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).

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.
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
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Arabic	**للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.**
Urdu	**لسانی خدمات تک مُفت رسائی کے لیے، اپنے بیمہ کے ID کارڈ پر درج نمبر پر کال کریں۔**
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
Hindi	**बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।**
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.
Gujarati	**તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કોલ કરવો.**
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
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。
Lao	**ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງ ທ່ານ.**

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.
- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 515 Congress Avenue, Suite 1875 Austin, TX 78701	**Texas Department of Insurance** P.O Box 12030, Austin, TX 78711-2030

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Aetna, Inc.

To get information or file a complaint with your insurance company or HMO:

Call: Aetna's toll-free telephone number at 1-888-416-2277
Toll-free: 1-888-416-2277
Online: www.aetna.com
Email: aetnamemberservices@aetna.com
Mail: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Aetna, Inc.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: al numero de teléfono gratis de Aetna al 1-888-416-2277
Teléfono gratuito: 1-888-416-2277
En línea: www.aetna.com
Correo electrónico: aetnamemberservices@aetna.com
Dirección postal: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Protección al Consumidor, MC: CO-CP, Departamento de Seguros de Texas, P.O. Box 12030, Austin, TX 78711-2030

Aetna Health Inc.

2777 Stemmons Freeway, Dallas, TX 75207

1-800MY-Health (694-2358)

www.aetna.com

Health maintenance organization (HMO) Evidence of Coverage (EOC)

2024 TX Silver 5: HMO + Ped Dental

Important note:
This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in evidence of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

Important note:
This is not a policy of workers' compensation insurance. The employer does not become a subscriber to the workers' compensation system by purchasing this EOC, and if the employer is a non-subscriber, the employer loses those benefits which would otherwise accrue under the workers' compensation laws. The employer must comply with the workers' compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.

Important note:
A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.

You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers).

If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: https://www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html.

If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.

You may obtain a current directory of network physicians and providers at the following website: https://www.aetna.com or by calling the toll-free number on your ID card for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

This Evidence of coverage (EOC) is by and between Aetna Health Inc. (Aetna®, we, us, or our) and the subscriber (you, your).

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

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

Health plans are offered or underwritten or administered by Aetna Health Inc. (Texas)(Aetna). Aetna is part of the CVS Health family of companies.

Read your EOC carefully

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

Right to examine the EOC

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

Guaranteed renewable

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

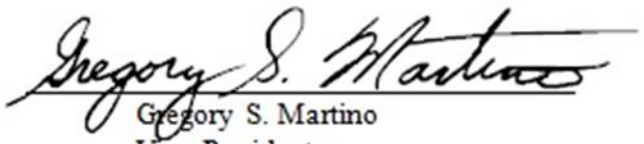
You may keep this EOC in force by meeting the EOC requirements and by paying the premium on time. See the *What does the EOC cost you?* section for more information.

Your application

By applying for coverage under this EOC, 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 EOC are true, correct and complete, to the best of your knowledge and belief; and you agree to all terms, conditions and provisions of the EOC.

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 EOC. We may also report fraud to criminal authorities. See the *Honest mistakes and intentional deception* topic in the *General provisions – other things you should know* section for more information.

By: 

Gregory S. Martino
Vice President

Table of contents

Welcome

At Aetna® , your health goals lead the way, so we're joining you to put them first. We believe that whatever you decide to do for your health, you can do it with the right support. And no matter where you are on this personal journey, it's our job to enable you to feel the joy of achieving your best health.

Welcome to Aetna.

Introduction

This is your EOC. It describes your **covered services** – what they are and how to get them. The second document is the schedule of benefits. It tells you how we share expenses for **covered services** and explains any limits – like when your EOC covers only a certain number of visits.

The EOC, applications, if any, and any attachments constitute the entire contract between the parties and that, to be valid, any change in the form must be approved by an officer of the HMO and attached to the affected form and that no agent has the authority to change the form or waive any of the provisions.

How we use words

When we use:

- "You" and "your" we mean you as the subscriber and any covered dependents, if dependent coverage is available under the EOC
- "Us," "we," and "our" we mean Aetna
- Words that are in bold, these are defined in the *Glossary* section

Contact us

For questions about your EOC, you can contact us by:

- Calling the toll-free number on your ID card
- Writing us at PO Box 981106, El Paso, TX 79998-1106
- Visiting https://www.aetna.com to register and access your member website

Your member website is available 24/7. With your member website, you can:

- See your coverage, benefits and costs
- Print an ID card and various forms
- Find a **provider**, research **providers**, care and treatment options
- View and manage claims
- Find information on health and wellness

Your ID card

Your member ID card tells doctors, **hospitals**, and other **providers** that you are covered by this EOC. Show your ID card each time you get **covered services** from a **provider.**

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. You can also print your ID card. See the *Contact us* section for help.

Wellness and other rewards

You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to access certain health services or categories of healthcare **providers**, participate in programs, including but not limited to financial wellness programs; utilize tools, improve your health metrics or continue participation as an Aetna member through incentives. Talk with your **provider** about these and see if they are right for you. We may provide incentives based on your participation activity and outcomes such as:

- Modifications to **copayment**, **deductible** amounts
- Contributions to a health savings account
- Merchandise
- Coupons
- Gift or debit cards
- Any combination of the above

The award of participation incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health status. Rather, you can obtain these benefits simply by participating in a wellness or health improvement program that we offer you. Once you earn benefits, you can accept or decline them. We won't charge you for choosing to accept any benefits you earn. You can earn benefits as long as we offer wellness and health improvement programs and you participate in them. If we stop offering a wellness and health improvement program or you stop participating in a program, you won't continue to earn these benefits. We will let you know at least 60 days in advance before we stop offering these benefits.

Discount arrangements

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.

What does the EOC cost you?

Premium payment

This EOC requires you to make premium payments. We will not pay benefits under this EOC 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 *Complaints, claim decisions and appeal procedures* section of this EOC.

The first premium payment is due on or before your coverage start date. When we calculate the premium you owe, we use our records to determine who is covered under the EOC. You owe premium for each person covered under the EOC 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 coverage start date. 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 EOC 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 end on 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 EOC because you have not paid your premium. If this happens, we can reactivate ("reinstate") the EOC without a break in coverage. You must ask us to do so within 30 days of the EOC 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 EOC.

Premium agreement

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

Your premium rate is based on factors such as:

- The EOC 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.

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

Premium – changes in rates
We may change the premium rates as of a premium due date during the initial term only if:

- There is a change in factors that materially affects the risk we assumed with this coverage. We will explain these changes in factors in our rate quote to you.

We may change the premium rates as of a premium due date during any following term. Any rate change, however, will not be applied more frequently than annually or as allowed by federal or state law or regulation.

We will let you know in writing of any change in premium rates 60 days before they take effect.

Coverage and exclusions

Providing covered services

Your EOC provides **covered services**. These are:

- Described in this section.
- Not listed as an exclusion in this section or the *General EOC exclusions* section.
- Not beyond any limits in the schedule of benefits.
- **Medically necessary**. See the *How your EOC works – Medical necessity, referral and preauthorization requirements* section and the *Glossary* section for more information.
- Services that are not prohibited by law. See *Services not permitted by law* in the *General plan exclusions* section for more information.

This EOC provides coverage for many kinds of **covered services**, such as a doctor's care and **hospital stays,** but some services aren't covered at all or are limited. For other services, the EOC pays more of the expense. For example:

- **Physician** care generally is covered but **physician** care for cosmetic **surgery** is never covered. This is an exclusion.
- Home health care is generally covered but it is a **covered service** only up to a set number of visits a year. This is a limitation that appears in your schedule of benefits
- Your **provider** may recommend services that are considered **experimental or investigational** services. But an **experimental or investigational** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of services below.
- Preventive services. Usually the EOC pays more and you pay less. Preventive services are designed to help keep you healthy, supporting you in achieving your best health. To find out what these services are, see the *Preventive care* section in the list of services below. To find out how much you will pay for these services, see *Preventive care* in your schedule of benefits.

Some services require **preauthorization** from us. For more information see the *How your EOC works – Medical necessity, referral and preauthorization requirements* section.

The **covered services** and exclusions below appear alphabetically to make it easier to find what you're looking for. If a service isn't listed here as a **covered service** or is listed as not covered under a specific service, it still may be covered. If you have questions, ask your **provider** or contact us. You can find out about limitations for **covered services** in the schedule of benefits.

Alzheimer's disease

Covered services include the following services by a **physician** to diagnose Alzheimer's disease:

- A history and physical
- A neurological evaluation
- A psychological or psychiatric evaluation
- Lab services

Ambulance services

An ambulance is a vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Emergency

Covered services include emergency transport to a **hospital** by a licensed ambulance:

- To the nearest **hospital** to provide **emergency services**
- From one **hospital** to another if the first **hospital** can't provide the **emergency services** you need
- When your condition is unstable and requires medical supervision and rapid transport

Non-emergency

Covered services also include **preauthorized** transportation to a **hospital** by a licensed ambulance:

- From a **hospital** to your home or to another facility 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 treatment

Important note:

- **Out-of-network providers** do not have a contract with us. We will pay the **provider** at our usual and customary rate or at an agreed rate charge. The **provider** may not accept payment of your cost share (**copayment**), as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the 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.

The following are not **covered services**:

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

Applied behavior analysis

Covered services include applied behavior analysis for a diagnosis of autism spectrum disorder. Applied behavior analysis is the process of applying interventions that:

- Systematically change behavior
- Are responsible for observable improvements in behavior

Autism spectrum disorder

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

Covered services include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

Behavioral health

Mental health treatment

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

- Inpatient **room and board** at the **semi-private room rate** (your EOC 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 that are 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** or **telehealth** consultation)
  - Individual, group, and family therapies for the treatment of **mental health disorders**
  - 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
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - Observation
    - Peer counseling support by a peer support specialist (includes **telemedicine** or **telehealth** consultation)

Covered services will be covered on the same terms and conditions as medical and surgical benefits for any other physical illness.

Substance related disorders treatment

Covered 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** (your EOC will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are 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 psychologist, social worker, or licensed professional counselor (includes **telemedicine** or **telehealth** consultation)
  - Individual, group, and family therapies for the treatment of **substance related disorders**
  - Other outpatient **substance related disorders** treatment such as:
    - Partial hospitalization treatment provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Ambulatory or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Peer counseling support by a peer support specialist (includes **telemedicine** or **telehealth** consultation)

Important note:
Covered services will be covered on the same terms and conditions as medical and surgical benefits for any other physical illness. The plan will not impose quantitative or nonquantitative treatment limitations on benefits for **mental health disorders** or **substance related disorders** that are generally more restrictive than quantitative or nonquantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.

Behavioral health important note:
A peer support specialist serves as a role model, mentor, coach, and advocate. Peer support must be supervised by a **behavioral health provider**.

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a provider in connection with participation in a phase I, phase II, phase III or phase IV approved clinical trial for the prevention, detection or treatment of cancer or other life-threatening disease or condition, as defined in the federal Public Health Service Act, Section 2709. An approved clinical trial must satisfy one of the following:

- Federally funded trials:
  - The study or investigation is approved or funded by one or more of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare & Medicaid Services
    - Cooperative group or center of any of the entities described above or the Department of Defense or the Department Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs
    - The Department of Defense

    - The Department of Energy
    - The Food and Drug Administration
    - An institutional review board of a Texas institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services
- The study or investigation is a drug trail that is exempt from having such an investigational new drug application

The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising **experimental or investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** under an "approved clinical trial" only when you have cancer or a **terminal illness**. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- Your **provider** determines, and we agree, you may benefit from the treatment

An approved clinical trial is one that meets all of these requirements:

- The Food and Drug Administration (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, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
    - It conforms to standards of the NCI or other applicable federal organization
    - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the procedures of that study

Dental care services and anesthesia in a hospital or surgery center

Covered services include dental care and anesthesia in a **hospital** or surgery center only if your **provider** tells us you:

- Have a physical, mental, or medical condition that requires you be treated in a **hospital** or surgery center
- Are developmentally disabled
- Are in poor health and have a medical need for general anesthesia

Diabetic services, supplies, equipment, and self-care programs

Covered services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Injection devices including syringes, needles and pens
  - Test strips - blood glucose, ketone and urine
  - 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
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

All supplies, including medications, equipment for controlling diabetes shall be dispensed as written unless substitution is approved by your **physician** who issues the written order.

Durable medical equipment (DME)

Covered services are DME and the accessories needed to operate it when:

- Made to withstand prolonged use
- Mainly used in the treatment of 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

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

Covered services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. If you purchase DME, that purchase is only covered if you need it for long-term use.

Covered services also include:

- One item of DME for the same or similar purpose
- Repairing DME due to normal wear and tear
- A new DME item you need because your physical condition has changed
- Buying a new DME item to replace one that was damaged due to normal wear, if it would be cheaper than repairing it or renting a similar item

The following are not **covered services**:

- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table

- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

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 help.

Covered services include:

- A medical screening examination or other evaluation, required by state or federal law and provided to covered enrollees in a **hospital** emergency facility, freestanding emergency care facility or comparable facility, necessary to determine if an **emergency medical condition** exists
- Treatment to stabilize your condition
- Care in an emergency facility, freestanding emergency care facility or comparable facility or a free-standing emergency care facility after you become stable. But only if the treating **provider** asks us and we approve the service within the time appropriate to the circumstances relating to the delivery of the service and the condition of the patient. We will approve or deny the request within an hour after receiving the request

You can get **emergency services** from **network providers** or **out-of-network providers**.

If you get care from an **out-of-network provider** for an **emergency medical condition** or urgent condition, we will pay the **provider** at our usual and customary rate or at an agreed rate charge. You can contact Member Services at the toll-free number on your ID card if you receive a bill from the **out-of-network provider**. We will work with the **provider** so that all you pay is the appropriate network level **copayment**.

Important note:

- **Out-of-network providers** do not have a contract with us. We will pay the **provider** at our usual and customary rate or at an agreed rate charge. The **provider** may not accept payment of your cost share (**copayment**), as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the 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 (or comparable facility/freestanding emergency medical care facility) and you have an emergency room **copay**, your **copay** will be waived.

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

- You are evaluated and your condition is stabilized

- Your attending **physician** determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another **provider** if you need more care

If your **physician** decides you need to stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. See the *How your EOC works – Medical necessity, referral and preauthorization requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your network **physician** or **primary care physician** (**PCP**).

Non-emergency services
If you go to an emergency room for what is not an **emergency medical condition**, the EOC will not cover your expenses.

