by this policy. This document may have amendments or riders too. Under certain circumstances, we or an **applicable law** may change your policy. When an emergency or epidemic is declared, we may modify or waive **precertification, prescription** quantity limits or your cost share if you are affected. Only we may waive a requirement of your policy. No other person – including your **provider** – can do this.

Financial sanctions exclusions

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

If you become eligible for Medicare

If you are eligible for Medicare Parts A, B or D, we will base our payment for **eligible health services** on the benefits covered by the Medicare part that you're eligible for. We will do this even if you are not enrolled in Medicare.

If you have questions about Medicare, you can contact your local Social Security Administration office.

Workers' compensation

If benefits are paid by us and we determine you received worker's compensation benefits for the same event, we have the right to get back the payment we made ("recover") as described under the *When you are injured* section. We will work to recover the money from you.

These recovery rights will be applied even though:

- The workers' compensation benefits are in dispute or are made by means of settlement or compromise
- No final determination is made that bodily **injury** or **illness** was sustained in the course of, or resulted from, your employment
- The amount of workers' compensation due to medical or health care is not agreed upon or defined by you or the workers' compensation carrier
- The medical or health care benefits are specifically excluded from the workers' compensation settlement or compromise

You agree that you will notify us of any workers' compensation claim you make, and that you will reimburse us as described above. If benefits are paid under this policy and you or any covered dependent recover payment or benefits from a responsible party, we have a right to recover from you or any covered dependent an amount equal to the amount we paid.

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.

Benefits not transferable

Only you and your covered dependents may receive benefits under this policy.

Following the law

If, on the policy's effective date, language in the policy is different from a law that applies to it, the policy will follow **applicable law**.

When you are no longer the policyholder

If you are no longer the policyholder, and the policy wasn't cancelled, your covered spouse or domestic partner will become the policyholder. For a covered dependent child, the parent or legal guardian who is also covered under the policy will become the policyholder. If there is no policy holder at the end of a **premium** period, the policy will be cancelled.

Child-only coverage

In the case of child-only coverage, the parent or legal guardian in whose name the coverage under the policy is issued is considered the policyholder. As a parent or legal guardian, the policyholder has subscribed on behalf of the child for the benefits described in this policy. It is the policyholder's responsibility to make sure the child fulfills all terms and conditions outlined in this policy.

Effect of benefits under other policies

Non-duplication of benefits

If, while covered under this policy, you are covered by another Aetna individual coverage policy:

- You have a right only to benefits of the policy with the better benefits
- We will refund any **premium** charges you paid for the policy with the lesser benefits during the time you were covered by both plans

If, while covered under this policy, you are covered under an Aetna group plan:

- You have a right only to benefits of the group plan
- We will refund any **premium** charges you paid for the individual policy during the time you were covered by both plans

Physical examinations and evaluations

At our expense, we have the right to have a **physician** 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 **physicians** and **providers** who provide services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

You 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 the date you defrauded us or intentionally misrepresented material facts
- 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 you lose coverage:

- We will give you 30 days advanced written notice of any loss 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 **applicable law**, we will not accept an assignment to an **out-of-network provider**.

Recovery of overpayments

We sometimes pay too much for **eligible health services** or pay for something that this policy 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. 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, your employer or another insurance company.

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

- You are agreeing to repay us from money you receive because of your **injury**.
- 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.

We don't have to reduce the amount we're due for any reason, even to help pay your lawyer or pay other costs you incurred to get a 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 number on your ID card. When you accept coverage under this 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

Aetna

Aetna Health Inc., 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.

Applicable law

All federal, state and local laws, as passed or issued, that apply to topics covered by this policy. These may change over time.

Behavioral health provider

A **health professional** licensed or certified to provide diagnostic and/or therapeutic services for **mental health disorders** and **substance related disorders** under the laws of the state where they practice.

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

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

Copay, 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 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 is prescribed by a **physician** or given by trained medical personnel.

Deductible

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

Dentist

A **health professional** trained and licensed to perform dental work under the **applicable laws** of the state where they practice.

Dental provider

A **physician, health professional, dentist, specialty dentist, person, or facility**, licensed or certified by **applicable law** to provide you with dental care services.

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 **physician** or a nurse practitioner 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 state in which it is located.

