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.

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

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

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

Tagalog Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.

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

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

Urdu کے لیے، اپنے بیمہ ID لسانی خدمات تک مُفت رسائی کے لیے۔ کارڈ پر درج نمبر پر کال کریں

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

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

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

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

Bengali আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন।

Igbo Inweta enyemaka asụsụ na akwughi ụgwọ obụla, kpọọ nọmba nọ na kaadi njirimara gị

Kru-Bassa I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla

Yoruba Láti ráyèsí àwọn iṣẹ́ èdè fún ọ lọ́fẹ̀ẹ́, pe nọ́mbà tó wà lórí káàdì ìdánimọ̀ rẹ.

Aetna Life Insurance Company

Subject: Insurance Contact Notice

NOTICE OF
PROTECTION PROVIDED BY
VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

Life Insurance
- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance
- $500,000 for health benefit plans
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of accident and sickness insurance benefits

Annuities
- $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also
various residency requirements and other limitations under Virginia law. To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINA LIFE, ACCIDENT
AND SICKNESS
INSURANCE GUARANTY
ASSOCIATION c/o APM
Management Services, Inc.

1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION
COMMISSION Bureau of
Insurance
P. O. Box 1157
Richmond, VA 23218-1157
804-371-9741

Toll Free Virginia only:
1-800-552-7945
http://scc.virginia.gov/boi/index.aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

Aetna Life Insurance Company
151 Farmington Ave, Hartford, CT 06156
844-365-7373
Aetna.com

Exclusive provider organization (EPO) medical policy

SAMPLE - Policy name will print here

This policy is by and between **Aetna Life Insurance Company** (**Aetna**, we, us, or our) and the policyholder (you, your).

This policy is underwritten by **Aetna Life Insurance Company** and is governed by federal law and the laws of the Commonwealth of Virginia. Aetna is part of the CVS Health family of companies.

Aetna Life Insurance Company is regulated in Virginia by both the State Corporation Commission Bureau of Insurance under Title 38.2 of the Code of Virginia and the Virginia Department of Health under 32.1 of the Code of Virginia.

This policy does not provide the ACA-required minimum essential pediatric oral health benefits. Stand-alone dental coverage that includes such benefits must be available to you for purchase separately from a qualified stand-alone dental plan.

Right to examine the policy

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

Guaranteed renewable

You can renew this policy each year ("guaranteed renewable"). We decide the **premium** rates. But, we may decide not to renew the policy under the following conditions:

- You do not pay the required **premium** payment by the end of the grace period.
- You commit fraud or intentionally misrepresent yourself under the terms of this policy. You can refer to the Intentional misrepresentation provision in the *General provisions – other things you should know* section for more information.
- You no longer reside, live or work in the **service area.**
- We stop offering this product in the state.
- We withdraw from the individual market in the state.

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

This policy is issued in consideration of your completed application and your first premium payment. Coverage starts on your **effective date of coverage** and continues until it ends as described in this policy. Once we receive your completed application, you will receive an acknowledgement letter with the coverage start date, end date and time and the premium amounts due for your coverage. The acknowledgement letter is attached and becomes part of this policy.

Read your policy carefully

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

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

Your application

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

It is your responsibility to make sure the application that you submitted is accurate and complete. It is important that you notify us or, if you applied through the federal Exchange (the Exchange) the Exchange immediately of any mistakes that you find in your application.

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

Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Welcome

Thank you for choosing us.

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

This policy will tell you about your **covered benefits** – what they are and how you get them. The second document is the schedule of benefits. It tells you how we share expenses for **eligible health services** and tells you about limits – like when your policy covers only a certain number of visits.

This policy is provided following your application for coverage through the Exchange. Coverage under this policy is subject to any conditions and rights as set forth in this policy and by the Exchange and the Federal Department of Health and Human Services. Individuals covered under this policy agree to all its requirements.

Sometimes, these documents have amendments, inserts or riders which we will send you. These change or add to the documents they're part of. When you receive these, they are considered part of your **Aetna** policy. See also the Entire contract; changes provision in the *General provisions – other things you should know* section.

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

Welcome to **Aetna**.

Table of Contents

Let's get started!