Gender affirming treatment

Covered 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 toll-free number on your ID card.

Habilitation therapy services

Habilitation therapy services are services needed to 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). The services must follow a specific treatment plan, ordered by your **physician**. The services must be performed by a:

- Licensed or certified physical, occupational, or speech therapist
- Hospital, **skilled nursing facility**, or hospice facility
- **Home health care agency**
- **Physician**
- Other **provider** acting within the scope of their license

Outpatient physical, occupational, and speech therapy

Covered services include:

- Physical therapy if it is expected to develop any impaired function
- Occupational therapy if it is expected to develop any impaired function
- Speech therapy if it is expected to develop speech function that resulted from delayed development (speech function is the ability to express thoughts, speak words and form sentences.)

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Hearing aids

Hearing aid means:

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

Covered services include prescribed hearing aids and the following hearing aid services:

- 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
    - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
    - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
  - Any **provider** acting within the scope of their license
- 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, including ear molds to maintain optimal fit of a hearing aid
- Habilitation and rehabilitation necessary for educational purposes

The following are not **covered services**:

- Replacement of a hearing aid that is lost, stolen, or broken
- 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

Hearing aids and Cochlear implants and related services

Covered services include cochlear implants and the following related services and supplies:

- Fitting and dispensing services and ear molds necessary to maintain optimal fit of hearing aids
- Treatment related to cochlear implants, including:
  - Habilitation and rehabilitation necessary for educational gain
  - For cochlear implants, an external speech processor and controller
- Internal replacement of cochlear implants as medically necessary or audiologically necessary

The following are not covered under this benefit:

- Hearing aids and Cochlear implants and related services, except as described above

Home health care

Covered services include home health care provided by a **home health care 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 a 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

Skilled nursing services are services provided by a registered nurse or licensed practical nurse within the scope of their license.

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 provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home. See *Short-term rehabilitation services* and *Habilitation therapy services* in this section and the schedule of benefits.

The following are not **covered services**:
- 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 when a family member or caregiver is not present

Hospice care

Covered 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 will be covered, even if the **providers** are not employees 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 services**:

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

Hospital care

Covered services include inpatient and outpatient **hospital** care. This includes:

- Semi-private **room and board**. Your EOC will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians**.
- Operating and recovery rooms
- Intensive or special care units of a **hospital**
- General nursing care
- General nursing care.
- Private duty nursing.
- Administration of blood and blood derivatives, including the expense of the blood or blood product (e.g. blood plasma and blood plasma expanders) that is not replaced by you or for you, but not the expense of the donated blood or blood product.
- Radiation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy
- Anesthesia, oxygen and oxygen therapy
- Inhalation therapy
- Radiological services, laboratory testing and diagnostic services
- Meals and special diets
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a **hospital**

The following are not **covered services**:

- All services and supplies provided in:
  - Rest homes
  - Any place considered a person's main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

Important note:
Even if you receive **eligible health services** at a health care facility that is a **network provider**, not all services may be in network. Other services you receive may be from a **physician** or facility that is an **out-of-network provider**. **Providers** that may not be **network providers** include anesthesiologists, radiologists, pathologists, neonatologists, emergency room physicians and assistant surgeons. You may receive a bill for services from these **out-of-network providers**, as we paid them at our usual and customary rate or at an agreed rate. We will work with the **providers** so that all you pay is your appropriate network level **copayments**. If you are in receipt of a balance bill for covered services from any physician or **provider**, including a facility-based physician or other health care practitioner please contact us.

Infertility services

Basic infertility

Covered services include seeing a **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**.

Infertility services exclusions

The following are not **covered services**:

- 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, sperm, or reproductive tissue.
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests and any charges associated with care of the donor required for donor egg retrievals or transfers.
  - 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 eggs or donor sperm
- Reversal of voluntary sterilizations, including follow-up care
- Any charges associated with obtaining sperm from a person not covered under this EOC for ART services
- Ovulation induction with menotropins, intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)

Jaw joint disorder treatment

Covered services include the diagnosis, surgical, and non-surgical treatment of **jaw joint disorder** by a **provider**, including:

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

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services, including care and services for complications of pregnancy. After your child is born, **covered services** include:

- No less than 48 hours of inpatient care in a health care facility after a vaginal delivery
- No less than 96 hours of inpatient care in a health care facility after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

If you and your **physician** agree to a shorter **stay**, you and your newborn will receive timely post-delivery care. A **physician**, registered nurse, or other licensed health care **provider** can provide the post-delivery care. You can choose to get the post-delivery care in:

- Your home
- A health care **provider's** office
- A health care facility
- Another location determined to be appropriate under applicable Texas law

Complications of Pregnancy

Covered services include treatment of complications of pregnancy that will be determined on the same basis as treatment for any other sickness.

We will cover congenital defects for a newborn the same as we would for any other illness or injury.

Covered services also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Nutritional support

For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are 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.

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease or disorder of amino and organic acids. We will cover these items to the same extent that the plan covers drugs that are available only on the orders of a **physician**.

The following are not **covered services**:

- Any food item, including:
  - Infant formulas
  - Nutritional supplements
  - Vitamins
  - **Prescription** vitamins
  - Medical foods
  - Other nutritional items

For coverage of drugs available only on the orders of a **physician**, please refer to *Prescription drugs-outpatient* in this section

Orthotic device

Covered services include the initial orthotic device and subsequent replacement that your **physician** orders and administers.

We will cover the same type of devices that are covered by Medicare. Your **provider** will tell us which device best fits your needs. But we cover it only if we **preauthorize** the device.

The following are not **covered services**:

- Services covered under any other benefit
- Repair and replacement due to loss, misuse, abuse or theft

Outpatient surgery

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

Covered services also include the following oral **surgery** services:

- Removal of tumors, cysts, all malignant and premalignant lesions and growths of the jaws, cheeks, lips, tongue, roof and floor of the mouth
- Incision and drainage of facial abscess
- **Surgical procedures** involving salivary glands and ducts and non-dental related procedures for the accessory sinuses
- Removal of complete bony impacted teeth

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

The following are not **covered services**:

- A **stay** in a **hospital** (see *Hospital care* in this section)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Important note:
Even if you receive **eligible health services** at a health care facility that is a **network provider**, not all services may be in network. Other services you receive may be from a **physician** or facility that is an **out-of-network provider**. **Providers** that may not be **network providers** include anesthesiologists, radiologists, pathologists, neonatologists, emergency room physicians and assistant surgeons. You may receive a bill for services from these **out-of-network providers**, as we paid them at our usual and customary rate or at an agreed rate. We will work with the **providers** so that all you pay is your appropriate network level **copayments**. If you are in receipt of a balance bill for covered services from any physician or **provider**, including a facility-based physician or other health care practitioner please contact us.

Pediatric dental care

Covered services include dental services and supplies, described in the *Pediatric dental care* section of the schedule of benefits, when provided by a **dental provider**. It also includes coverage for health care services or procedures delivered by a preferred or contracted **health professional** as a **teledentistry** service.

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

A dental emergency is any dental condition which:

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

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

Orthodontic treatment

Orthodontic treatment is covered for a severe, dysfunctional, disabling condition such as:

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

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

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

Replacements

The EOC's "replacement rule" applies to:

- Crowns
- Inlays
- Onlays
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

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

- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay, onlay and veneer, complete denture, removable partial denture, fixed partial denture (bridge) or other prosthetic service was installed at least 5 years before its replacement and cannot be fixed.
- You had a tooth (or teeth) extracted. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Missing teeth that are not replaced

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

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

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

Pediatric dental care exclusions

The following are not **covered services**:

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

Physician services

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

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

Important note:
For behavioral health services, all in-person, **covered services** with a **behavioral health provider** are also **covered services** if you use **telemedicine** or **telehealth** instead.

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

Covered services include the services of:

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

The following are not **covered services**:

- A **stay** in a **hospital** (See *Hospital care* in this section)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Prescription drugs - outpatient

Read this section carefully. This EOC does not cover all **prescription** drugs and some coverage may be limited. This doesn't mean you can't get **prescription** drugs that aren't covered; you can, but you have to pay for them yourself. For more information about **prescription** drug benefits, including limits, see the schedule of benefits.

Important note:
A pharmacy may refuse to fill or refill a **prescription** when, in the professional judgement of the pharmacist, it should not be filled or refilled.

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

Covered services are based on the drugs listed in the **drug guide**. We exclude **prescription** drugs not in the **drug guide** unless we approve a formulary exception request. Any **prescription** drug approved or covered under the plan for a medical condition or mental illness and has been removed from the **drug guide** before your plan renewal will be covered at the contracted benefit level until the plan's renewal date. Our P&T Committee meets no less than quarterly to review existing therapeutic classes as well as new drugs to the market. The P&T Committee's clinical decisions are based on scientific evidence, standards of practice, peer-reviewed medical literature, accepted clinical practice guidelines, and other sources of appropriate information. If it is **medically necessary** for you to use a **prescription** drug that is not in this **drug guide**, you or your **provider** must request a formulary exception. See the *Requesting a formulary exception* section for more information.

Your **provider** can give you a **prescription** in different ways including:

- A written **prescription** that you take to a network pharmacy
- Calling or e-mailing a **prescription** to a network pharmacy
- Submitting the **prescription** to a network pharmacy electronically

Partial fill dispensing for certain prescription drugs

We allow a partial fill of your **prescription** if:

- Your pharmacy or prescriber tells us that:
  - The quantity requested is to synchronize the dates that the pharmacy fills your **prescription** drugs
  - The synchronization of the dates is in your best interest
- You agree to the synchronization

Your out-of-pocket expenses will be prorated based on the number of days' supply.

How to access network pharmacies

A network pharmacy will submit your claim. You will pay your cost share to the pharmacy. You can find a network pharmacy either online or by phone. See the *Contact us* section for help.
You may go to any of our network pharmacies. If you don't get your **prescriptions** at a network pharmacy, they will not be a **covered service** under the EOC.

Any **prescription** drug made to work beyond one month shall require the **copayment** amount that equals the expected duration of the medication.

The pharmacy may substitute a **generic prescription drug** for a **brand-name prescription drug**. Your cost share may be less if you use a generic drug when it is available.

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 90 day supply of a **prescription** drug.

Mail order pharmacy

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. A **mail order pharmacy** may be used for up to a 90 day supply of a **prescription** drug.

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

Specialty pharmacy
A **specialty pharmacy** may be used for up to a 30 day supply of a **specialty prescription drug**. You can view the list of **specialty prescription drugs**. See the *Contact us* section for help. **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.

All **specialty prescription drug** fills including 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.

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

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

When the pharmacy you use 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 us to find another network pharmacy in your area.

How to get an emergency prescription filled

You may not have access to a network pharmacy in an emergency or urgent situation or you may be traveling outside of your EOC's **service area**. If you must fill a **prescription** in any of these situations, we will reimburse you as shown in the table below:

Type of pharmacy	Your cost share is
A network pharmacy	The EOC cost share
An out-of-network pharmacy	The full cost of the **prescription**

When you pay the full cost of the **prescription** at an out-of-network pharmacy:

- You will fill out and send a **prescription** drug refund form to us, including all itemized pharmacy receipts
- Coverage will be limited to items obtained in connection with the out-of-area emergency or urgent situation
- Submission of the refund form doesn't guarantee a refund. If approved, you will be reimbursed the cost of the **prescription** less your network cost share

Other covered services

Anti-cancer drugs taken by mouth, including chemotherapy drugs

Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment. Coverage for oral anti-cancer **prescription** drugs will not be less favorable than for intravenously or injected anti-cancer **prescription** drugs. Your prescriber or your pharmacist may need to get approval from us before we will agree to cover the drug for you. See the *How your EOC works – Medical necessity, referral and preauthorization* section for details.

Contraceptives (birth control)

Covered services include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at a network pharmacy. Your outpatient **prescription** drug plan also covers related services and supplies needed to administer covered devices. At least one form of each FDA-approved contraception method is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for help.

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the **brand-name prescription drug** or device at no cost share.

Preventive contraceptives important note:
You may qualify for a formulary exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the EOC are not medically appropriate for you. Your **provider** may request a formulary exception and submit it to us for review. If the exception is approved, the **brand-name prescription drug** contraceptive will be covered at 100%.

Diabetic supplies and insulin

Covered services include but are not limited to the following:

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

See the *Diabetic services, supplies, equipment, and self-care programs* provision for medical **covered services**.

Immunizations

Covered services include preventive immunizations as required by the ACA when given by a network pharmacy. You can find a participating network pharmacy by contacting us. Check with the pharmacy before you go to make sure the vaccine you need is in stock. Not all pharmacies carry all vaccines.

Nutritional support

Covered services include coverage for formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease or disorder of amino and organic acids. This includes coverage for amino acid-based elemental formula.

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 are 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.

Prescription eye drops

You may refill **prescription** eye drops to treat a chronic eye disease or condition if:

- The original **prescription** states that additional quantities are needed
- The refill does not exceed the total quantity of dosage units stated on the original **prescription**, including refills
- The refill dispensed on or before the last day of the prescribed dosage period and not earlier than the:
  - 21st day after the date a 30-day supply is dispensed
  - 42nd day after the date a 60-day supply is dispensed
  - 63rd day after the date a 90-day supply is dispensed

Preventive care drugs and supplements

Covered services include preventive care drugs and supplements, including OTC ones, as required by the ACA.

Risk reducing breast cancer prescription drugs

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

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

Tobacco cessation prescription and OTC drugs

Covered services include FDA-approved **prescription** and OTC drugs to help stop the use of tobacco products. You must receive a **prescription** from your **provider** and submit the **prescription** to the pharmacy for processing.

Outpatient prescription drugs exclusions

The following are not **covered services**:

- Abortion drugs used for termination of pregnancy except when the pregnancy places the woman's life in serious danger or poses a serious risk of substantial impairment of a major bodily function
- Allergy sera 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**
- Compound **prescriptions** containing bulk chemicals that have not been approved by the U.S. FDA, including compounded bioidentical hormones
- Cosmetic drugs including medications or preparations used for cosmetic purposes
- Devices, products and appliances, unless listed as a **covered service**

- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or dispensed
  - Which do not require a **prescription** by law even if a **prescription** is written, except where stated above unless we have approved a formulary exception
  - That are therapeutically the same as or an alternative to a covered **prescription** drug unless we approve a formulary exception
  - Not approved by the FDA or not proven safe and effective
  - Provided under your medical benefits while inpatient at a healthcare facility
  - Recently approved by the FDA, but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a formulary exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - For which the cost is covered by a federal, state or government agency (for example: Medicaid or Veterans Administration)
  - 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 **preauthorization** and clinical policies
- Duplicative drug therapy, for example, two antihistamines for the same condition
- 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 stated above
- Implantable drugs and associated devices except as specifically stated above
- **Infertility**
  - **Prescription** drugs used primarily for the treatment of **infertility**
- Injectables including:
  - Any charges for the administration or injection of **prescription** drugs.
  - Needles and syringes, except those used for insulin administration.
  - Any drug, which due to its characteristics, as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting, with the exception of Depo Provera and other injectable drugs for contraception.
- Off-label drug use, except for indications recognized through peer-reviewed medical literature or a prescription drug reference compendium approved by the commissioner
- **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 stated as a **covered service**.
  - 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**
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the EOC's **drug guide**.
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the EOC's **drug guide**.