Directory

The list of **network providers** for your policy. The most up-to-date **directory** for your policy appears on our website. See the *How to contact us for help* section. When searching for **providers**:

- Make sure you are searching for **providers** that participate in your specific plan
- Remember, some **network providers** may only be considered **network providers** for certain Aetna plans
- Search under dental plans for network **dental providers**

Drug guide

A list of **prescription drugs** and OTC drugs and devices established by us or an affiliate. It does not include all **prescription drugs** and OTC drugs and devices. This list can be reviewed and changed by us or an affiliate. A copy of the **drug guide** is available at your request. Or you can find it on our website. See the *How to contact us for help* section.

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 the policyholder's coverage begins under this policy.

Eligible health services

The health care services and supplies listed as **covered benefits** in the *Coverage and exclusions* section. Eligible health services may have limits. See the schedule of benefits.

Emergency medical condition

A recent and severe medical condition that would lead a prudent person 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 an unborn child

Emergency services

Treatment given in a **hospital's** emergency room for an **emergency medical condition**. This includes evaluation of, and treatment to stabilize, an **emergency medical condition**.

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** stating 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 and are considered to be as effective as the brand-name product. It offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional

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

Home health care agency

An agency licensed, certified or otherwise authorized by **applicable law** 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 **physician** or other health care practitioner to be provided in the home setting. These services are usually provided after your discharge from a **hospital** or if you are homebound.

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 law** to provide **hospice care**. These services may be available in your home or inpatient setting.

Hospice care program

A program prescribed by a **physician** or other **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 law** to provide **hospice care**.

Hospital

An institution licensed as a **hospital** by **applicable law** 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 behavioral health
- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

Illness

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
- Because an individual or their partner has been clinically diagnosed with gender identity disorder

Injury

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

Intensive outpatient program (IOP)

Services 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. 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.

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 **deductible**, if one applies, for **eligible health services** as listed in the schedule of benefits.

Medically necessary, medical necessity

Health care services that we determine a **provider** using sensible clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms, and that we determine are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease
- Not primarily for the convenience of the patient, **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 benefit or diagnostic results as to the diagnosis or treatment of that patient's **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
- Consistent with the standards set forth in policy issues involving clinical judgment

Mental health disorder

Mental health disorders are defined in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM is a book published by the American Psychiatric Association. It describes all recognized **mental health disorders**. In general, a **mental health disorder** is a serious disturbance in a person's thought process, emotions or behavior that causes problems in mental functioning. **Mental health disorders** are often connected to significant distress or disability in social, work or other important activities.

Morbid obesity

This means the body mass index is well above the normal range (greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared) and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea
- Diabetes

Body mass index is a degree of obesity and is calculated by dividing your weight in kilograms by your height in meters squared.

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 you. This does not include **prescription drug** services from a **network pharmacy**.

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

- The coordination of care for members
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing
- Accountable care arrangements

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

*For **prescription drug** services from a **network pharmacy**:*

The amount we established for each **prescription drug** obtained from a **network pharmacy** under this policy. 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 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 policy.

Network provider

A **provider** listed in the **directory** for your policy.

Network pharmacy

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

Non-preferred drug

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

Out-of-network provider

A **provider** who is not a **network provider** or a **network provider** that is seen without a **referral**.

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 disorders** 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 place where **prescription drugs** are legally dispensed. This can be a **retail, mail order** or **specialty pharmacy**.

Physician

A skilled health care professional trained and licensed to practice medicine under the **applicable laws** of the state where they practice; specifically, doctors of medicine or osteopathy. Under some plans, a physician can also be a **primary care physician (PCP)**.

Precertification, precertify

A requirement that you or your **physician** contact us 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 are required to pay to us for your coverage.

Prescriber

Any **provider** acting within the scope of his or her 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** 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**.

Primary care physician (PCP)

A **physician** who:

- The **directory** lists as a **PCP** and is selected by a person from the list of **PCPs** in the **directory**
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care **physician**, an internist or a pediatrician
- Initiates **referrals** for **specialist** care
- Maintains continuity of patient care
- Is shown on our records as your **PCP**

Provider

A **physician**, other **health professional**, **hospital**, **skilled nursing facility**, **home health care agency** or other entity or person licensed or certified under **applicable law** to provide health care services to you. 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 law** 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.

R.N.

A registered nurse.

Referral

For plans that require one, this is a written or electronic authorization made by your **PCP** to direct you to a **network provider** for **medically necessary** services and supplies.