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

Some notes on how we use words

- When we say "you" and "your", we mean you as the policyholder and any covered dependents, if dependent coverage is available under the policy.
- When we say "us", "we", "our", and "**Aetna**", we mean **Aetna Life Insurance Company**.
- Some words appear in **bold** type. We define them in the *Glossary* section.

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

What your policy does – providing covered benefits

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

How your policy works – starting and stopping coverage

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

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

Your coverage typically ends when you stop paying your **premium**. A covered dependent can lose coverage for many reasons. To learn more see the *When coverage ends* section.

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

How your policy works while you are covered

Your coverage:

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

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

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

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

2. **Providers**

Our network of doctors, **hospitals** and other health care **providers** is there to give you the care you need. You can find **network providers** and see important information about them most easily on our online **provider directory**. Just log in to our website. See the *How to contact us for help* section.

You may choose a **primary care physician** (we call that doctor your **PCP**) to oversee your care. Your **PCP** will provide your routine care, and send you to other **providers** when you need specialized care. You don't have to access care through your **PCP**. You may go directly to network **specialists** and **providers** for **eligible health services**.

Your policy often will pay a bigger share for **eligible health services** that you get through your **PCP**, so choose a **PCP** as soon as you can.

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

3. **Service area**

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

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

4. **Paying for eligible health services– the general requirements**

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

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

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

5. **Paying for eligible health services– sharing the expense**

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

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

6. **Disagreements**
   We know that people sometimes see things differently.

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

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

How to contact us for help– important information about your insurance

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

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

You can also contact us by:

- Calling us at the number on your ID card
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT, 06156

If you have been unable to contact or obtain satisfaction from us or the agent, you can contact the Virginia State Corporation Commission's Bureau of Insurance (BOI) at:

P.O. Box 1157
Richmond, Virginia 23218-1157

(804) 371-9741, local
(800) 552-7945, in-state toll-free number
(877) 310-6560, national toll-free number
Fax: (804) 371-9944

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting us, the agent or the BOI, have your member ID and group number available.

Your member ID card

Your member ID card tells doctors, **hospitals**, and other **providers** that you are covered by this policy. Show your ID card each time you get health care from a **provider** to help them bill us correctly and help us better process their claims.

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

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

Tell the Exchange of any changes

If there are any changes which will affect your policy, or the eligibility of anyone covered under the policy, you must contact the Exchange as soon as possible. This may include changes in:

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

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

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

What does the policy cost you?

Premium payment

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

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

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

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

Grace period

You have a grace period of 31 days after the due date for the payment of each **premium** due after the first **premium** payment. Your coverage will remain in force during the grace period. If **premiums** are not paid by the end of the grace period, your coverage will automatically end at the end of the 31 day grace period.

Important note:
If you are currently getting advanced payments of the **premium** tax credit, as determined by the Exchange, the grace period above does not apply to you. Instead, the following applies:

If you are getting advance payment of the **premium** tax credit now, and you have paid at least one full month's **premium** as your binder payment, when applicable:

- You will have a grace period of three months
- Your coverage will not end during the grace period

If you receive services during the second and third months of the grace period:

- We may wait to pay claims until the **premium** is paid
- We will tell you and your **providers**

If **premium** is not paid by the end of the three month period:

- Your coverage may end
- Your coverage will end on the last day of the first month's 31 day grace period
- We may take back payment for any claims paid after the first month's 31 day grace period

Reinstatement

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

Premium agreement

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

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

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

Each **premium** will be based on the rates that apply on that **premium** due date.

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

Who the policy covers

The eligibility process and enrollment process are subject to any rules or other standards of the Exchange and/or the Federal Department of Health and Human Services.

You will find information in this section about:

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

You are enrolled as the policyholder after you complete the eligibility and enrollment process, are approved by the Exchange and we have issued the policy to you.

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

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

- Your legal spouse
- Your domestic partner who meets eligibility requirements under **applicable law**
- Your dependent children – your own or those of your spouse, or domestic partner

  The children must be under 26 years of age and they include your:
  - Biological children
  - Stepchildren
  - Legally adopted children, including children placed with you for adoption
  - Foster children
  - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
  - Grandchildren in your court-ordered custody
  - Any children approved by the Exchange

You can enroll your dependent:

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

A dependent must be approved by the Exchange.