Preventive care

Preventive **covered services** are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing for the treatment or diagnosis of a medical condition, except for diagnostic breast imaging, you may pay more as these services aren't preventive. If a **covered service** isn't listed here under preventive care, it still may be covered under other **covered services** in this section. For more information, see your schedule of benefits.

The following agencies set forth the preventive care guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

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

For frequencies and limits, contact your **physician** or us. This information is also available at https://www.healthcare.gov/.

Important note:
Gender-specific preventive care benefits include **covered services** described regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

Breast-feeding support and counseling services

Covered services include assistance and training in breast-feeding and counseling services during pregnancy or after delivery. Your EOC will cover this counseling only when you get it from a certified breast-feeding support **provider**.

Breast pump, accessories and supplies

Covered services include renting or buying equipment you need to pump and store breast milk. Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and 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.

Counseling services

Covered services include preventive screening and counseling by your **health professional** for:

- Alcohol or drug misuse
  - Preventive counseling and risk factor reduction intervention
  - Structured assessment
- Genetic risk for breast and ovarian cancer
- Obesity and healthy diet
  - Preventive counseling and risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- Sexually transmitted infection
- Tobacco cessation
  - Preventive counseling to help stop using tobacco products
  - Treatment visits
  - Class visits

Family planning services – contraceptives

Covered services include family planning services as follows:

- Counseling services provided by a **physician** or other **provider** on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Contraceptive devices (including any related services or supplies) when they are prescribed, provided, administered, or removed by a **health professional**.
- Voluntary sterilization including 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 preventive **covered services**:

- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA
- Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a **health professional**

Immunizations

Covered services include preventive immunizations for infectious diseases, including adult immunizations under the United States Department of Health and Human Services Centers for Disease Control Recommended Adult Immunization Schedule by Age Group and Medical Condition.

Immunizations for children from birth to age 18

Covered services include:

- Diphtheria, tetanus, pertussis
- Haemophilus influenza type b
- Hepatitis A
- Hepatitis B
- Human papillomavirus
- Inactivated poliovirus

- Influenza
- Measles, mumps, rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella
- Any other immunization that is required for children by law

The following are not preventive **covered services**:

- Immunizations that are not considered preventive care, such as those required due to your employment or travel

Prenatal care

Covered services include your routine pregnancy physical exams at the **physician**, **PCP**, OB, GYN or OB/GYN office. The exams include initial and subsequent visits for:

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

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including a follow-up colonoscopy if the findings are abnormal, pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms (all forms of low-dose mammography, including digital mammography and breast tomosynthesis)
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

Routine physical exams

A routine preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the USPSTF.

- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
- Screening and counseling services on topics such as:
  - Interpersonal and domestic violence
  - Sexually transmitted diseases
  - Human immune deficiency virus (HIV) infections
- High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

- Office visit to a **physician**
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns, an initial **hospital** checkup and the administration of the newborn screening tests as required by applicable Texas law including the cost of a newborn screening test kit in the amount provided by the Department of State Health Services.

Routine physical exams for women also include:

- Diagnostic exams for early detection of ovarian cancer, including any other tests or screening approved by the United States Food and Drug Administration, cervical cancer, and the CA 125 blood test
- Pap smear or screening using liquid-based cytology methods, either alone or in conjunction with a test approved by the United States Food and Drug Administration
- Breast cancer mammography screenings

Well woman preventive visits

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 and also includes:

- Office visit to a **physician**, **PCP**, OB, GYN or OB/GYN for services including Pap smears
- Preventive care breast cancer (BRCA) gene blood testing
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

Prosthetic device

A prosthetic device is a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects.

We will cover the same type of devices that are covered by Medicare. Your **provider** will tell us which device best fits your needs. But, we cover it only if we **preauthorize** the device.

Covered services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers. This includes coverage for:

- Bone anchored hearing aid
- Cochlear implants, including accessories and upgrades

Coverage includes:

- Instruction and other services (such as attachment or insertion) so you can properly use the device
- Repairing or replacing the original device unless you misuse or lose the device. Examples of these are:
  - 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

If you receive a prosthetic device as part of another **covered service**, it will not be covered under this benefit.

The following are not **covered services**:

- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Repair and replacement due to loss, misuse, abuse or theft

Reconstructive breast surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** 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 symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prostheses
- Unless you or your **physician** decide that a shorter time period for inpatient care is appropriate, **covered services** for reconstructive breast **surgery** include:
  - 48 hours of inpatient care following a mastectomy
  - 24 hours of inpatient care in a network health care facility after lymph node dissection for treatment of breast cancer

Reconstructive surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect, including a congenital dental defect, present at birth. 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

- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.
- Your **surgery** corrects a craniofacial abnormality. This includes an abnormal structure that is caused by developmental deformities, congenital defects, trauma, tumors, infections or disease. The **surgery** will be covered if:
    - The purpose of the **surgery** is to improve function or attempt to create a normal appearance

Covered services also include the procedures or **surgery** to sound natural teeth**,** injured due to an accident, except as a result of chewing or biting, and performed as soon as medically possible, when:

- The teeth were stable, functional and free from decay or disease at the time of the injury
- The **surgery** or procedure returns the injured teeth to how they functioned before the accident

These dental related services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth
- The first placement of dentures or bridgework to replace lost teeth
- Orthodontic therapy to pre-position teeth

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

Covered 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

Covered services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if they are part of a treatment plan ordered by your **physician**. A course of outpatient pulmonary rehabilitation may also be covered if it is performed at a **hospital**, **skilled nursing facility**, or **physician's** office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services are services needed to restore or develop skills and functioning for daily living. The services must follow a specific treatment plan, ordered by your **physician**. 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**

Important note:
When the service or therapy is considered **medically necessary** by your **physician**, your service or therapy will continue as long as the service or therapy meets or exceeds treatment goals.

Spinal manipulation

Covered 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.

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

- Physical therapy, but only if it is expected to improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure** or help you maintain or prevent loss of function
- Occupational therapy, but only if it is expected to do one of the following:
  - 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 improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to do one of the following:
  - Improve or restore lost speech function or correct a speech impairment resulting from 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

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.

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Inpatient and outpatient treatment for acquired brain injury

Covered services include treatment of an acquired brain injury and will be determined on the same basis as treatment for any other physical condition. Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation; Neurobehavioral, Neuropsychological, Neurophysiological and Psychophysiological Testing and Treatment; Neurofeedback Therapy, Remediation, Post-Acute Transition Services and Community Reintegration Services, including Outpatient Day Treatment Services, or any other Post-Acute Treatment Services are covered, if such services are necessary as a result of and related to an acquired brain injury.

Treatment for an acquired brain injury may be provided at a **hospital**, an acute or post-acute rehabilitation **hospital**, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Service means the work of testing, treatment, and providing therapies to an individual with an acquired brain injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

To ensure that appropriate post-acute care treatment is provided, this plan includes coverage for reasonable expenses related to periodic reevaluation for the care of an individual covered who:

- Has incurred an acquired brain injury
- Has been unresponsive to treatment and
- Becomes responsive to treatment at a later date

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Skilled nursing facility

Covered services include **preauthorized** inpatient **skilled nursing facility** care. This includes:

- **Room and board**, up to the **semi-private room rate**
- Services and supplies provided during a **stay** in a **skilled nursing facility**

Telemedicine teledentistry or telehealth

Covered services include **telemedicine, teledentistry** or **telehealth** consultations when provided by a **physician, specialist,** or **behavioral health provider** acting within the scope of their license at a different physical location than the **physician** or **health professional** using telecommunications or information technology.

Covered services for **telemedicine, teledentistry** or **telehealth** consultations are available from a number of different kinds of **providers** under your plan. Log in to your member website at https://www.aetna.com to review our **telemedicine, teledentistry or telehealth provider** listing. Contact us to get more information about your options, including specific cost sharing amounts.

The following are not **covered services**:

- Telephone calls
- **Telemedicine** or **telehealth** kiosks
- Electronic vital signs monitoring or exchanges (e.g., Tele-ICU, Tele-stroke)

Tests, images and labs – outpatient

Cardiovascular disease

Covered services include the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

- Computed tomography (CT) scanning measuring coronary artery calcifications; or
- Ultrasonography measuring carotid intima-media thickness and plaque

Tests are available to each covered individual who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Diagnostic complex imaging services

Covered services include:

- Computed tomography (CT) scans, including for preoperative testing
- 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 imaging service where the billed charge exceeds $500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic follow-up care related to newborn hearing screening

Covered services include necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

These are covered only when you get them from a licensed radiology **provider** or lab.

Diagnostic radiological services (X-ray)

Covered services include x-rays, scans and other services (but not complex imaging) only when you get them from a licensed radiology **provider**. See *Diagnostic complex imaging services* above for more information.

Important note:
Even if you receive **covered services** at a health care facility that is a **network provider**, not all services may be in network. Oher services you receive may be from a **physician** or facility that is an **out-of-network provider**. **Providers** that may not be in **network providers** include anesthesiologists, radiologists, pathologists, neonatologists, emergency room **physicians** and assistant surgeons. You may receive a bill for services from these **out-of-network providers**, as we paid them at our usual and customary rate or at an agreed rate. We will work with the **providers** so that all you pay is your appropriate network level **copayments**. If you are in receipt of a balance bill for **covered services** from any **physician** or **provider**, including a facility-based **physician** or other health care practitioner, please contact us.

Important Note:
Coverage for diagnostic imaging using mammography, ultrasound imaging, or magnetic resonance imaging to evaluate an abnormality of the breast, including abnormalities detected by you or where there is a personal history of breast cancer or dense breast tissue will be considered the same as mammograms performed for routine cancer screenings as described in the *Preventive care* section.

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

Covered 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**.

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

Covered 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 **covered 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 **covered 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 **covered services**.

The following are not **covered 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
  - Lab
  - Radiology
  - Anesthesia
  - Nursing services

See the *How your EOC works – Medical necessity, referral and preauthorization requirements* section.

Infusion therapy
Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions. **Covered services** include infusion therapy you receive in an outpatient setting including but not limited to:

- A freestanding outpatient facility
- The outpatient department of a **hospital**
- A **physician's** office
- Your home from a home care **provider**

You can access the list of preferred infusion locations by contacting us.

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

Certain infused medications may be covered under the *Prescription drugs - outpatient* section. You can access the list of **specialty prescription drugs** by contacting us.

Radiation therapy (therapeutic radiology)
Covered services include the following radiology services provided by a **health professional**:

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

Transplant services
Covered 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 treatments

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**, **deductible**, maximum out-of-pocket and limits, unless stated differently in this EOC and schedule of benefits.

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

The following are not **covered services**:

- 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

Urgent care services

Covered services include services and supplies to treat an urgent condition at an urgent care center. An urgent condition is an illness or injury that requires prompt medical attention but is not a life-threatening **emergency medical condition**. An urgent care center is a facility licensed as a freestanding medical facility to treat urgent conditions.

Covered services include services and supplies to treat an urgent condition at an urgent care center as described below:

- Urgent condition within the **service area**
  - If you need care for an urgent condition, you should first seek care through your **physician** or **PCP**. If your **physician** is not reasonably available, you may access urgent care from an urgent care center that is in-network.

If you go to an urgent care center for what is not an urgent condition, the plan will not cover your expenses.

The following are not **covered services**:

- Urgent care obtained from a facility that is out-of-network
- Non-urgent care in an urgent care center

Vision care

Pediatric vision care

Covered services include:

- Routine vision exam provided by an ophthalmologist, optometrist or any other provider acting within the scope of their license including refraction, glaucoma testing
- Eyeglass frames, **prescription** lenses or contact lenses

The following are not **covered services**:

- Office visits to an ophthalmologist, optometrist, optician or any other provider acting within the scope of their license related to the fitting of **prescription** contact lenses
- Non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Walk-in clinic

Covered 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** or **telehealth** consultation
- Preventive screening and counseling services that will help you:
  - With obesity or healthy diet
  - To stop using tobacco products

Important note:
Even if you receive **covered services** at a health care facility that is a **network provider**, not all services may be in network. Oher services you receive may be from a **physician** or facility that is an **out-of-network provider**. **Providers** that may not be in **network providers** include anesthesiologists, radiologists, pathologists, neonatologists, emergency room **physicians** and assistant surgeons. You may receive a bill for services from these **out-of-network providers**, as we paid them at our usual and customary rate or at an agreed rate. We will work with the **providers** so that all you pay is your appropriate network level **copayments**. If you are in receipt of a balance bill for **covered services** from any **physician** or **provider**, including a facility-based **physician** or other health care practitioner, please contact us.

General EOC exclusions

The following are not **covered services** under your EOC:

Abortion

Services and supplies provided for an abortion except when the pregnancy places the woman's life in serious danger or poses a serious risk of substantial impairment of a major bodily function

Abortion drugs

Drugs used for termination of pregnancy except when the pregnancy places the woman's life in serious danger or poses a serious risk of substantial impairment of a major bodily function

Acupuncture

- Acupuncture
- Acupressure

Behavioral health treatment

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

- **Stay** in a facility for treatment for dementia and 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 as described in the *Coverage and exclusions* section
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions-Preventive care* section

Blood, blood plasma, synthetic blood, blood derivatives or substitutes, except as described in the *Coverage and exclusions – Hospital care* section

Examples of these are:

- The provision of donated blood to the **hospital**, other than blood derived clotting factors
- Any related services for donated blood including processing, storage or replacement expenses
- The service of blood donors, including yourself, apheresis or plasmapheresis
- The blood you donate for your own use, excluding administration and processing expenses
- Volunteer donation expenses for which there is no charge

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

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

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

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
    - Special education
    - Remedial education
    - Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
    - Job training
    - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, 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 trials

Please see the *Complaints, claim decisions and appeal procedures* section for more information on your appeals rights in these situations

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, except for complications of diabetes. See the *Coverage and exclusions* 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

Hearing exams

Hearing exams performed for the evaluation and treatment of illness, injury or hearing loss

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. These items are usually included in the cost of other services and are not billed separately. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Missed appointments
Any cost resulting from a canceled or missed appointment

Obesity (bariatric) surgery and services
Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Coverage and exclusions* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric **surgery**
- **Surgical procedures**, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Other non-covered services
- Services you have no legal obligation to pay
- Services that would not otherwise be charged if you did not have the coverage under the EOC

Other primary payer
Payment for a portion of the charges that Medicare or another party is responsible for as the primary payer. This exclusion does not apply to laws that make the government program the secondary payer after benefits under this EOC have been paid.