Residential treatment facility (mental health disorders)

An institution specifically licensed as a **residential treatment facility** by **applicable law** to provide for mental health residential treatment programs. And is credentialed by us 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 law** to provide for **substance related disorders** residential treatment programs. And is credentialed by us 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**

Retail pharmacy

A community **pharmacy** that dispenses outpatient **prescription drugs**.

Room and board

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

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, we will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service area

The geographic area where **network providers** for this policy are located.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by **applicable law** to provide skilled nursing care.

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

Skilled nursing facility does not include institutions that provide only:

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

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

Skilled nursing services

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

Specialist

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

Specialty prescription drug

An FDA-approved **prescription drug** that typically has a higher cost and requires special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

Specialty pharmacy

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

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 prerequisite drug(s) before a step therapy drug is covered. The prerequisite drugs have FDA approval, may cost less and treat the same condition. If you don't try the appropriate prerequisite drug first, you may need to pay full cost for the step therapy drug.

Substance related disorder

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a **mental health disorder** that are a focus of attention or treatment or an addiction to nicotine products, food or caffeine intoxication.

Surgery center

A facility specifically licensed as a freestanding ambulatory surgical facility by **applicable law** 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, surgical procedure

The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means. This includes:

- Cutting
- Scraping
- Suturing
- Destruction
- Removal
- Lasering

It also includes:

- Introduction of a catheter (e.g. heart or bladder catheterization) or scope (e.g. colonoscopy, endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint or injection of sclerosing solution
- Physically changing body tissues and organs

Telemedicine

A consultation between you and a **provider** who is performing a clinical medical or behavioral health service.

Services can be provided by:

- Two-way audiovisual teleconferencing
- Any other method required by **applicable law**

Terminal illness

A medical prognosis that you are not likely to live more than 6-24 months.

Urgent care facility

A facility licensed as a freestanding medical facility by **applicable law** to treat an **urgent condition**.

Urgent condition

An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

Walk-in clinic

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in-clinic** may be located in, near, or within a:

- Drug store
- **Pharmacy**
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- **Hospital**
- Outpatient department of a **hospital**
- Physician's office
- **Urgent care facility**

SAMPLE

Discount programs

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third party service providers”. These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We are not responsible. But, we have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

Wellness and other incentives

We may encourage and incent you to access certain medical services or categories of health care providers, to use online tools that enhance your coverage and services, and to continue participation as an **Aetna** member. You and your doctor can talk about these medical services and decide if they are right for you. We may also encourage and incent you in connection with participation in a wellness or health improvement program, including but not limited to financial wellness programs. Incentives include but are not limited to:

- Modification to **copayment, deductible or coinsurance** amounts
- Contributions to health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards
- Any combination of the above

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- (1) all stages of reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, <http://www.cms.gov/home/regsguidance.asp>, and this U.S. Department of Labor website, <https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans>.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.



Health maintenance organization (HMO)

Schedule of benefits

Underwritten by Aetna Health Inc. in the state of Utah

Schedule of benefits

This schedule of benefits lists the **deductibles, copayments or coinsurance**, if any, which apply to the **eligible health services** you get under this plan. You should read this schedule to become aware of these and any limits that apply to the services.

How to read your schedule of benefits

- You must pay any **deductibles, copayments or coinsurance**, if they apply.
- You must pay the full amount of any health care service you get that is not a **covered benefit**.
- This plan has limits for some **covered benefits**. For example, these could be:
 - Visit limits
 - Day limits
 - Dollar limits

Important note:

All **covered benefits** are subject to the **calendar year deductible, maximum out-of-pocket limit, copayments or coinsurance** unless otherwise noted in this schedule of benefits below.

How your deductible works

This schedule of benefits shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **eligible health services**. You will continue to pay **copayments or coinsurance**, if any, for **eligible health services** after you meet your **deductible**.

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **eligible health services** from the **PCP** you select. You will pay the **specialist** cost share when you get **eligible health services** from a network **PCP** that is not your **PCP**. If you did not select a **PCP** you will pay the **specialist** cost share for **eligible health services** from any network **PCP** or network **specialist**.

How your maximum out-of-pocket limit works

This schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **eligible health services** for the remainder of that year.