Special or limited enrollment periods

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

- You 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 (below) 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 or 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 policy before because they had other coverage and now that other coverage has ended.
- A court orders you to cover a current spouse, domestic partner or a child on your health policy.
- You or your dependent are newly eligible or 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 plans 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 a citizen, a national or lawfully present in the United States.
- You are an American Indian or Alaska Native as defined by the Indian Health Care Improvement Act.
    - You, or you and your dependents, can enroll in a qualified health plan (QHP) or change from one QHP to another.
    - You can do this one time per month.
- You or your dependent become eligible for State **premium** assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.
- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan.
- You or your dependent are released from incarceration.

The completed enrollment form may be submitted within 60 days of the event.

Adding new dependents

You can add the following new dependents to your policy:

- A spouse -If you marry, you can put your spouse on your policy.
    - The Exchange 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 policy. The Exchange 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 policy for the first 60 days after birth.
    - To keep your newborn covered, the Exchange must receive your completed enrollment 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 policy when 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.
    - The Exchange must receive your completed enrollment information within 60 days after the date of the adoption or the date the child was placed for adoption.
    - Benefits for your adopted child will begin on the date of the adoption (or placement) or the first day of the month following adoption (or placement). A child whose adoption or placement for adoption occurs within 31 days of birth will be considered a newborn child as of the date of the adoption or placement for adoption.
- A foster child – You may put a foster child on your policy 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.
    - The Exchange 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 of the first day of the month following this event.
- A stepchild - You may put a child of your spouse , or domestic partner on your policy.
    - You must complete your enrollment information and send it to the Exchange within 31 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 support order or court-order on your policy.
    - You must complete your enrollment information and send it to the Exchange 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 following month if completed enrollment information is received by the 15th of the month
- No later than the first day of the second month if completed enrollment information is received between the 16th and the last day of the month
- In accordance with the effective date of a court order
- An appropriate date based on the circumstances of the special enrollment period

Medical necessity and precertification requirements

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

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

- The **eligible health service** is **medically necessary**
- You get the **eligible health service** from a **network provider**
- You or your **provider precertifies** the **eligible health service** when required. **Precertification** includes determining that services are not more costly than an alternative service or sequence of services or site of service at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

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

Medically necessary; medical necessity

As we said in the *Let's get started!* section, **medical necessity** is a requirement for you to receive **eligible health services** under this policy.

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

Precertification

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

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

For **emergency services**, **precertification** is not required, but your **physician** or **PCP** should still notify us. This includes an emergency interhospital transfer for a life-threatening condition for a newborn and for the mother to accompany the newborn.

Coverage and exclusions

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

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

For example:

- **Physician** care generally is covered but **physician** care for **cosmetic** services is not covered and is an exclusion, except where described in the *Specific conditions – Reconstructive surgery and supplies* section.
- Home health care is generally covered but it is a **covered benefit** only up to a set number of visits a year. This is a limitation.

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

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

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

1. Preventive care and wellness

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

Important notes:

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

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

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

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

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or us. This information can also be found at **Healthcare.gov.** For a detailed listing of preventive care services described in this section refer to https://www.healthcare.gov/prevention/.

Routine physical exams

Eligible health services include office visits to your **physician**, **PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam.

A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and it includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
    - Screening and counseling services on topics such as:
        - Interpersonal and domestic violence
        - Sexually transmitted infections
        - Human Immune Deficiency Virus (HIV) infections
    - Screening for gestational diabetes for women
    - High risk Human Papillomavirus Virus (HPV) DNA testing for women

- Radiological services, lab and other tests given in connection with the exam.
- For adults this includes:
    - Screening for
        - Abdominal aortic aneurysm
        - Alcohol misuse
        - Colorectal cancer
        - High blood pressure
        - Type 2 Diabetes
        - Cholesterol
        - Depression
        - Hepatitis B and C
        - HIV
        - Lung cancer
        - Obesity
        - Syphilis
        - Tobacco use
    - Counseling for
        - Alcohol misuse
        - Nutrition
        - Obesity
        - Sexually transmitted infection prevention
    - Smoking and tobacco cessation products, including nicotine patches and gum when obtained with a **prescription**
    - Aspirin use to prevent cardiovascular disease.
- For infants, children and adolescents this includes:
    - Assessments for alcohol and drug use, behavioral, and oral health risk
    - Medical history
    - BMI measurements
    - Screenings for autism (18 and 24 months), blood pressure, cervical dysplasia, depression, development, dyslipidemia, hematocrit or hemoglobin, Hepatitis B, HIV, lead, obesity, sexually transmitted infection (STI), tuberculin, and vision.
    - Counseling for obesity and STI
- Supplements for fluoride chemoprevention and iron
- For covered newborns, an initial **hospital** checkup.
- Infant hearing screenings and audiological examinations, including follow-up audiological examinations by a **provider** to confirm hearing loss, when services are provided:
    - Using U. S. Food and Drug Administration (FDA) approved technology
    - As recommended by the Joint Committee on Infant Hearing in its most current position statement.