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 as described in the *Coverage and exclusions- Hospital care* section

Services not permitted by law
Some laws restrict the range of health care services a **provider** may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

Services provided by a family member
Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law, or any household member

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 EOC.

Sexual dysfunction and enhancement

Any treatment, **prescription** drug, 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 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, except when used to treat an illness or injury

Therapies and tests

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

Tobacco cessation

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 USPSTF.
This also includes:

- Counseling, except as specifically provided in the *Coverage and exclusions* section
- Hypnosis and other therapies
- Medications, except as specifically provided in the *Coverage and exclusions* section
- Nicotine patches
- Gum

Treatment in a federal, state, or governmental entity

Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity unless coverage is required by applicable laws

Vision care for adults

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

Voluntary sterilization

- Reversal of voluntary sterilization procedures, including related follow-up care

Wilderness treatment programs

See *Educational services* in this section

Work related illness or injuries

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

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

How your EOC works

How your EOC works while you are covered

Your HMO EOC helps you get and pay for a lot of - but not all - health care services. The EOC usually pays only when you get care from network provider**s**.

Providers

Our **provider** network is there to give you the care you need. The easiest way to find **network providers** and see important information about them is by logging in to your member website. There you'll find our online **provider** directory. See the *Contact us* section for more information.

You choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care.

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

Service area

Your EOC generally pays for **covered services** only within a specific geographic area, called a **service area**. See *Appendix A – Service area map* for a **service area** map and a detailed list of counties within the **service area**. You must reside, live or work in the **service area**. There are some exceptions, such as for **emergency services**, urgent care, and transplants. See the *Who provides the care* section below.

Important note for dependents under a qualified medical support:
if you are required to cover a dependent who lives outside the **service area** under a qualified medical or dental support order, we will provide your dependent with coverage that is comparable health or dental coverage to that provided to other dependents under a separate EOC.

Important note for other dependents (not under a qualified medical support order) outside the service area:
If you have a dependent 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.

Who provides the care

Network providers

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

To get network benefits, you must use **network providers**. There are some exceptions:

- **Emergency services** – see the description of **emergency services** in the *Coverage and exclusions* section.
- Urgent care – see the description of urgent care in the *Coverage and exclusions* section.

- **Network provider** not reasonably available – You can get services from an **out-of-network provider** if an appropriate **network provider** is not reasonably available. You must request approval from us before you get the care. Contact us for assistance. We will make a decision as soon as your medical condition requires but not later than 5 working days after we receive all of the information we need from your **provider**. We may decide not to approve your request. Before we disapprove the request, a **specialist** of the same or similar specialty as the **provider** you are requesting to see will review your request. If access is approved, we will pay the **out-of-network** provider at our usual and customary charge or an agreed rate. We will work with the **provider** so that all you pay is the appropriate network level **copayment**. Contact us for assistance.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

You may select a **network provider** from the online directory through your member website.

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

Your PCP

To receive benefits, you must get **covered services** through your **PCP**. Your **PCP** will provide you with primary care.

Your **PCP** can provide care for obstetrical or gynecological services. Or, you can choose an OB, GYN or OB/GYN **network provider** to provide care for those services. You can access an OB, GYN or OB/GYN network provider without a referral from your **PCP**. A female has direct access to OB, GYN, or OB/GYN in addition to a **PCP**.

If you have a chronic, disabling or life-threatening illness, you can request to use a **network specialist** as your **PCP**. Your **network specialist** must let us know that they agree to act as your **PCP**. You can contact us for information as to how to apply for this exception.

Designation of your **network specialist** as your **PCP** will not be retroactive. If your request is denied, you may appeal the decision. See the *When you disagree – claim decisions and appeals procedures* section.

How you 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 choose 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** will give you a written or electronic **referral** to see other **network providers**.

You may receive treatment for up to 15 consecutive business days from certain physical therapists without a **referral**. Please contact your physical therapist for additional information.

You will never need a **referral** or authorization form your **PCP** to go to an OB/GYN **network provider**.

Changing your PCP
You may change your **PCP** at any time by contacting us.

If you do not select a PCP
Because having a **PCP** is so important, we may choose one for you. You will get an ID card in the mail. We will tell you the name, address and telephone number of your **PCP**. If you wish, you can change the **PCP** by following the directions above for *Changing your PCP*.

Until a **PCP** is selected, benefits will be limited to care provided by direct access **network provider**, **emergency services** and urgent care services.

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

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

- You join the EOC and the **provider** you have now is not in the network
- You are already an Aetna member and your **provider** stops being in our network

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

If this situation applies to you, contact us for details. If you are being treated for an acute or chronic condition and as long as the **provider** didn't leave the network based on fraud, lack of quality standards, you'll be able to receive transitional care from your **provide**r for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

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

	If you have a disability, acute condition, or life-threatening condition and your provider stops participation with Aetna
Request for approval	You or your **provider** should call us for approval to continue any care. You can call Member services at the toll-free number on your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period for up to 90-days. This date is based on the date the **provider** terminated their participation with us.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.

	If you have a terminal illness and your provider stops participation with Aetna
Request for approval	You or your **provider** should call us for approval to continue any care. You can call Member services at the toll-free number on your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period for up to nine (9) months. This date is based on the date the **provider** terminated their participation with us.

How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.

	If you are pregnant and have entered your second trimester and your provider stops participation with Aetna
Request for approval	You or your **provider** should call us for approval to continue any care. You can call Member services at the toll-free number on your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period through delivery, including the time required for postpartum care directly related to delivery. This includes a post-delivery checkup within six weeks.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.

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

Medical necessity, referral and preauthorization requirements

Your EOC pays for its share of the expense for **covered services** only if the general requirements are met. They are:

- The 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 preauthorizes** the service when required

Medically necessary, medical necessity

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

Important note:
We cover **medically necessary**, sex-specific **covered services** regardless of identified gender.

Referrals

You need a **referral** from your **PCP** for most **covered services**. If you do not have a **referral** when required, you will have to pay for services yourself. You do not need a **referral** for **covered services** in a network **walk-in clinic**.

Preauthorization

You need pre-approval from us for some **covered services**. Pre-approval is also called **preauthorization**.

Your network **physician** or **PCP** is responsible for obtaining any necessary **preauthorization** before you get the care. **Network providers** can't bill you if they fail to ask us for **preauthorization**. But if your **physician** or **PCP** requests **preauthorization** and we deny it, and you still choose to get the care, you will have to pay for it yourself.

A preauthorization may not be required if your provider meets the requirements of prior preauthorization approvals. Please contact your **physician** or us for additional information.

Your physician or PCP may request a renewal of an existing preauthorization within 60 days of the expiration date of the preauthorization. We will notify you of our decision before the expiration of the existing preauthorization.

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

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 policies. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

Certain **prescription** drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following **preauthorization** information applies to these **prescription** drugs:

- For certain drugs, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**.

Step therapy is a type of **preauthorized** where you must try one or more prerequisite drugs before a step therapy drug is covered. A 'prerequisite' is something that is required before something else. Step therapy will not apply to prescription drugs used for the treatment of stage-four advanced, metastatic cancer and associated conditions. Prerequisite drugs are FDA-approved, may cost less and treat the same condition. If you don't try the prerequisite drugs first, the step therapy drug may not be covered.

Contact us or go online to get the most up-to-date **preauthorization** requirements and list of step therapy drugs.

Requesting a formulary exception

Sometimes you or your **provider** may ask for a formulary 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 the toll-free number on your ID card
- Go online at https://www.aetna.com
- Submit the request in writing to:
  CVS Health
  ATTN: Aetna PA
  1300 E Campbell Road
  Richardson, TX 75081

You, someone who represents you, or your **provider** may seek a quicker medical exception when the situation is urgent. It's an urgent situation when you have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug. A formulary exception request for a drug that is not listed in the **drug guide** is an adverse determination and you can have the adverse determination reviewed as an appeal of an adverse determination including an expedited appeal.

What the EOC pays and what you pay

Who pays for your **covered services** – this EOC, both of us, or just you? That depends.

The general rule

The schedule of benefits lists what you pay for each type of **covered service**. In general, this is how your benefit works:

- You pay the **deductible**, when it applies.
- Then the EOC and you share the expense. Your share is called a **copayment**.
- Then the EOC pays the entire expense after you reach your **maximum out-of-pocket limit**.

When we say "expense" in this general rule, we mean the **negotiated charge** for a **network provider**.

Negotiated charge

For health coverage:

This is the amount a **network provider** has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid).

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

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 EOC.

*For **prescription** drug services:*

When you get a **prescription** drug, we have agreed to this amount for the **prescription** or paid this amount to the network pharmacy or third party vendor that provided it. The **negotiated charge** may include a rebate, additional service or risk charges and administrative fees. It may include additional amounts paid to or received from third parties under price guarantees.

Surprise bill

There may be times when you unknowingly receive services or don't consent to receive services from an **out-of-network provider**, even when you try to stay in the network for your **covered services**. You may then get a bill at the out-of-network rate that you didn't expect. This is called a surprise bill.

An **out-of-network provider** can't balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirements, such as **deductibles**, **copayments,** for the following services:

- **Emergency services** provided by an **out-of-network provider** and ancillary services initiated from your **emergency services**
- Non-emergency services provided by an **out-of-network provider** at an in-network facility, except when the **out-of-network provider** has given you the following:
  - The out-of-network notice for your signature
  - The estimated charges for the items and services
  - Notice that the **provider** is an **out-of-network provider**
- Out-of-network air ambulance services

The **out-of-network provider** must get your consent to be treated and balance billed by them.

Ancillary services mean any professional services including:

- Items and services related to emergency medicine
- Anesthesiology
- Hospitalist services
- Laboratory services
- Neonatology
- Pathology
- Radiology
- Services provided by an **out-of-network provider** because there was no **network provider** available to perform the service

A facility in this instance means an institution providing health care related services, or a health care setting. This includes the following:

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory, and imaging centers
- Rehabilitation facilities
- Other therapeutic health settings

A surprise bill claim is paid based on the median contracted rate for all plans offered by us in the same insurance market for the same or similar item or service that is all of the following:

- Provided by a **provider** in the same or similar specialty or facility of the same or similar facility type
- Provided in the geographic region in which the item or service is furnished

The median contracted rate is subject to additional adjustments specified in federal regulations.

Any cost share paid with respect to the items and services will apply toward your in-network **deductible maximum** out-of-pocket **limit**, if you have one.

It is not a surprise bill when you knowingly choose to go out-of-network and have signed a consent notice for these services. In this case, you are responsible for all charges.

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

Paying for covered services – the general requirements

There are several general requirements for the EOC to pay any part of the expense for a **covered service**. They are:

- The 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 preauthorizes** the service when required

Generally, your EOC and you share the cost for **covered services** when you meet the general requirements. But sometimes your EOC will pay the entire expense, and sometimes you will. For details, see your schedule of benefits and the information below.

You pay the entire expense when:

- You get services or supplies that are not **medically necessary**.
- Your EOC requires **preauthorization**, your **physician** requests it, we deny it and you get the services without **preauthorization**.
- You get care without a **referral** and your EOC requires one.
- You get care from someone who is not a **network provider**, except for emergency, urgent care and transplant services. See *Who provides the care* in this section for details.

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

Your **copayments** will not exceed 50% of the total cost of services provided or 200% of the total annual **premium** cost. If your **copayments** have exceeded 200% of the total annual **premium** cost, you must submit a detailed explanation of benefits (EOB) showing the dates and total amount of the **copayments** paid.

Important note:
Although health care services may be or have been provided to you at a health care facility that is a member of the **provider** network used by your health benefit plan, other professional services may be or have been provided at or through the facility by **physicians** and other health care practitioners who are not members of that network. You may be responsible for payment of part of the fees for those professional services that are not paid or covered by your health benefit plan. If you are in receipt of a balance bill for **covered services** from any **physician** or **provider**, including a facility-based **physician** or other health care practitioner please contact us.

Where your schedule of benefits fits in

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

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

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 EOC.

Coordination of benefits

This EOC does not coordinate benefits with any other policies, except for any Medicare coverage or plan you may have. Please see the *If you become eligible for Medicare section of General provisions – other things you should know* for more information.

Benefit payments and claims

A claim is a request for payment that you or your health care **provider** submits to us when you want or get **covered services**. There are different types of claims. You or your **provider** may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

It is important that you carefully read the previous sections within *How your EOC works*. When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have to tell you about our decision on a claim depends on the type of claim.

Claim type and timeframes

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. It could also be a situation in which you need care to avoid severe pain. We will make a decision no later than 1 hour after we receive the request.

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 **preauthorize** them.

Retrospective claim

A retrospective claim is a claim that involves health care services you have already received.

Concurrent care claim extension

A concurrent care claim extension occurs when you need 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 extension decision
You or your **provider** may ask for a concurrent care claim extension to request more services. We will notify you of such a determination. If we make an adverse determination, 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 independent review organization if the situation is eligible for independent review.

During this concurrent care claim extension period, you are still responsible for your share of the costs, such as **copayments**, and **deductibles** that apply to the service or supply. If your request for extended services is not approved after your adverse determination appeal, and we uphold our decision to reduce or terminate such services, you will be responsible for all of the expenses for the service or supply received during the concurrent care claim extension period.

The chart below shows a timetable view of different types of claims we **preauthorize** and how much time we have to tell you about our decision.

Initial claim determinations				
Type of notice	**Initial determination (us)**	**Extensions**	**Additional information request (us)**	**Response to additional information request (you)**
Pre-service claim*	No later than 3 calendar days after we receive the request	Not applicable	Not applicable	Not applicable
Concurrent care claim* If you are hospitalized (may include concurrent care claim of **hospital stays)**	No later than 24 hours after we receive the request followed by written notification within 3 business days	Not applicable	Not applicable	Not applicable
Care to make sure you are stable following emergency treatment (post-stabilization) or for a life threatening condition.	No later than one (1) hour after we receive request, or within the time appropriate to your condition.	Not applicable	Not applicable	Not applicable

Requests for **step therapy** (non-emergency)	No later than 72 hours after we receive the request	Not applicable	Not applicable	Not applicable

*If we approve the care and services, we will send you a letter no later than 2 business days after we receive the request. The *Adverse determinations* section explains how and when we tell you about an adverse determination.