How to contact us for help

We are here to answer your questions. You can:

- Log in to our website at [Aetna.com](https://www.aetna.com)
- Call the number on your ID card

Aetna Health Inc.'s HMO policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your policy.

Plan features –deductible and maximum out-of-pocket limits

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible	In-network
Individual	\$4,000
Family	\$8,000

Deductible waiver

The in-network **deductible** is waived for all of the following **eligible health services**:

- Preventive care and wellness
- Family planning services - female contraceptives

Maximum out-of-pocket limit

Maximum out-of-pocket limit	In-network
Individual	\$8,700
Family	\$17,400

General coverage provisions

This section explains the **deductible**, **maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible provisions

- Your **deductible** may apply to **eligible health services** provided under the medical plan and the outpatient **prescription drug** plan.
- The **deductible** may not apply to certain **eligible health services**. You must pay any applicable cost share for **eligible health services** to which the **deductible** doesn't apply.

Individual deductible

You pay for **eligible health services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. Once you have reached the **deductible**, this plan will begin to pay for **eligible health services** for the rest of the year.

Family deductible

You pay for **eligible health services** each year before the plan begins to pay. After the amount paid for **eligible health services** reaches your family **deductible**, this plan will begin to pay for **eligible health services** for the rest of the year.

To satisfy this family **deductible** for the rest of the year, the combined **eligible health services** that you and each of your covered dependents incur towards the individual **deductible** must reach this family **deductible** in a year.

When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

Deductible credit

If you paid part or all of your **deductible** under other coverage for the year that this plan went into effect, we will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If we ask, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

Maximum out-of-pocket limit provisions

- **Eligible health services** that are subject to the **maximum out-of-pocket limit** may include **covered benefits** provided under the medical plan and the outpatient **prescription drug** plan.
- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.

Individual maximum out-of-pocket limit

Once you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered benefits** that apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

Once you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered benefits** that apply toward the limit for the remainder of the year for all covered family members.

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

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members
- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

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

- All costs for non-covered services
- Any out of pocket costs for non-emergency use of the emergency room
- Any out of pocket costs incurred for non-urgent use of an urgent care **provider**
- Amounts received from a third-party **copay** assistance program, like a manufacturer coupon or rebate, for a **specialty prescription drug**

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of services on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the policy.

Eligible health services

1. Preventive care and wellness

Description	In-network
Preventive care and wellness	0%, no deductible applies

Preventive care and wellness includes:

- Routine physical exams performed at a **physician** office
- Preventive care immunizations performed at a facility or at a **physician** office
- Well woman preventive visits including routine gynecological exams and Pap smears) performed at a **physician**, obstetrician (OB), gynecologist (GYN) or OB/GYN office
- Preventive screening and counseling services which includes obesity and/or healthy diet counseling, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling, genetic risk counseling for breast and ovarian cancer - office visits
- Routine cancer screenings performed at a **physician, specialist** office or facility
- Prenatal care services - provided by an OB, GYN, or OB/GYN
- Comprehensive lactation support and counseling services - facility or office visits
- Breast feeding durable medical equipment - breast pump supplies and accessories
- Family planning services – female contraceptive counseling services office visit, devices, voluntary sterilization

Preventive care and wellness benefit limits

Routine physical exams

- Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents
- Limited to 7 exams from age 0 - 12 months, 3 exams age 1-2, 3 exams age 2-3 and 1 exam every 12 months after that up to age 22, 1 exam every 12 months after age 22
- High risk Human Papillomavirus Virus (HPV) DNA testing for woman age 30 and older limited to one every 36 months

Preventive care immunizations

Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician**.

Well woman preventive visits

Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive screening and counseling services

Limits are per 12 months unless stated below:

Description	Limit
Obesity and/or healthy diet	Unlimited visits from age 0-22, 26 visits every 12 months age 22 or older, of which up to 10 visits may be used for healthy diet counseling
Misuse of alcohol and/or drugs	5 visits every 12 months
Use of tobacco products	8 visits every 12 months
Sexually transmitted infection	2 visits every 12 months
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations

Routine cancer screenings

Subject to any age; family history; and frequency guidelines as set forth in the most current:

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

Lung cancer screenings that exceed the cancer-screening limit are covered under the *Outpatient diagnostic testing* section.

Prenatal care services

Review the *Maternity and related newborn care* section of your policy. It will give you more information on coverage levels for maternity care under this plan.