Preventive care immunizations

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

The following is not covered under this benefit:

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

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **physician**, **PCP**, obstetrician (OB), gynecologist (GYN) or obstetrician-gynecologist (OB/GYN). This includes an annual cervical cancer screening (pap smear) and testing using any FDA approved gynecologic cytology screening technologies. Your policy covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
- Osteoporosis screening.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Breast cancer chemoprevention.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.

Preventive screening and counseling services

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

- **Obesity and/or healthy diet counseling**
  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- **Misuse of alcohol and/or drugs**
  Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment
- **Use of tobacco products**
  Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:
  - Preventive counseling visits
  - Treatment visits
  - Class visits

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

  - Cigars
  - Smoking tobacco
  - Snuff
  - Smokeless tobacco
  - Candy-like products that contain tobacco
- **Sexually transmitted infection counseling**
  Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.
- **Genetic risk counseling for breast and ovarian cancer**
  Eligible health services include the counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Diagnostic mammograms
- Screening mammograms
  - Age 35 to 39, one baseline
  - Age 40 and older, one per year
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure and a pathology exam on any removed polyp
- Lung cancer screenings
- Radiologic imaging in appropriate circumstances

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

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

In addition, diagnostic examinations, and one digital rectal examination and prostate specific antigen (PSA) test in a 12-month period are covered for individuals age 50 and over and individuals age 40 and over who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society (ACS).

Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging are provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for ages, family histories and frequencies referenced in such recommendations.

Prenatal care

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

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height
- Anemia screening
- Chlamydia infection screening
- Hepatitis B screening
- Rh incompatibility screening
- Gestational diabetes screening
- Urinary tract or screening for other infection
- Expanded tobacco intervention and counseling for pregnant users
- Prenatal screenings:
    - Fetal screenings for genetic and/or chromosomal status of fetus
    - Anatomical, biochemical, or biophysical tests to better define likelihood of genetic and/or chromosomal anomalies

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

See the *Outpatient prescription drugs* section for *over-the counter drugs* and *preventive care drugs and supplements* such as folic acid supplements that you can get at a **pharmacy**.

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

Comprehensive lactation support and counseling services

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

Breast feeding durable medical equipment

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

Breast pump

Eligible health services include:

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

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

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

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

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

Family planning services – female contraceptives counseling, devices and voluntary sterilization

Eligible health services include family planning services such as:

Counseling services
Eligible health services include counseling services provided by a **physician**, **PCP**, OB, GYN, or OB/GYN on contraceptive methods. These will be covered when you get them in either a group or individual setting.

Devices

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

Voluntary sterilization

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

The following are not covered under this benefit:

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

2. Physicians and other health professionals

Physician services

Eligible health services include medical care from a **physician**, **PCP**, specialist, nurse, nurse practitioner or physician assistant to examine, diagnose, and treat an **illness** or **injury** or provide a second opinion. You can get those services:

- At the **physician's** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine** which includes interaction via audio, video, or other electronic technology or media
- Online medical visit with your **physician** using the internet by a webcam, chat or voice

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

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

Other services and supplies that your **physician** may provide in the above listed settings:

- Allergy testing and treatment including allergy shots and allergy serum
- Injectable drugs
- **Medically necessary services for the administration of prescription drugs.**
- Charges for supplies, radiological services, x-rays, and tests provided by the **physician**
- **Medically necessary** treatment of varicose veins
- **Surgery** performed in a **physician's** office
- Radiological supplies, services, and tests
- Diagnostic hearing and vision tests
- Chronic disease management
- Immunizations that are not covered as preventive care

Physician surgical services

Eligible health services include the services of:

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

The following are not covered under this benefit:

- The services of any other **physician** who helps the operating **physician** unless approved by the plan as **medically necessary**.
- A **stay** in a **hospital**. (See the *Eligible health services under your plan – Hospital and other facility care* section.)
- A separate facility charge for **surgery** performed in a **physician's** office.
- Services of another **physician** for the administration of a local anesthetic unless approved by the plan as **medically necessary.**

Alternatives to physician office visits

Walk-in clinic

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

- Scheduled and unscheduled visits for **illnesses, injuries** and routine care that are not **emergency medical conditions**
- Preventive care immunizations administered within the scope of the clinic's license
- Telemedicine consultation
- Preventive screening and counseling services that will help you:
  - With obesity or healthy diet
  - To stop using tobacco products

3. Hospital and other facility care

Hospital care

Eligible health services include inpatient and outpatient **hospital** and surgical care for an **illness**, **injury** or pregnancy.

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

- **Room and board** charges up to the **hospital's semi-private room rate**. Your policy will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians** employed by the **hospital**.
- Operating and recovery rooms, including pre- and post-operative care.
- Intensive or special care units of a **hospital**.
- Administration of blood and blood derivatives.
- Anesthesia and anesthesiologist services.
- Radiation therapy.
- Rehabilitation and habilitation services and devices including speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services including invasive procedures such as:
    - Angiogram
    - Arteriogram
    - Amniocentesis
    - Tap or puncture of the brain or spine
    - Endoscopic exams (arthroscopy, bronchoscopy, colonoscopy, laparoscopy).
- Nuclear medicine.
- Medical and surgical supplies (hypodermic needles, syringes, surgical dressings, splints etc.)
- Sleep studies, sleep testing and sleep disorder treatments.
- Treatment of fractures and dislocations.
- Cognitive rehabilitation.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications and injectable drugs. **Eligible health services** also include off-label drug use when:
    - Indications are recognized through peer-reviewed medical literature.
    - A dosage of an FDA approved drug is in excess of the recommended amount for use by a patient with intractable cancer pain.
- Intravenous (IV) preparations and infusion services.
- Laparoscopy-assisted vaginal hysterectomy or vaginal hysterectomy. **Eligible health services** also include:
    - A minimum stay of not less than 23 hours following a laparoscopy-assisted vaginal hysterectomy
    - A minimum stay of not less than 48 hours following a vaginal hysterectomy.

  A shorter inpatient stay will be allowed if the attending **provider** and you determine that a shorter length of stay is appropriate.
- Discharge planning.

- Services and supplies provided by the outpatient department of a **hospital**.

Anesthesia and hospital charges for dental care

Eligible health services include general anesthesia and hospitalization or outpatient facility charges for dental care if any of the following apply:

- You have a disability or condition that requires that a dental procedure be done in a **hospital** or outpatient **surgery center**.
- You are severely disabled.
- You have a medical need for general anesthesia.
- You are under 5 years old.

Alternatives to hospital stays

Outpatient surgery

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

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

The following are not covered under this benefit:

- The services of any other **physician** who helps the operating **physician** unless approved by the plan as **medically necessary**.
- A **stay** in a **hospital**. (A **hospital stay** is an inpatient **hospital** benefit. See *the Coverage and exclusions – Hospital and other facility care* section.)
- A separate facility charge for **surgery** performed in a **physician's** office.
- Services of another **physician** for the administration of a local anesthetic unless approved by the plan as **medically necessary**.

Home health care

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

- You are homebound.
- Your **physician** orders them.
- The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**, or you are unable to receive the same services outside your home.
- The services are part of a **home health care plan**.
- The services are intermittent **skilled nursing services**, diagnostic services, home health aide services or medical social services, **remote patient monitoring** services, nutritional guidance, training, medical supplies, durable medical equipment or 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.

Home health services include visits by licensed health care professionals, including a

- Nurse
- Therapist

- Home health aide

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.

Physical, speech and occupational therapy services provided in the home as part of a **home health care** plan are not subject to the limitations for therapy provided outside the home.