Important Note:
We will tell you about an initial determination within the time appropriate to the circumstances relating to the delivery of the services and your condition. We will always tell you no later than the time shown in the chart above.

Filing a claim

When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider** must send us the bill within 95 days of the date you received services, unless you are legally unable to notify us. You must send it to us with a claim form that you can either get online or contact us to provide.

The benefit payment determination is made based on many things, such as your **deductible** or **copayments**, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and backward. If we paid claims for your past coverage, we will want the money back.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions and appeal procedures* section for that information.

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

A complaint is any oral or written expression of dissatisfaction regarding any aspect of our operation. You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. Some examples of complaints are when you are not happy with:

- How we have administered the plan
- How we have handled the appeal process
- When we deny a service that is not related to **medical necessity** issues
- The manner in which a service is provided
- A disenrollment decision

It is not a complaint if:

- We resolve a misunderstanding or misinformation, to your satisfaction, by providing an explanation or more information.
- You or your **provider** call or write to tell us you are unhappy with, or disagree with, an adverse determination. Instead, this is an appeal of the adverse determination. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determination* sections for more information

Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will let you know that we have received your complaint within 5 business days. Our letter will tell you about our complaint procedures and timeframes. If you call us to complain, we will send you a complaint form to complete and return.

We will review the information and give you a written response within 30 calendar days of receiving the complaint. If your complaint is for services that you have not already received, we will provide you with a written response within 15 calendar day s of receiving the complaint. We will let you know if we need more information to make a decision.

If your complaint concerns an emergency, or denial of continued hospitalization or **prescription drugs** and intravenous infusions, we will investigate and provide resolution not later than 1 business day or 72 hours whichever is less, after receiving the complaint.

We will not engage in any retaliatory action against you, including termination or refusal to renew this EOC, because you have reasonably filed a complaint against us or appealed a decision from us. We shall not retaliate against a **physician** or **provider**, including termination or refusal to renew their contract, because the **physician** or **provider** has, on behalf of a Member, reasonably filed a complaint against us or appealed a decision from us.

An Appeal

Your request to reconsider an adverse determination is an appeal of an adverse determination. It is also an appeal if you ask us to re-review a complaint because you are not happy with our initial response. The *Appeal of a complain*t and *Appeal of adverse determinations* sections below explain the appeal process for both types of appeals.

An appeal of a complaint

You, someone who represents you, or your **provider** can ask us to re-review your complaint. You can appeal to us by contacting us.

We will let you know that we have received your appeal within 5 business days. This notice will describe the appeals process and your rights. Part of this process is that we will assign a panel to review your appeal. You will have the opportunity to provide additional information for the panel to review your appeal. You will have the opportunity to provide additional information for the panel to consider. You or an authorized representative can attend the appeal hearing in person or by telephone.

The panel will include an equal number of:

- Non-employee HMO members.
- HMO representatives who were not involved in making the initial decision.
- **Providers** (including **specialists**) who were not involved in making the decision. We will us a **provider** with experience in the area of care that is disputed.

We will send you the following information at least 5 days before the appeal panel hearing, unless you agree otherwise:

- A copy of any documentation to be presented by our staff
- The specialties of the **physician** or **providers** consulted during the review
- The name and affiliation of all HMO representatives on the appeal panel

You may respond to this information. The appeal panel will consider your response in their review.

The panel will review the information and provide us with their decision. We will send you the final decision in writing within 30 calendar days of receiving the appeal. If your appeal is for services that you have not already received, we will send you the final decision in writing within 15 calendar days of receiving the appeal. The letter will include:

- The date we received the appeal request
- The panel's understanding of your complaint and the facts
- The clinical basis and criteria used to make the decision
- Documents supporting the decision
- If applicable, a statement of your right to request an independent review
- A statement of your right to appeal to the department of insurance at:

  Texas Department of Insurance
  P.O. Box 12030
  Austin, TX 78711-2030
  1-800-252-3439

If your appeal of a complaint concerns an emergency, or denial of continued hospitalization or **prescription drugs** and intravenous infusions, we will investigate and provide resolution not later than 1 business day or 72 hours whichever is less, after receiving the complaint.

Due to the ongoing emergency or continued hospitalization and at your request, we will provide a review by a **physician** or **provider** instead of a review panel who:

- Has not previously reviewed the case
- Is of the same or a similar specialty as the **physician** or **provider** who would typically manage the medical condition, procedure or treatment under consideration for the review of the appeal

The physician or provider may interview the patient or patient's authorized representative and shall decide the appeal. The initial notice of the decision of the appeal may be given orally by the physician or provider if a written notice of the decision is also provided not later than the third day after the decision is made.

If you ask, we will give you or your representative reasonable access to appeal information. This includes all documents, records and other information we used to decide the claim, or appeal. We will not charge you for the information.

Claim decisions and appeal procedures

Your **provider** may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in *Benefit payments and claims* in the *How your EOC works* section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an "adverse determination" or "adverse decision." For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse determination. This is the internal appeal process. If you still don't agree, you can also appeal that decision. There are times you may skip internal appeal. But in most situations you must complete before you can take any other actions, such as an Independent review.

An adverse determination is our determination that the health care services you have received, or may receive are:

- **Experimental or investigational**
- Not **medically necessary**

If we deny health care services because your **provider** does not request **preauthorization,** a prospective or concurrent review or a concurrent claim extension, it is not an adverse determination.

If we make an adverse determination, we will tell you in writing. Our written decision will tell you:

- The main reason for denial
- The clinical reason for denial
- The source of the screening criteria used as a guideline to make the decision
- How to ask for an appeal of the denial, including your right to appeal to an independent review organization (IRO) and how to obtain an independent review
- How to obtain an immediate review by the IRO when the claim denial involves:
  - A life threatening condition
  - The provision of **prescription drugs** or intravenous infusions for which the patient is receiving health benefits under the EOC
  - Requests for **step therapy** exception

The chart below shows how much time we have to tell you about an adverse determination.

Type of notice	When you need care to make sure you are stable following emergency treatment (post-stabilization)	While you are in the hospital	When not hospitalized at the time of the decision	**Prescription drugs** or other intravenous infusions that you are currently receiving	Retrospective
Initial decision	No later than 1 hour after the request to the treating **provider**	Within 1 business day by phone or email to your **provider** followed by written notice within 3 business days to you and your **provider**	Within 3 business days to you and your provider	No later than 30th day before on which the **prescription drugs** or intravenous infusions will be discontinued	Within 30 days after the date on which the claim is received
Extensions	Not applicable	Not applicable	Not applicable	Not applicable	15 days
Additional Information Request (us)	Not applicable	Not applicable	Not applicable	Not applicable	30 days
Response to additional information request (you)	Not applicable	Not applicable	Not applicable	Not applicable	45 days

Appeal of an adverse determination

We will let you know that we have received your appeal of the adverse determination within 5 business days. This notice will describe the appeals process and your rights. If you call us to appeal, we will send you an appeal form to complete and return.

Timeframes for deciding appeals of adverse determination

The amount 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. We may tell you about our decision orally or in writing. If we tell you orally, we will send you a letter within 3 calendar days after the oral notice.

Type of claim	Our response time from receipt of appeal
Urgent care claim	1 business day or 72 hours whichever is less
Emergency medical condition	As soon as possible but no later than 1 business day or 72 hours whichever is less
When you need care to make sure you are stable following emergency treatment (post-stabilization)	No later than (1) hour after the request
If you are hospitalized at the time of the adverse determination (may include concurrent care claim of **hospital** stays)	No later than 1 business day or 72 hours whichever is less *
If you are receiving **prescription drugs** or intravenous infusions	As soon as possible but no later than 1 business day or 72 hours whichever is less
Pre-service claim requiring **preauthorization**	As soon as possible but no later than 15 calendar day
Requests for **step-therapy** exception (non-emergency)	No later than 72 hours after we receive the request
Requests for step-therapy exception (emergency)	No later than 24 hours after we receive the request
Acquired brain **injury**	No later than 3 business after the request including a request for an extension of coverage based on medical necessity or appropriateness
Retrospective claim	As soon as possible but not later than 30 calendar days*

*If your appeal is denied, your **provider** may ask us in writing to have a certain type of specialty **provider** review your case. The request must be made no later than 10 business days after the appeal was denied. A **provider** of the same or a similar specialty who would typically manage this type of condition will do the review. A decision will be made within 15 working days of the date we receive such a request.

Any other claim appeal

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse determination.

You can appeal by sending a written appeal to the address on the notice of adverse determination, or by contacting us. You need to include:

- Your name
- A copy of the adverse determination
- Your reasons for making the appeal
- Any other information you would like us to consider

We will assign your appeal to someone who was not involved in making the original decision.

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 you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at your appeal.

The review and decision of your appeal will be made by personnel not involved in making the initial adverse decision.

At your appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision. This decision is called the final adverse determination. You can respond to the information before we tell you what our final decision is.

Expedited internal appeal

You are entitled to an expedited internal appeal process for emergency care denials, denials of care for life-threatening conditions, and denials of continued stays in a **hospital**. You can also ask for an expedited internal appeal if we deny a request for **step therapy** exception or a request for **prescription drugs** or intravenous infusions you are currently receiving.

Important note:
You can skip our standard and expedited internal appeal process to an independent review organization (IRO) in some situations. See the *Exhaustion of appeals* process section.

Exhaustion of appeal process

In most situations, you must complete an appeal with us before you can take these other actions:

- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding

Sometimes you do not have to complete an appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
- We did not follow all of the claim determination and appeal requirements of Texas or the 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
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us
- You have a life-threatening condition. You can have your appeal reviewed through the independent review process.
- If you are receiving prescription drugs or intravenous infusion treatment and we deny them. You can have your appeal reviewed through the independent review process.

Independent review

External review is a review done by people in an organization outside of Aetna. This is called an independent review organization (IRO).

You have a right to independent review only if all the following conditions are met:

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

You may also request an independent review if you are seeking to determine if the federal surprise bill law applies to your situation.

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse determination or final adverse determination we send you. That notice also will describe the independent review process. It will include a copy of the Request for Review by an Independent Review Organization (IRO) form at the final adverse determination level.

You must submit the Request for Review by an Independent Review Organization (IRO) form:

- To Aetna
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

We will contact the IRO that will conduct the review of your claim.

If your request is based on exigent circumstances your request will be sent as soon as possible. An "exigent circumstance means when you are:

- Experiencing a health condition that may seriously jeopardize your life, health or ability to regain maximum function
- Undergoing a current course of treatment using a non-formulary drug

The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have 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

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

How long will it take to get an IRO decision?

We will give you the IRO decision not more than 45 calendar days after we receive your notice of external review form with all the information you need to send in.

Sometimes you can get a faster independent review decision. Your **provider** must call us or send us a request for Request for Review by an Independent Review Organization (IRO) form.

There are two scenarios when you may be able to get a faster independent review:

For adverse determinations
Your **provider** tells us a delay in receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment), or
- The 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
- A request for step therapy exceptions
- A request for intravenous infusions you are currently receiving

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request or within 24 hours if your request is for exigent circumstances.

Utilization review

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

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

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 in pursuing a complaint or appeal. But we will pay the fees or expenses incurred for the review of the IRO.

Eligibility, starting and stopping coverage

Eligibility

You will find information in this section about:

- Who is eligible
- Who can be on your EOC (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 subscriber when you are:

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

You are enrolled as the subscriber after you complete the eligibility and enrollment process, and we have issued the EOC to you. Your effective date of coverage is when this process is complete.

Who can be a dependent on your EOC

You can enroll the following family members on your EOC. 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
    - Dependent children must be under 26 years of age and include your:
        - Natural children
        - Stepchildren
        - Adopted children*, including those placed with you for adoption
        - Foster children
        - Children you are responsible for under a qualified medical or dental support order or court-order (whether or not the child resides with you)
        - Grandchildren in your court-ordered custody
        - A grandchild who is your dependent for federal tax purposes

    *Your adopted child may be enrolled as shown in the *Who is eligible, Adding new dependents or Special or limited enrollment periods* sections at your option, after the date:
    - You become a party in a suit for adoption or
    - The adoption becomes final

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 EOC was issued and be approved by us.

Adding new dependents

You can add the following new dependents to your EOC:

- A spouse - If you marry, you can put your spouse on your EOC:
  - We, must receive your completed enrollment information 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 EOC:
  - We, must receive your completed enrollment information 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 EOC for the first 60 days after birth:
  - To keep your newborn covered, we, must receive your completed enrollment information or you can call to notify us. You must provide the information within 60 days of birth
  - You must still enroll the child within 60 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 60 days
- An adopted child – You may put an adopted child on your EOC when you become a party in a suit for adoption, the adoption is complete or the date the child is placed for adoption. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child:
  - We, must receive your completed enrollment information within 60 days after you become a party in a suit for adoption, 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)
- A foster child – You may put a foster child on your EOC when the child is placed with you in foster care. 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 within 60 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 EOC:
  - You must complete your enrollment information and send it to us within 60 days after the date of your marriage or Declaration of Domestic Partnership with your stepchild's parent
- Court order – You can put a child you are responsible for under a qualified medical or dental support order or court-order on your EOC:
  - You must complete your enrollment information and send it to us, within 60 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 month following the date we receive your completed enrollment information
- In accordance with the effective date of a court order
- An appropriate date based on the circumstances of the special enrollment period

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

Special or limited enrollment periods

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

- You or your dependent have lost minimum essential coverage.
- You have added a dependent because of marriage, birth, adoption, placement for adoption, or placement in foster care. See the *Adding new dependents* section for more information.
    - To qualify for a special enrollment period due to marriage, at least one spouse must be able to demonstrate they were enrolled in a plan with minimum essential coverage for at least one day in the 60 days before the date of marriage, or
        - Lived in a foreign country or US territory at least one day in the 60 days before the date of marriage; or
        - Is an American Indian or Alaskan Native.
- You or your dependent are enrolled in any non-calendar year group health plan, individual health insurance coverage, or qualified small employer health reimbursement arrangement.
- You or your dependent's enrollment or non-enrollment in a plan through the Exchange was not intended, was by accident or a mistake, and is because of an error, false information or delay by the Exchange.
- You or your dependent have proven to the Exchange that their plan did not honor or maintain an important provision of its contract with you or that you meet other unusual circumstances.
- You did not enroll a dependent in this EOC 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 EOC.
- You or your dependent are not eligible for the premium tax credit or change in eligibility for cost share reduction, for Exchange coverage.
- You or your dependent are eligible for new policies because you have moved to a new permanent location.
- You or your dependent are the victim of domestic abuse or spousal abandonment.
- 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 EOC.
- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan.
- You no longer receive employer contributions or government subsidies for COBRA coverage.