Comprehensive lactation support and counseling services

- Lactation counseling services limited to 6 visits per 12 months either in a group or individual setting
- Any visits that exceed the lactation counseling services maximum are covered under **physician** services office visits

Breast feeding durable medical equipment

See the *Breast feeding durable medical equipment* section of the policy for limitations on breast pump and supplies.

Family planning services

Contraceptive counseling services limited to 2 visits per 12 months in either a group or individual setting

2. Physicians and other health professionals

Physician services

Description	In-network
Office hours visits (non-surgical) non preventive care	\$30 copay , no deductible applies
Telemedicine consultation by a physician	Covered based on the type of service and where it is received

Specialist office visits

Description	In-network
Office hours visit (non-surgical)	\$75 copay , no deductible applies

Telemedicine

Description	In-network
Consultation by a specialist	Covered based on the type of service and where it is received

Allergy injections

Description	In-network
Without physician or specialist office visit	Covered based on the type of service and where it is received

Allergy testing and treatment

Description	In-network
Performed at a physician or specialist office visit	Covered based on the type of service and where it is received

Immunizations that are not considered preventive care

Description	In-network
Immunizations that are not considered preventive care	Covered based on the type of service and where it is received

Medical injectables

Description	In-network
Performed at a physician or specialist office	40%, after deductible

Physician surgical services

Description	In-network
Inpatient surgical services	40%, after deductible
Performed at a physician or specialist office	40%, after deductible

Alternatives to physician office visits

Walk-in clinic visits

Description	Designated in-network	Non-designated in-network
Non-emergency services	0%, no deductible applies	\$30 copay , no deductible applies
Preventive care immunizations	0%, no deductible applies	0%, no deductible applies

Important note:

Designated network provider

A network provider listed in the **directory** under *Best results for your plan* as a **provider** for your plan.

Non-designated network provider

A **provider** listed in the **directory** under the *All other results* tab as a **provider** for your plan. You will pay less cost share when you use a designated network walk-in clinic **provider**. Non-designated network walk-in clinic **providers** are available to you, but the cost share will be at a higher level when these **providers** are used.

Preventive screening and counseling services at a walk-in clinic

Includes obesity and/or healthy diet counseling, use of tobacco products

Description	In-network
Preventive screening and counseling services	0%, no deductible applies

Limits:

- Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- For details, contact your **physician**
- Refer to the *Preventive care and wellness section* earlier in this schedule of benefits for limits that may apply to these types of services

Important note:

Not all preventive care services are available at **walk-in clinics**. The types of services offered will vary by the **provider** and location of the clinic. These services may also be obtained from a network **physician**.

3. Hospital and other facility care

Hospital care

Description	In-network
Inpatient hospital	40%, after deductible

Anesthesia for certain dental procedures

Description	In-network
Performed in hospital inpatient department	Covered based on the type of service and where it is received
Performed in hospital outpatient department	Covered based on the type of service and where it is received

Alternatives to hospital stays

Outpatient surgery

Description	In-network
Performed in hospital outpatient department	40%, after deductible
Performed in facility other than hospital outpatient department	20%, after deductible
Physician services	40%, after deductible

Home health care

Description	In-network
Outpatient	40%, after deductible
Visit limit per year	100 visits

Important note:

Limited to 3 intermittent visits per day provided by a participating **home health care agency**. 1 visit equals a period of 4 hours or less. Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge.

Hospice care

Description	In-network
Inpatient services	40%, after deductible
Outpatient services	40%, after deductible

Skilled nursing facility

Description	In-network
Inpatient facility	40%, after deductible
Day limit per year	100 days

Private duty nursing

Description	In-network
Private duty nursing	50%, after deductible
Day limit per year	Coverage is limited to 100 days per year when provided in hospital, surgery center, skilled nursing facility or hospice care facility

4. Emergency services and urgent care

A separate **hospital** emergency room or urgent care cost share will apply for each visit to an emergency room or an urgent care **provider**.

Description	In-network
Hospital emergency room	40%, after deductible
Non-emergency care in a hospital emergency room	Not covered

Important note:

Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share (**deductible, copayment, coinsurance**) as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill. If you are admitted to a **hospital** as an inpatient right after a visit to an emergency room and you have an emergency room **copay**, your **copay** will be waived.