Regulatory changes may occur that impact and expand special enrollment periods which will apply to this EOC. Please visit www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ for up-to-date information. The completed enrollment form may be submitted within 60 days of the event. However, if you did not receive notice of your triggering event, you will have 60 days from the time you are made aware of the event.

Notification of change in status

Tell us of any changes that may affect your benefits. Please contact us as soon as possible when you have a:

- Change of address or phone number
- Change in marital status
- Covered dependent status change
- Change in health coverage through a job-based plan or a program like Medicare, Medicaid or the Children's Health Insurance Program (CHIP) for you or your dependent

When coverage ends

When will your coverage end?

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.

Your coverage under this EOC will end if:

- This EOC is no longer available. Coverage ends 90 days after we notify you of the termination
- You ask to end coverage by notifying us in writing 31 days before the date you want your coverage to end
- You are no longer eligible for coverage**.** Coverage ends 30 days after we notify you of the termination
- You stop making premium payment by the end of the grace period. Coverage ends on the last date for which the premium was paid or as of the date required by law
- This product is discontinued in the state, if approved by the insurance department of the state where this EOC was issued. Coverage ends 90 days after we notify you of the termination
- We withdraw from the individual market in the state, if approved by the insurance department of the state where this EOC was issued. Coverage ends 180 days after we notify you of the termination
- We end your coverage, as permitted under this EOC

When dependent coverage ends

Dependent coverage will end if:

- They are no longer eligible for coverage
- You stop making premium contribution toward the cost of dependent coverage
- Your coverage ends for any of the reasons listed above

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 end your coverage upon 15 days written notice to you if you commit fraud or intentionally misrepresent yourself when you applied for or got coverage. Please see 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

When coverage may continue under the EOC

This section explains options you may have after your, or your dependent's, coverage ends under this EOC. Your individual situation will determine what options you will have. To request an extension of coverage, call the number on your ID card.

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

You have the right to extend coverage for your dependent **child** beyond the EOC 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 EOC remains in effect.

We may ask you to send us proof of the disability within 31 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.

How you can extend coverage after divorce or termination of a domestic partnership

When you get divorced, coverage ends for your former spouse. When your domestic partnership ends, coverage ends for your former domestic partner. In these situations, the former spouse or domestic partner may continue coverage. We must receive your request to continue coverage within 60 days of the divorce or the termination of the domestic partnership. The former spouse or domestic partner can apply for new coverage that is similar to this EOC. The new coverage will not have fewer benefits than this EOC. The new coverage will have the same effective date as this EOC. You will need to pay premium for this new coverage.

What exceptions are there for dental work completed after your coverage ends?

Your dental coverage may end while you or your dependent are in the middle of treatment. The EOC does not cover dental services that are given after your coverage terminates. There is an exception. The EOC will cover the following **covered services** if they are ordered while you were covered by the EOC, and installed within 30 days after your coverage ends:

- Inlays
- Onlays
- Crowns
- Removable bridges
- Cast or processed restorations
- Dentures
- Fixed partial dentures (bridges)
- Root canals

Ordered means:

- For a denture, the impressions from which the denture will be made were taken
- For a root canal, the pulp chamber was opened
- For any other item, the teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item
  - Impressions have been taken from which the item will be prepared

How can you extend coverage for hearing services and supplies when coverage ends?

Your EOC will cover hearing services and supplies within 30 days after your coverage ends if:

- The **prescription** for the hearing aid is written in the 30 days before coverage ended
- The hearing aid is ordered during the 30 days before the date coverage ends

How can you extend coverage for vision care services and supplies when coverage ends?

Your EOC will cover vision services and supplies for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete vision exam was performed in the 30 days before your coverage ended, and the exam included refraction
- The exam resulted in contact or frame lenses being prescribed for the first time, or new contact or frame lenses ordered due to a change in **prescription**

General provisions – other things you should know

Administrative provisions

How you and we will interpret this EOC

We prepared this EOC according to ERISA and other federal and state laws that apply. You and we will interpret it according to these laws.

If the EOC contains any provision or a part of a provision not in conformity with the Texas Insurance Codes (Insurance Code Chapter 1271) or other applicable laws, the remaining provision or parts of the provision are not rendered invalid. The remaining provisions or parts of provisions not invalid must be construed and applied as if they were in compliance with the Texas Insurance Codes (Insurance Code Chapter 1271) and other applicable laws.

How we administer this EOC

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

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**. Even **network providers** are not our employees or agents.

When you are no longer the subscriber

If you are no longer the subscriber, and the EOC wasn't cancelled, your covered spouse or domestic partner will become the subscriber. For a covered dependent child, the parent or legal guardian who is also covered under the EOC will become the subscriber. If there is no subscriber at the end of a premium period, the EOC 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 EOC is issued is considered the subscriber. As a parent or legal guardian, the subscriber has subscribed on behalf of the child for the benefits described in this EOC. It is the subscriber's responsibility to make sure the child fulfills all terms and conditions outlined in this EOC.

Coverage and services

Your coverage can change

Your coverage is defined by this EOC. This document may have amendments or riders too. Under certain circumstances, we or an applicable law may change your EOC. When an emergency or epidemic is declared, we may modify or waive **preauthorization**, **prescription** quantity limits or your cost share if you are affected. Any modification made will be no less favorable than current requirements. Only we may waive a requirement of your EOC. No other person, including your **provider**, can do this.

Physical examination and evaluations

At our expense, we have the right to have a **physician** of our choice examine you. This will be done at 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. Important things to keep are:

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

Honest mistakes and intentional deception

Honest mistakes

You or the subscriber 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.

We also will not use any statement made to void, cancel or non-renew your coverage or reduce benefits unless it is in a written enrollment application, signed by the contract holder and furnished to you.

Intentional deception

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

- Rescission, coverage going
- Loss of coverage going forward
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage:

- We will give you 30 days advance written notice of any rescission of coverage
- You have the right to an Aetna appeal
- You have the right to a third party review conducted by an IRO

In the absence of fraud, any statement made on your application for coverage is considered a representation and not a warranty.

Some other money issues

Assignment of benefits

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

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

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

Financial sanctions exclusions
If coverage provided under this EOC violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **covered 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 Assets Control (OFAC). You can find out more by visiting https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Recovery of overpayments
We sometimes pay too much for **covered services** or pay for something that this EOC 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 by a third party
If a third party caused you to need care – say, a careless driver who injured you in a car crash – you may have a legal right to get money for your injuries. If you have a legal right to get money from a third party for causing your injuries, then we are entitled to that money, up to the amount we pay for your care. When you have a legal right to get money from one or more third parties for causing your injuries, you are:

- Agreeing to repay us from money you receive from those third parties because of your injuries.
- Giving us the right to seek money in your name, from those third parties because of your injuries.
- Agreeing to cooperate with us so we can get paid back in full, up to the applicable amount noted below. For example, you'll tell us within 30 days of when you seek money from those third parties for your injuries or illness. You'll hold any money you receive until we are paid in full. And you'll give us the right to our portion of the money you get, ahead of everyone else.
- 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 will only seek money from your own uninsured/underinsured motorist or medial payments coverage (if any) if you or your immediate family member did not pay premiums for the coverage.

If you are not represented by an attorney, then we can recover the lesser of:

- One-half of the money you receive
- The total amount paid by us

If you are represented by an attorney, then we can recover the lesser of:

- One-half of the money you receive, less attorney's fees and costs for the recovery
- The total amount paid by us, less attorney's fees and costs for the recovery

How will attorney's fees be determined?

- If we do not use an attorney: We (and any other payors) will pay your attorney a fee agreed to between us (and other payors) and your attorney plus a pro rata share of the recovery expenses
- If no agreement exists, then the court will award your attorney a reasonable fee payable for our (and any other payors') share of the recovery, not to exceed 1/3 of the recovery

If we use an attorney:

- The court will award attorney's fees to our attorney and your attorney based on the benefit accruing as a result of each attorney's service. The total attorney's fees may not exceed 1/3 of our (and any other payors') recovery

Payor means a plan issuer that:

- Has a contractual right of subrogation and
- Pays benefits to you or on your behalf as a result of personal injuries caused by someone else's tortious conduct

A payor includes, but is not limited to, an issuer of:

- A health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness
- A disability benefit plan
- An employee welfare benefit plan

Effect of benefits under other policies

If you become eligible for Medicare

If you are eligible for Medicare Part B, we will base our payment for **covered services** on the benefits covered under Medicare Part B. We will do this even if you are not enrolled in Medicare Part B. Medicare will be the primary payor for the **covered services**.

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 by a third party* 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 EOC 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.

Non-duplication of benefits

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

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

If, while covered under this EOC, 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 EOC during the time you were covered by both plans

Your health information

We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your EOC.

You can get a free copy of our *Notice of Privacy Practices*. Just contact us.

When you accept coverage under this EOC, you agree to let your **providers** share information with us. We need information about your physical and mental condition and care.

Glossary

Behavioral health provider
A **health professional** who is properly licensed or certified to provide **covered services** for **mental health** and **substance related disorders** in the state where the person practices.

Brand-name prescription drug
An FDA-approved drug marketed with a specific name or trademark name by the company that manufactures it; often the same company that developed and patents it.

Copay, copayment
Copays are flat fees for certain visits. A **copay** can be a dollar amount or percentage.

Covered service
The benefits, subject to varying cost shares, covered under this EOC. These are:

- Described in the *Providing covered services* section
- Not listed as an exclusion in the *Coverage and exclusions – Providing covered services* section or the *General EOC exclusions* section
- Not beyond any limits in the schedule of benefits
- **Medically necessary**. See the *How your EOC works – Medical necessity, referral and preauthorization requirements* section and the *Glossary* for more information

Deductible
A **deductible** is the amount you pay out-of-pocket for **covered services** per year before we start to pay.

Dental provider
Any individual legally qualified to provide dental services or supplies.

Detoxification
The process of getting alcohol or other drugs out of an addicted person's system and getting them physically stable.

Drug guide
A list of **prescription** and OTC drugs and devices established by us or an affiliate that provides coverage, approves payment and encourages or offers incentives. It does not include all **prescription** and OTC drugs and devices. This list can be reviewed and changed by us or an affiliate only upon renewal and with 60 days notice to you. A copy is available at your request. Go to https://www.aetna.com/individuals-families/find-a-medication.html.

Emergency medical condition
An acute, severe medical condition that:

- Needs immediate medical care
- Leads a person with average knowledge of health and medicine to believe that, without immediate medical care, it could result in:
  - Danger to life or health

- Loss of a bodily function
- Loss of function to a body part or organ
- Jeopardy to the health of the fetus
- Serious disfigurement

Emergency services

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

Experimental or investigational

Drugs, treatments or tests not yet accepted by **physicians** or by insurance plans as standard treatment. They may not be proven as effective or safe for most people.

A drug, device, procedure, or treatment is **experimental or investigational** if:

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

Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product, that is 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 authorized by law to provide health care services to the public; for example, **physicians**, nurses and physical therapists.

Home health care agency

An agency authorized by law to provide home health services, such as skilled nursing and other therapeutic services.

Hospital
An institution licensed as a **hospital** by applicable law. This is a place that offers medical care. Patients can stay overnight for care. Or they can be treated and leave the same day. All **hospitals** must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

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
- For an individual or their partner who has been clinically diagnosed with gender dysphoria

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

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

Maximum out-of-pocket limit
The **maximum out-of-pocket limit** is the most a covered person will pay per year in **copayments**, and **deductible**, if any, for **covered services**.

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

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

Generally accepted standards of medical practice means:

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

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

Mental health disorder

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

Negotiated charge

See *How your EOC works – What the EOC pays and what you pay*.

Network provider

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

Out-of-network provider

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

Physician

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

Preauthorization, preauthorize

Pre-approval that you or your **provider** receives from us before you receive certain **covered services**. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage.

Prescription

This is an instruction written by a **physician** or other **provider** that authorizes a patient to receive a service, supply, medicine or treatment.

Primary care physician (PCP)

A **physician** who:

- The directory lists as a **PCP**
- Is selected by a covered person from the list of **PCPs** in the directory
- Supervises, coordinates and provides initial care and basic medical services to a covered person
- Initiates **referrals** for **specialist** care, if required by the EOC, and maintains continuity of patient care
- Shows in our records as your **PCP**

A **PCP** can be any of the following **providers**:

- General practitioner
- Family **physician**
- Internist
- Pediatrician
- OB, GYN, and OB/GYN
- Medical group (primary care office)

Provider

A **physician**, pharmacist, **health professional**, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare.

Psychiatric hospital

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

Referral

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

An institution specifically licensed by applicable laws to provide residential treatment programs for **mental health disorders**, **substance related disorders**, or both. It 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/day for 7 days/week
  - The patient must be treated by a psychiatrist at least once per week

  - The medical director must be a psychiatrist
  - It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)
- For residential treatment programs treating **substance related disorders**:
  - 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**
  - It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)
- For **detoxification** programs within a residential setting:
  - An R.N. must be onsite 24 hours/day for 7 days/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 plan are located.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable laws to provide skilled nursing care. **Skilled nursing facilities** also include:

- Rehabilitation **hospitals**
- Portions of a rehabilitation **hospital**
- A **hospital** designated for skilled or rehabilitation services

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- Custodial care
- Ambulatory care
- Part-time care

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

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

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

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

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

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

Substance related disorder
The use of drugs, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association, that directly affect the brain's reward system in an amount or frequency that causes problems with normal activities.

Surgery, surgical procedure
The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution
- Otherwise physically changing body tissues and organs

Teledentistry
A health care service delivered by a dentist or a **health professional** acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or **health professional's** license or certification to a patient at a different physical location than the dentist or **health professional** using telecommunications or information technology.

Telehealth
A health service, other than a **telemedicine** medical service, delivered by a **health professional** licensed, certified or otherwise entitled to practice in the State of Texas and acting within the scope of their license, certification or entitlement to a patient at a different physical location than the **health professional** using telecommunications or information technology.