Description	In-network
Urgent medical care at a free standing facility that is not a hospital	\$75 copay , no deductible applies
Non-urgent use of urgent care provider at a free standing facility that is not a hospital	Not covered

5. Specific conditions

Autism spectrum disorder

Description	In-network
Autism spectrum disorder	Covered based on the type of service and where it is received
Applied behavior analysis	40%, after deductible

Diabetic equipment, supplies and education

Description	In-network
Diabetic equipment	Covered based on the type of service and where it is received
Diabetic supplies	Covered based on the type of service and where it is received
Diabetic education	Covered based on the type of service and where it is received

Family planning services - other**Inpatient services**

Description	In-network
Voluntary sterilization for males	40%, after deductible

Outpatient services

Description	In-network
Voluntary sterilization for males	Covered based on the type of service and where it is received

Jaw joint disorder treatment

Description	In-network
Jaw joint disorder treatment	Covered based on the type of service and where it is received

Maternity and related newborn care**Prenatal care services**

Description	In-network
Inpatient and other maternity related services and supplies	40%, after deductible
Other prenatal care services and supplies	Covered based on the type of service and where it is received

Delivery services and postpartum care services

Description	In-network
Inpatient and newborn care services and supplies	40%, after deductible
Performed in a facility or at a physician office	40%, after deductible

Important note:

Any cost share that is collected applies to the delivery and postpartum care services provided by an OB, GYN, or OB/GYN only. This cost share does not apply to prenatal care services provided by an OB, GYN, or OB/GYN.

Behavioral health

Mental health treatment

Coverage provided under the same terms, conditions as any other **illness**.

Description	In-network
Inpatient mental health treatment	40%, after deductible
Inpatient residential treatment facility	
Other inpatient mental health treatment services and supplies	40% after deductible
Other inpatient residential treatment facility services and supplies	
Outpatient mental health treatment visits to a physician or behavioral health provider	\$30 copay , no deductible applies
Outpatient mental health telemedicine cognitive therapy consultations by a physician or behavioral health provider	\$0, no deductible applies
Outpatient mental health telemedicine visit	Covered based on type of service and where it is received
Other outpatient mental health treatment or skilled behavioral health services in the home, partial hospitalization treatment and intensive outpatient program	40%, after deductible
The cost share doesn't apply to in-network peer counseling support services, after you meet your deductible	

Substance related disorders treatment

Coverage provided under the same terms, conditions as any other **illness**.

Description	In-network
Inpatient substance related disorders detoxification	40%, after deductible
Inpatient substance related disorders rehabilitation	
Inpatient substance related disorders treatment in residential treatment facility	
Other inpatient substance related disorders detoxification services and supplies	40%, after deductible
Other inpatient substance related disorders rehabilitation services and supplies	
Other inpatient substance related disorders residential treatment facility services and supplies	

Description	In-network
Outpatient substance abuse treatment visits to a physician or behavioral health provider	\$30 copay , no deductible applies
Outpatient substance abuse telemedicine cognitive therapy consultations by a physician or behavioral health provider	\$0, no deductible applies
Outpatient substance related disorders telemedicine visit	Covered based on type of service and where it is received
Other outpatient substance related disorders services or partial hospitalization treatment and intensive outpatient program The cost share doesn't apply to in-network peer counseling support services, after you meet your deductible	40%, after deductible

Reconstructive breast surgery

Description	In-network
Reconstructive breast surgery	Covered based on the type of service and where it is received

Reconstructive surgery and supplies

Description	In-network
Reconstructive surgery and supplies	Covered based on the type of service and where it is received

Transplant services

Description	Network(Exchange IOE facility)	Out-of-network (Includes providers who are otherwise part of Aetna's network but are non-Exchange IOE providers)
Services and supplies	Coverage is limited to Exchange IOE only	Not covered

Treatment of infertility

Basic infertility services

Description	In-network
Basic infertility services	Covered based on the type of service and where it is received

Comprehensive infertility services

Inpatient services

Description	In-network
Inpatient hospital	40%, after deductible
Other inpatient hospital care services and supplies	40%, after deductible

Outpatient services

Description	In-network
Performed at an infertility specialist office	40%, after deductible
Performed in hospital outpatient department	40% after deductible
Performed in facility other than hospital outpatient department	40%, after deductible

Limits

Description	In-network
Maximum number of ovulation induction and intrauterine insemination cycles per lifetime**	6