Telemedicine
A health care service delivered by a **physician** licensed in the State of Texas, or a **health professional** acting under the delegation and supervision of a **physician** licensed in the State of Texas and acting within the scope of their license to a patient at a different physical location than the **physician** or **health professional** using telecommunications or information technology.

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

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

Appendix A

Service Area Maps

August 7, 2019

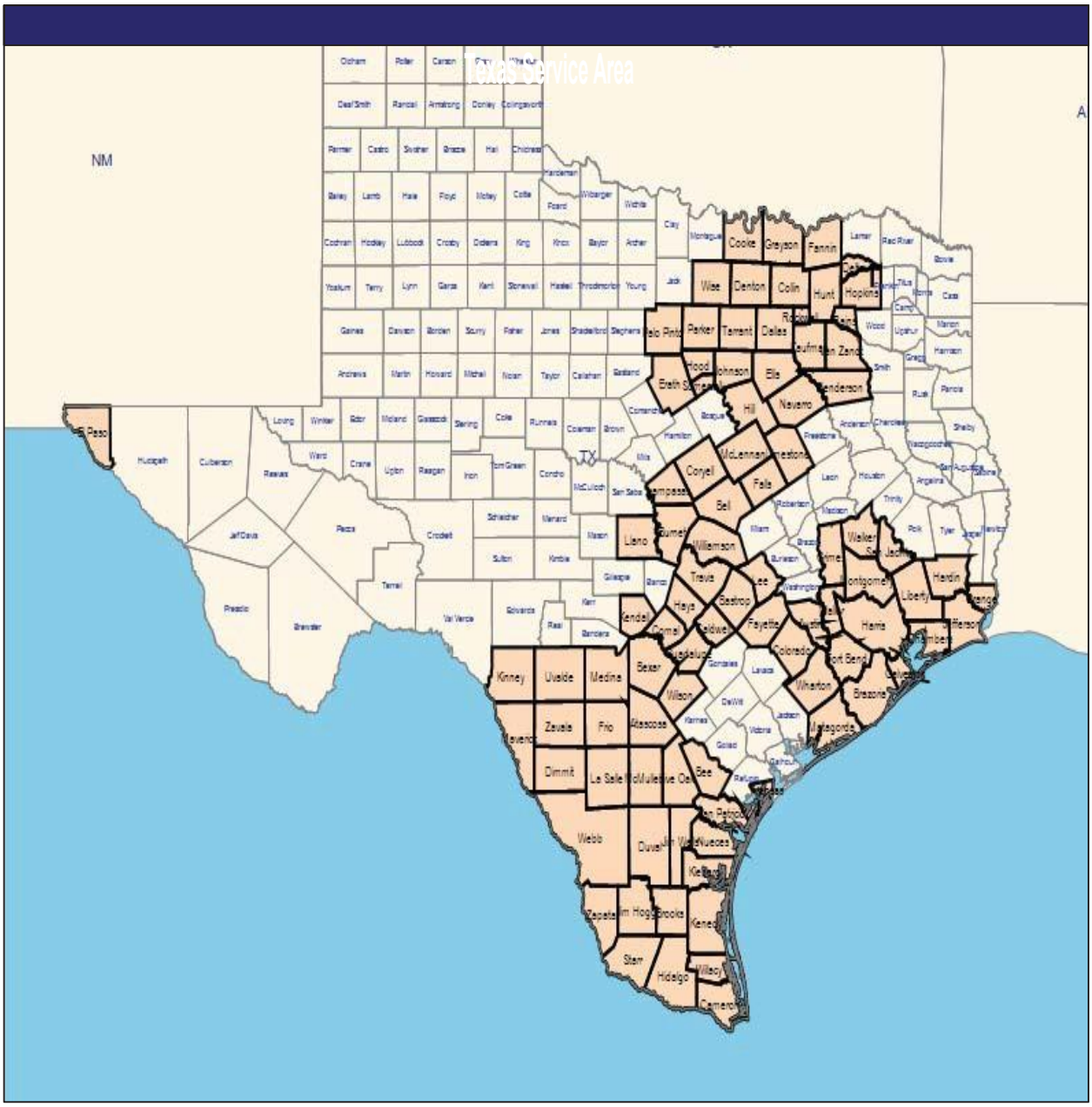
Created by...

Aetna Network Management

Service Areas

Statewide

109.14 miles



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, 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, 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.

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments,** if any, that apply to the **covered services** you get under this plan. You should read this schedule to become aware of these and any limits that apply to the **covered services**. This schedule takes the place of any others sent to you before.

How your cost share works

- You are responsible to pay any **deductibles**, **copayments**, if they apply.
- You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit or day limits.

Important note:
All **covered services** are subject to the calendar year **deductible**, **maximum out-of-pocket limit**, limits, **or copayment**, unless otherwise noted in this schedule. The *Surprise bill* section of the EOC explains your protection from a surprise bill.

Contact us

We are here to answer your questions. See the *Contact us* section of the EOC.

Plan features

Deductible

You will continue to pay **copayments** or **coinsurance**, if any, for **covered services** after you meet your **deductible**.

Deductible	Network
Individual	$8,395 per year
Family	$16,790 per year

Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

Family deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward 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.

Maximum out-of-pocket limit

Maximum out-of-pocket limit	Network
Individual	$8,885per year
Family	$17,770 per year

Your **copayments** will not exceed 50% of the total cost of services provided or 200% of the total annual **premium** cost. If your **copayments** have exceeded 200% of the total annual **premium** cost, you must submit a detailed explanation of benefits (EOB) showing the dates and total amount of the **copayments** paid.

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

Family maximum out-of-pocket limit
After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

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

- 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 any health care service you get that is not a **covered service**
- 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 EOC.

Covered services

Your cost share for a **covered service** not listed with a specific cost share is dependent upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*.

Allergy injections

Description	Network
Without a **physician** or **specialist** office visit	Cost share same as **PCP** or **specialist** office hours visit under **Physician** services Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Allergy testing and treatment

Description	Network
At a **physician** or **specialist** office	Cost share same as **PCP** or **specialist** office hours visit under **Physician** services Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Alzheimer's disease

Description	In-network coverage
Alzheimer's disease	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Ambulance service

Description	Network
Emergency ambulance	50% after **deductible**
Non-emergency ambulance	50% after **deductible**

Important note:
Services received by an out-of-network air ambulance provider will be covered the same as services received by an **in-network provider**, regardless of emergency status. This includes applying cost shares towards the in-network **deductible** and **out-of-pocket maximum.** An out-of-network air ambulance provider cannot balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirements, such as **deductibles** or **copayments**, except for those services not covered in your plan.

Important note:

- **Out-of-network providers** do not have a contract with us. We will pay the **provider** at our usual and customary rate or at an agreed rate charge. The **provider** may not accept payment of your cost share (**copayment**), 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.

Applied behavior analysis

Description	Network
Applied behavior analysis	50% after **deductible**

Autism spectrum disorder

Description	Network
Autism spectrum disorder	50% after **deductible**

Behavioral health

Mental health disorders and **substance related disorders** are covered under the same terms and conditions as any other illness.

Description	Network
Inpatient services	Cost share same as Inpatient services under **Hospital** care
Outpatient office visit to a **physician** or **behavioral health provider** (Includes **telemedicine** or **telehealth** consultation)	$50 no **deductible** applies
Other outpatient services including behavioral health services in the home, partial hospitalization treatment, and intensive outpatient program The cost share does not apply to network peer counseling support services (Includes **telemedicine** or **telehealth** consultation) after you meet your **deductible**, if you have one	50% after **deductible**

Durable medical equipment (DME)

Description	Network
DME	50% after **deductible**

Emergency services

A separate **hospital** emergency room (or comparable facility/freestanding emergency medical care facility)cost share will apply for each visit to an emergency room.

Description	Network
Hospital emergency room (or comparable facility/freestanding emergency medical care facility)	50% after **deductible**

Emergency services important note:
Out-of-network providers do not have a contract with us. We will pay the **provider** at our usual and customary rate or at an agreed rate charge. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by you and the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room (or comparable facility/freestanding emergency medical care facility), you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Habilitation therapy services

Description	Network
Physical, occupational, and speech therapies	50% after **deductible**

Hearing aids and cochlear implants and related services

Description	Network
Hearing aids and cochlear implants and related services	50% after **deductible**
Replacement of cochlear implant external speech processor and controller components limit	Once every 3 years

Home health care

Description	Network
Outpatient	30% after **deductible**
Visit limit per year	60

Home health care important note:
Limited to 3 intermittent visits per day provided by a **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	Network
Inpatient services	50% after **deductible**
Outpatient services	50% after **deductible**

Hospital care

Description	Network
Inpatient services	50% after **deductible**

Jaw joint disorder

Description	Network
Jaw joint disorder treatment	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Maternity and related newborn care

Description	Network
Inpatient delivery services and postpartum care	50% after **deductible**
In a facility or at a **physician** office	50% after **deductible**

Maternity and related newborn care Important note:
When you receive services from an OB, GYN or OB/GYN for prenatal care, you will not incur a cost share. However, you will incur a cost share for delivery and postpartum care services received by an OB, GYN or OB/GYN.

Medical injectables

Description	Network
Medical injectables	50% after **deductible**

Nutritional support

Description	Network
Nutritional support	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Outpatient surgery

Description	Network
At a **hospital** outpatient department	50% after **deductible**
At a facility that is not a **hospital**	50% after **deductible**

Pediatric dental care

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

Description	Network
Type A services	0% after **deductible**
Type B services	30% after **deductible**
Type C services	50% after **deductible**
Orthodontic services	50% after **deductible**

Your plan pays when you see a **dental provider** who is an **out-of-network provider** for a dental emergency.

Diagnostic and preventive care (type A services)
Visits and images

- Periodic oral examination, established patient (limited to: 2 visits per year)
- Comprehensive oral evaluation (limited to: 2 visits per year)
- Comprehensive periodontal evaluation, new or established patient (limited to: 2 visits per year)
- Problem-focused examination (limited to: 2 visits per year)
- Detailed and extensive oral evaluation – problem focused, by report (limited to: 2 visits per year)
- Prophylaxis (cleaning) (limited to: 2 treatments per year)
- Topical application of fluoride (limited to 2 year)
- Topical fluoride varnish (limited to: 2 treatments every 12 months)
- Sealants, per tooth (limited to: 1 application every 3 years for permanent molars only)
- Preventive resin restorations in a moderate to high caries risk patient-permanent tooth (limited to: 1 application every 3 years for permanent molars only)
- Bitewing images (limited to: 2 sets per year)
- Intraoral comprehensive image series, including bitewings if **medically necessary** (limited to: 1 set every 3 years)
- Panoramic radiographic image (limited to: 1 every 3 years)
- Vertical bitewing images (limited to: 2 sets per year)
- Periapical images
- 2D Cephalometric radiographic image
- Intraoral tomosynthesis-comprehensive series of radiographic images (limited to 1 set every 3 years)
- Intraoral tomosynthesis-bitewing radiographic images (limited to 2 sets per year)
- Intraoral tomosynthesis-periapical radiographic images
- Intraoral tomosynthesis-comprehensive series of radiographic images-image capture only (limited to 1 set every 3 years)
- Intraoral tomosynthesis-bitewing radiographic images-image capture only (limited to 2 sets per year)
- Intraoral tomosynthesis-periapical radiographic images-image capture only
- 2D Oral/facial photographic images
- Interpretation of diagnostic image
- Intra-oral, occlusal view, maxillary or mandibular
- Resin infiltration lesion, 1 per tooth every 3 years
- Diagnostic models
- Emergency palliative treatment per visit

Space maintainers

- Fixed unilateral
- Fixed-bilateral, upper
- Fixed bilateral, lower
- Removable (unilateral)
- Removable-bilateral upper
- Removable-bilateral lower

- Re-cementation of space maintainer
- Removal of fixed space maintainer

Basic restorative care (type B services)
Visits and images

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Consultation (by other than the treating provider)
- Therapeutic drug injection, by report
- Infiltration of sustained release therapeutic drug – per quadrant (Eligible in conjunction with impacted wisdom tooth removal)

Images and pathology

- Extra-oral first 2D projection radiographic image
- Extra-oral posterior dental radiographic image
- Extra-oral posterior dental radiographic image-image

Oral surgery

- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants (primary tooth)
  - Coronectomy-intentional partial tooth removal, impacted teeth only
  - Removal of residual tooth roots (cutting procedure)
  - Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth
  - Exposure of an unerupted tooth
- Impacted teeth
  - Removal of tooth (soft tissue)
- Removal of impacted teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (completely bony)
  - Removal of tooth (completely bony with unusual surgical complications)
  - Incision and drainage of abscess
- Other surgical procedures
  - Alveoplasty, in conjunction with extractions -- four or more teeth or tooth spaces – per quadrant
  - Alveoplasty, in conjunction with extractions – 1 to 3 teeth or tooth spaces – per quadrant
  - Alveoplasty, not in conjunction with extraction-- four or more teeth or tooth spaces – per quadrant
  - Alveoplasty, not in conjunction with extractions -- 1 to 3 teeth or tooth spaces – per quadrant
  - Excision of hyperplastic tissue –per arch
  - Excision of periocoronal gingiva
  - Removal of lateral exostosis (maxilla or mandible)
  - Tooth re-implantation and/or stabilization
  - Transplantation of tooth or tooth bud
  - Oroantral fistula closure
- Placement of devise to facilitate eruption of impacted tooth

- Frenectomy (frenulectomy) buccal/labial
- Suture of small wound, up to 5 cm

Periodontics

- Occlusal adjustment (other than with an appliance or by restoration)
- Peridontal scaling and root planing, per quadrant-4 or more teeth (limited to 4 separate quadrants every 2 years)
- Peridontal scaling and root planing – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
- Periodontal maintenance procedures following active therapy (limited to 4 in 12 months combined with prophylaxis after completion of active periodontal therapy)
- Collection and application of autologous blood product

Endodontics

- Pulp capping
- Pulpotomy
- Pulpal therapy
- Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp; does not include final restoration)

Restorative dentistry

Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges (multiple restorations in 1 surface are considered as a single restoration)

- Amalgam restorations
- Protective restoration
- Resin-based composite restorations (other than for molars)
- Pins
- Pin retention – per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
  - Prefabricated stainless steel
  - Prefabricated resin crown (excluding temporary crowns)
  - Interim therapeutic restoration-primary teeth
  - Prefabricated porcelain/ceramic crown –primary teeth
- Re-cement or re-bond
  - Inlay
  - Crown
  - Fixed partial bridge
  - Fabricated –prefabricated post and core
  - Implant/abutment supported crown
  - Implant/abutment supported fixed partial denture
  - Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant

Prosthodontics

- Dentures and partials
  - Office reline
  - Laboratory relines

- Special tissue conditioning, per denture
- Rebase, per denture
- Adjustment to denture (more than 6 months after installation)

- Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth
  - Adding teeth to existing partial denture
    - Each tooth
    - Each clasp
- Repairs: bridges; partial bridges

General anesthesia, intravenous sedation and drugs

- Only when **medically necessary** and only when provided in conjunction with a covered dental surgical procedure
  - Evaluation for moderate sedation, deep sedation or general anesthesia
  - Deep sedation/general anesthesia-first 15 minutes
  - Deep sedation/general anesthesia-each 15 minute increment
  - Intravenous moderate (conscious) sedation/analgesia-first 15 minutes
  - Intravenous conscious sedation/analgesia-each subsequent 15 minute increment

Major restorative care (type C services)

Periodontics

- Osseous surgery, including flap and closure, 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Osseous surgery, including flap and closure, per quadrant (limited to 1 per quadrant every 3 years)
- Pedical soft tissue graft procedures
- Bone replacement graft, first site in quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy, 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure – per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Clinical crown lengthening
- Autogenous connective tissue graft procedures (including donor site surgery)
- Non-autogenous connective soft tissue allograft
- Free soft tissue graft procedures implant, or edentulous tooth position in same graft
- Full mouth debridement to enable a comprehensive periodontal evaluation (limited to 1 treatment per lifetime)

Endodontics

- Apexification/recalcification
- Apicoectomy
- Root canal therapy including **medically necessary** images:
  - Anterior tooth
  - Premolar tooth
  - Molar tooth

- Retreatment of previous root canal therapy including **medically necessary** images:
  - Anterior tooth
  - Premolar tooth
  - Molar tooth
- Root amputation
- Hemisection (including any root removal)

Restorative

- Inlays, onlays, labial veneers and crowns are covered only as a treatment for decay or acute traumatic injury and only when the teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge
- Inlays/onlays (limited to 1 per tooth every 5 years)
- Veneers, non-cosmetic (limited to 1 per tooth every 5 years)
- Crowns (limited to 1 per tooth every 5 years)
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain/ceramic substrate
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - ¾ cast metallic or porcelain/ceramic
  - Titanium
  - Post and core
  - Core build-up
- Repair
  - Replace all teeth and acrylic on cast metal framework – upper/lower
  - Crowns, inlays, onlays, veneers

Prosthodontics

- Installation of dentures and bridges is covered only if needed to replace teeth that were not abutments to a denture or bridge less than 5 years old
- Replacement of existing bridges or dentures (limited to 1 every 5 years)
- Bridge abutments (see inlays and crowns) (limited to 1 per tooth every 5 years)
- Pontics (limited to 1 per tooth every 5 years)
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
  - Titanium
  - Removable bridge (unilateral) (limited to 1 every 5 years)
- One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics (limited to 1 every 5 years)
- Retainer – cast metal for resin bonded fixed prosthesis (limited to 1 every 5 years)
- Retainer – porcelain/ceramic for resin bonded fixed prosthesis (limited to 1 every 5 years)

- Dentures and partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
- Complete upper denture (limited to 1 every 5 years)
- Complete lower denture (limited to 1 every 5 years)
- Immediate upper denture (limited to 1 every 5 years)
- Immediate lower denture (limited to 1 every 5 years)
- Immediate partial upper or lower, resin base, including any conventional clasps, rests and teeth (limited to 1 every 5 years)
- Immediate upper/lower partial denture, flexible base, including any clasps, rests and teeth (limited to 1 every 5 years)
- Immediate partial upper or lower, cast metal base with resin saddles, including any conventional clasps, rests and teeth (limited to 1 every 5 years)
- Partial upper or lower, resin base – including any conventional clasps, rests and teeth (limited to 1 every 5 years)
- Partial upper or lower, cast metal base with resin saddles – including any conventional clasps, rests and teeth (limited to 1 every 5 years)
- Implants – only if determined as a dental necessity (limited to 1 per tooth every 5 years)
- Implant supported complete denture, partial denture (limited to 1 every 5 years)
- Surgical placement of interium implant body
- Surgical placement of transosteal implant
- Implant maintenance procedures
- Custom abutment (limited to 1 every 5 years)
- Bone graft at time of implant placement (limited to 1 every 5 years)
- Repair implant prosthesis (limited to 1 every 5 years)
- Repair implant abutment (limited to 1 every 5 years)
- Replacement of semi-precision or precision attachment (limited to 1 every 5 years)
- Debridement/osseous contouring of a peri-implant defect (limited to 1 every 5 years)
- Surgical removal of Implant body (limited to 1 every 5 years)
- Implant index (limited to 1 every 5 years
- Connecting bar
- Stress breakers
- Removable appliance therapy
- Fixed appliance therapy
- Interim partial denture (stayplate), anterior only
- Occlusal guard (Occlusal guard adjustment not eligible within first 6 months after placement of appliance)

Orthodontic services

- **Medically necessary** orthodontic treatment (includes removal of appliances, construction and placement of retainer)
- Limited orthodontic treatment of the primary, transitional and adolescent dentition
- Comprehensive orthodontic treatment of the transitional and adolescent dentition
- Periodic orthodontic treatment visit (as part of contract)
- Pre-orthodontic treatment visit

Physician services

PCP

Description	Network
Office hours visit (not surgical and not preventive care) (includes **telemedicine** or **telehealth** consultation)	$50 no **deductible** applies

Specialist

Description	Network
Office hours visit (not surgical) (includes **telemedicine** or **telehealth** consultation)	$80 no **deductible** applies

Physician surgical services

Description	Network
Inpatient surgical services	50% after **deductible**
Outpatient surgical services	50% after **deductible**
Office surgical services	50% after **deductible**

Prescription drugs - outpatient

Your cost share for **prescription** drug fills greater than a 30 day supply but no more than a 90 day supply at a **retail pharmacy** are covered at the **mail order pharmacy** cost share on tiers 1, 2 and 3.

Tier 1A – low-cost generic prescription drugs

Description	Network
For each 30 day supply filled at a **retail pharmacy**	$5 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**	$12.50 no **deductible** applies

Tier 1 -- preferred generic prescription drugs

Description	Network
For each 30 day supply filled at a **retail pharmacy**	$25 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**	$62.50 no **deductible** applies

Tier 2 -- preferred brand-name prescription drugs

Description	Network
For each 30 day supply filled at a **retail pharmacy**	40% 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**	40% no **deductible** applies

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

Description	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**	45% after **deductible**

Important note:
If the **negotiated charge** or usual and customary fee is less than your **copayment**, you may only be required to pay the lower cost

Tier 4 -- specialty prescription drugs

Description	Network
For each 30 day supply filled at a **specialty pharmacy**	50% after **deductible**

Anti-cancer prescription drugs taken by mouth

Description	Network
For each 30 day supply filled at a **specialty pharmacy**	$0 after **deductible**

Contraceptive (birth control)

Description	Network
For each 30 day supply of **generic prescription drugs** and OTC drugs and devices	$0 no **deductible** applies
For each 30 day supply of **brand-name prescription drugs** and devices	Paid according to the tier of drug above

Contraceptive (birth control) Important note:
The **prescription** drug cost share will not apply to contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. 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.

Diabetic supplies, drugs, and insulin

Description	Network
For each 30 day supply filled at a **retail pharmacy**	Paid according to the tier of drug above
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	Paid according to the tier of drug above

Diabetic supplies, drugs, and insulin Important note:
Your cost share will not exceed $25 per 30 day supply of a covered **prescription** insulin drug filled at a network pharmacy. No **deductible** applies for insulin.

Important note:
When an emergency refill of diabetes supplies is provided, the emergency refill of insulin may not exceed a 30-day supply. The quantity of an emergency refill of insulin-related equipment or supplies may not exceed the lesser of a 30 day supply or the smallest available package.

Nutritional supports

Description	In-network coverage
Nutritional supports	Paid according to the tier of drug in the schedule of benefits, above

Preventive care drugs and supplements and risk reducing breast cancer prescription drugs

Description	Network
For each 30 day supply filled at a **retail pharmacy**	$0 no **deductible** applies
Limit	Subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For a current list of covered preventive care drugs and supplements and risk reducing cancer **prescription** drugs, see the *Contact us* section of the EOC.

Tobacco cessation prescription and over-the-counter drugs

Description	Network
For each 30 day supply filled at a **retail pharmacy** Cost share only includes **generic prescription drugs** when there is also a brand-name drug available.	$0 no **deductible** applies for the first two 90-day treatment programs. Additional treatment programs will be paid according to the tier of drug above.
Limit	Subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation **prescription** drugs and OTC drugs, see the *Contact us* section of the EOC.

Outpatient prescription drug important note:
If you or your **provider** 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 drug and the brand-name drug, plus the cost share that applies to the generic name drug.

Preventive care

Description	Network
Preventive care	0% no **deductible** applies
Breast feeding counseling and support limit	6 visits per 12 months in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump
Counseling for alcohol or drug misuse visit limit	5 visits every 12 months
Counseling for risk for breast and ovarian cancer	Not subject to any age or frequency limitations
Counseling for obesity, healthy diet visit limit	Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling
Counseling for sexually transmitted infection visit limit	2 visits every 12 months
Counseling for tobacco cessation visit limit	8 visits every 12 months
Family planning services (contraception and counseling) limit	Contraceptive counseling limited to 2 visits every 12 months in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Immunization limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Prenatal care	See the *Preventive care, Prenatal care* section of the EOC for more information

Description	Network
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: • Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF • The comprehensive guidelines supported by the Health Resources and Services Administration Lung cancer screenings that exceed this limit covered as outpatient diagnostic testing
Colorectal cancer screening	For adults over 45
Routine physical exam limits	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 for children and adolescents Limited to: 7 exams from age 0-1 year 3 exams age 1-2 3 exams age 2-3 and 1 exam after that age every 12 months High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older limited to 1 every 36 months
Well woman routine GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Prosthetic devices

Description	Network
Prosthetic devices	50% after **deductible**

Short-term cardiac and pulmonary rehabilitation services

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

Description	Network
Cardiac and pulmonary rehabilitation	$45 no **deductible** applies

Short-term rehabilitation therapy services

A visit is equal to no more than 1 hour of therapy. Therapy visit limits (physical, occupational, and speech and spinal manipulation) are combined.

Outpatient physical therapy

Description	Network
Physical therapy	$45 no **deductible** applies
Visit limit per year	35

Outpatient occupational therapy

Description	Network
Occupational therapy	$45 no **deductible** applies
Visit limit per year	35

Outpatient speech therapy

Description	Network
Speech therapy	$45 no **deductible** applies
Visit limit per year	35

Spinal manipulation

Description	Network
Spinal manipulation	$45 no **deductible** applies
Visit limit per year	35

Inpatient and outpatient treatment for acquired brain injury

Description	In-network coverage
Inpatient and outpatient treatment for acquired brain injury	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*
Visit limit per year	None

Skilled nursing facility

Description	Network
Inpatient services	50% after **deductible**
Limit	Coverage is limited to 25 days per calendar year.

Tests, images and lab – outpatient

Cardiovascular disease

Description	In-network coverage
Cardiovascular disease	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Diagnostic complex imaging services

Description	Network
At a facility	50% after **deductible**
At a **physician** office	50% after **deductible**
At a **specialist** office	50% after **deductible**

Diagnostic lab work

Description	Designated network	Non-designated network
At a facility	0% no **deductible** applies	$25 no **deductible** applies

Description	Network
At a **physician** office	$25 no **deductible** applies
At a **specialist** office	$25 no **deductible** applies

Diagnostic radiological services (X-ray)

Description	Network
At a facility	$30 after **deductible**
At a **physician** office	$30 after **deductible**
At a **specialist** office	$30 after **deductible**

Important Note:
Cost shares for diagnostic imaging using mammography, ultrasound imaging, or magnetic resonance imaging to evaluate an abnormality of the breast or where there is a personal history of breast cancer or dense breast tissue will be considered the same as mammograms performed for routine cancer screenings as described in the *Preventive care and wellness* section. Diagnostic imagings are not subject to any age limitation.

Important note:
Even if you receive **eligible health services** at a health care facility that is a **network provider**, not all services may be in network. Other services you receive may be from a **physician** or facility that is an **out-of-network provider**. **Providers** that may not be **network providers** include anesthesiologists, radiologists, pathologists, neonatologists, emergency room physicians and assistant surgeons. You may receive a bill for services from these **out-of-network providers**, as we paid them at our usual and customary rate or at an agreed rate. We will work with the **providers** so that all you pay is your appropriate network level **copayments**. If you are in receipt of a balance bill for covered services from any physician or **provider**, including a facility-based physician or other health care practitioner please contact us.

Diagnostic follow-up care related to newborn hearing screening

Description	In-network coverage
Hearing screening	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Therapies

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

Description	**Network (GCIT-designated facility/provider)**
Services and supplies	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Outpatient infusion therapy

Description	**Network**
In a **physician** office or in a person's home	$80 no **deductible** applies
In an outpatient facility	50% after **deductible**

Transplant services

Description	**Network (Exchange IOE facility)**	**Out-of-network** (Includes Aetna's **network providers** who are not Exchange IOE **providers**)
Services and supplies	50% after **deductible**	Not covered

Urgent care services

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

Description	**Network**
Urgent medical care at a freestanding facility that is not a **hospital**	$50 no **deductible** applies

Vision care

Pediatric vision care

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

Description	**Network**
Pediatric vision exam (including refraction)	$10 no **deductible** applies
Visit limit per year	1

Vision care services and supplies

Description	**Network**
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	$10 no **deductible** applies

Limits

Description	**Limit**
Limited to one per year	One pair of eyeglasses (**prescription** lenses and frames) or One pair of regular contacts or Up to 3 month supply of daily wear disposable contact lenses or Up to 6 month supply of extended wear contact lenses

Vision care important note:
See the *Vision care* section of the EOC for more information about vision services and supplies. This plan will cover either the purchase of **prescription** eyeglass lenses or contact lenses but not both. Coverage does not include the office visit for contact lenses fitting.

Voluntary sterilization

Description	Network
Vasectomy	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Walk-in clinic visits

Not all preventive care services are available at **walk-in clinics**. All services are available from a network **physician**.

Description	Network
Non-emergency services	$0 no **deductible** applies
Telemedicine consultation for non-emergency services	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*
Preventive care immunizations and preventive screening and counseling services (Includes **telemedicine** consultation) See the *Preventive care* section for more information	0% no **deductible** applies