As used for this benefit, "lifetime" is defined to include **covered benefits paid under this plan or another plan underwritten and/or administered by us or any Aetna® affiliate, with the same contract holder

6. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Description	In-network
Performed at a facility	40%, after deductible
Performed at physician office	40%, after deductible
Performed at specialist office	40%, after deductible

Diagnostic lab work

Description	Designated in-network	Non-designated in-network
Performed at a facility	0%, no deductible applies	\$50 copay , no deductible applies

Diagnostic lab work

Description	In-network
Performed at physician office	40%, after deductible
Performed at specialist office	40%, after deductible

Diagnostic radiological services (X-ray)

Description	In-network
Performed at a facility	40%, after deductible
Performed at physician office	40%, after deductible
Performed at specialist office	40%, after deductible

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

Description	In-network (GCIT-designated facility/provider)
Services and supplies	Covered based on the type of service and where it is received

Outpatient therapies

Chemotherapy

Description	In-network
Chemotherapy	Covered based on the type of service and where it is received

Outpatient infusion therapy

Description	In-network
Performed in a physician office or in a person's home	\$75 copay , no deductible applies
Performed in outpatient facility	40% after deductible

Radiation therapy

Description	In-network
Radiation therapy	Covered based on the type of service and where it is received

Specialty prescription drugs

Description	In-network
Performed in a physician office	Covered based on the type of service and where it is received
Performed in the outpatient department of a hospital	
Performed in an outpatient facility that is not a hospital or in the home	

Short-term cardiac and pulmonary rehabilitation services

A visit is equal to no more than 1 hour of therapy.

Description	In-network
Cardiac and pulmonary rehabilitation	40%, after deductible

Short-term rehabilitation therapy services

A visit is equal to no more than 1 hour of therapy.

Outpatient physical therapy

Description	In-network
Physical therapy	40%, after deductible
Visit limit per year	Coverage is limited to 120 visits per calendar year PT, OT and ST combined, separate from habilitation and includes all outpatient places of service for PT, OT and ST

Outpatient occupational therapy

Description	In-network
Occupational therapy	40%, after deductible
Visit limit per year	Coverage is limited to 120 visits per calendar year PT, OT and ST combined, separate from habilitation and includes all outpatient places of service for PT, OT and ST

Outpatient speech therapy

Description	In-network
Speech therapy	40%, after deductible
Visit limit per year	Coverage is limited to 120 visits per calendar year PT, OT and ST combined, separate from habilitation and includes all outpatient places of service for PT, OT and ST

Spinal manipulation

Description	In-network
Spinal manipulation	40%, after deductible
Visit limit per year	Coverage is limited to 20 visits per calendar year, separate from habilitation and includes all outpatient places of service for Chiro

Habilitation therapy services

Description	In-network
Physical, occupational, and speech therapies	40%, after deductible

7. Other services

Acupuncture

Description	In-network
Acupuncture	\$30 copay , no deductible applies
Visit limit per year	10 visits

Ambulance service

Description	In-network
Emergency ambulance	40%, after deductible
Non-emergency ambulance	40%, after deductible

Clinical trial therapies (experimental or investigational)

Description	In-network
Clinical trial therapies (including routine patient costs)	Covered based on the type of service and where it is received

Durable medical equipment (DME)

Description	In-network
DME	50%, after deductible
DME Limit	1 per item type every 3 years

Hearing aids

Description	In-network
Hearing aids	50%, after deductible
Hearing aids limit	Coverage is limited to 1 per ear every 3 years

Nutritional support

Description	In-network
Nutritional support	50%, after deductible

Obesity (bariatric) surgery

Description	In-network
Obesity (bariatric) surgery	50%, after deductible
Obesity (bariatric) surgery limit per lifetime	Coverage is limited to 1 procedure per lifetime

Orthotic devices

Description	In-network
Orthotic devices	Not covered

Prosthetic devices

Description	In-network
Prosthetic devices	50%, after deductible
Prosthetic devices limit	Coverage is limited to 1 per item type every 3 years

Vision care

Pediatric vision care

Coverage is limited to covered persons through the end of the month in which the person turns 19

Routine vision exams (including refraction)

Description	In-network
Performed by an ophthalmologist or optometrist	50% after deductible
Visit limit per year	1 exam

Vision care services and supplies

Description	In-network
Office visit for fitting of contact lenses	Not covered
Eyeglass frames, prescription lenses or prescription contact lenses	50%, after deductible

Limits

Description	Limit
Number of eyeglass frames per year	One set of eyeglass frames
Number of prescription lenses per year	One pair of prescription lenses
Number of prescription contact lenses per year	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set

Important note:

Refer to the *Vision care* section in the policy for the explanation of these vision care supplies. As to coverage for **prescription** lenses in a year, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.

8. Outpatient prescription drugs

Plan features - maximums and limits

Waiver for contraceptives

The **prescription drug** cost share will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means they will be paid at 100%. This includes certain over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription drug** cost share will apply to **prescription drugs** that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a **network pharmacy** unless you receive a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or **injury**.

Waiver for preventive care drugs and supplements

The **prescription drug** cost share will not apply to preventive care drugs and supplements when obtained at a **network pharmacy**. This means they will be paid at 100%.

Waiver for risk reducing breast cancer prescription drugs

The **prescription drug** cost share will not apply to risk reducing breast cancer **prescription drugs** when obtained at a **network pharmacy**. This means they will be paid at 100%.

Waiver for tobacco cessation prescription and over-the-counter drugs

The **prescription drug** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and over-the-counter (OTC) drugs when obtained at a **network pharmacy**. This means they will be paid at 100%. Your **prescription drug** cost share will apply after those two programs have been exhausted.

Per prescription cost share

Tier 1 - Preferred generic prescription drugs

Description	In-network
For each 30 day supply filled at a retail pharmacy	\$15 copay, no deductible applies
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a mail order pharmacy or CVS pharmacy	\$37.50 copay,, no deductible applies

Tier 2 - Preferred brand-name prescription drugs

Description	In-network
For each 30 day supply filled at a retail pharmacy	\$50 copay after deductible
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a mail order pharmacy or CVS pharmacy	\$125 copay, after deductible

Tier 3 - Non-preferred generic and brand-name prescription drugs

Description	In-network
For each 30 day supply filled at a retail pharmacy	45%, after deductible
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a mail order pharmacy or CVS pharmacy	45%, after deductible

Important note:
Tier 1, 2 and 3 **specialty prescription drugs** are not eligible for fill at a **retail pharmacy** or **mail order pharmacy**.

Tier 4 - Specialty prescription drugs

Description	In-network
For each 30 day supply filled at a specialty network pharmacy	50%, after deductible

Diabetic supplies and insulin

Description	In-network
For each 30 day supply filled at a retail pharmacy	Paid according to the tier of drug in the schedule of benefits, above

Orally administered anti-cancer medications

Description	In-network
For each 30 day supply filled at a specialty network pharmacy	\$0 per prescription or refill after deductible

Outpatient contraceptive prescription drugs and devices

Description	In-network
Female contraceptives that are generic prescription drugs and OTC drugs and devices. For each 30-day supply, up to a 12 month supply at one time	\$0 per prescription or refill, no deductible applies
Female contraceptives that are brand-name prescription drugs and devices. For each 30-day supply, up to a 12 month supply at one time	Paid according to the tier of drug in the schedule of benefits, above

Important note:
For in-network coverage, **brand-name prescription drugs** and devices are covered at 100% when a generic is not available.

Preventive care drugs and supplements

Description	In-network
For each 30 day supply filled at a retail pharmacy	\$0 per prescription or refill, no deductible applies
Limit	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, see the <i>How to contact us for help</i> section.

Risk reducing breast cancer prescription drugs

Description	In-network
For each 30 day supply filled at a retail pharmacy	\$0 per prescription or refill, no deductible applies
Limit	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, see the <i>How to contact us for help</i> section.

Tobacco cessation prescription and over-the-counter drugs

Description	In-network
For each 30 day supply filled at a retail pharmacy	\$0 per prescription or refill, no deductible applies
Limit	<ul style="list-style-type: none"> • Coverage is limited to two, 90-day treatment programs only. Any additional treatment programs will be paid according to the tier of drug per the schedule of benefits, above. • Coverage only includes a generic prescription drug when there is also a brand-name drug available. • Coverage is subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, see the <i>How to contact us for help</i> section.

Important note:
 See the *Outpatient prescription drugs, Other services* section for more information on other **prescription drug** coverage under this plan.

If you or your **prescriber** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the cost share that applies to **brand-name prescription drugs**.