The following are not covered under this benefit:

- **Custodial care**
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

Hospice care

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

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

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a **hospice care agency** or **hospice care** provided in a **hospital** or in a home
- Psychological and dietary counseling
- Pain management and symptom control
- Bereavement counseling
- Respite **hospital** stays

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

- A **physician** for consultation or case management
- An R.N. or L.P.N
- A physical, speech or occupational therapist
- A **home health care agency** for:
    - Physical, speech and occupational therapy
    - Home health aide and homemaker services
    - Durable medical equipment
    - Medical supplies
    - Outpatient **prescription drugs**
    - Infusion services
    - Routine lab services
    - Psychological counseling
    - Dietary counseling

Physical, speech and occupational therapy provided under the hospice benefit are not subject to any

visit limits.

The following are not covered under this benefit:

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

Outpatient private duty nursing

Eligible health services include private duty nursing care provided by an **R.N.** or **L.P.N.** for non-hospitalized acute **illness** or **injury** if:

- Your condition requires skilled nursing care
- Visiting nursing care is not adequate

Skilled nursing facility

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

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

- **Room and board**, up to the **semi-private room rate.** Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Medical, general nursing and convalescent services that are provided during your **stay** in a **skilled nursing facility**
- Radiological services and lab work
- Physical, occupational, or speech therapy
- Oxygen and other gas therapy
- Drugs and biologicals
- Rehabilitative services
- Medical supplies

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

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

4. Emergency services and urgent care

Eligible health services include emergency services and supplies needed to evaluate, treat and stabilize an **emergency medical condition** or services and supplies to treat an **urgent condition**.

The types of emergency services and urgent care services and supplies that are eligible for coverage include:

- Diagnostic x-ray
- Lab services
- Medical supplies
- Advanced diagnostic imaging, such as MRIs and CAT scans

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

Your coverage for **emergency services** will continue until you are evaluated and your condition is stabilized and 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 you choose to use an **out-of-network provider** to receive additional care, it will not be covered.

In case of a medical emergency

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and **ambulance** assistance. If possible, call your **physician**, but only if a delay will not harm your health. Your **physician** or a **physician** on-call for your **physician** can be reached 24 hours a day and can determine the best option for you.

Non-emergency condition

See the schedule of benefits for non-emergency services and the *Glossary* section for specific emergency defined terms.

In case of an urgent condition

Urgent condition within the service area

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

Urgent condition outside the service area

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

Non-urgent care

The following is not covered under this benefit:

- Non-**urgent condition** care in an **urgent care facility**

5. Specific conditions

Autism spectrum disorder

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

Eligible health services include the services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder. We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan they develop:

- Following a complete evaluation or reevaluation
- In accordance with the most recent clinical report or recommendation of one of the following:
  - American Academy of Pediatrics
  - American Academy of Child and Adolescent Psychiatry.

The following services will be covered when provided by a licensed **physician** or a licensed psychologist who determines the care to be **medically necessary**:

- Behavioral health treatment
- Pharmacy care
- Psychiatric care
- Psychological care
- Therapeutic care
- Applied behavioral analysis

We will cover certain early intensive behavioral interventions such as applied behavior analysis.

Applied behavior analysis is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Diabetic equipment, supplies and education

Eligible health services include:

- Services
  - Foot care to minimize the risk of infection (treatment of corns, calluses and care of toenails)
- Supplies
  - Diabetic needles, syringes and pens
  - Test strips – blood glucose, ketone and urine
  - Injection aids for the blind
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
  - Dressings
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Education
  - In-person self-management training and educational services, including medical

nutrition therapy provided by a certified, registered or licensed health care **provider**

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

Family planning services – other

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

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

The following are not covered under this benefit:

- Reversal of voluntary sterilization procedures including related follow-up care. See the *Specific conditions - Treatment of Infertility* section for coverage of reversal of a non-elective sterilization that was the result of an **illness** or **injury**.
- Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

Gender affirming treatment

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

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

Jaw joint disorder treatment

Eligible health services include the diagnosis, medical care and surgical treatment for a medical condition or **injury** that prevents normal function of the bone or joint of the head, neck, face or jaw which includes:

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

Maternity and related newborn care

Eligible health services include prenatal and postpartum care and obstetrical services provided by a **physician** or nurse midwife and facility. Pregnancy and childbirth services and supplies are covered at the same level as any **illness** or **injury** or with no cost share for **preventive** services (see the ***Eligible health services*** *under your policy – Preventive care and wellness* section*)*.

Eligible health services include the following for both a member and any covered dependent:

- Pregnancy testing
- Prenatal and postnatal care services for pregnancy

- Maternity-related check-ups
- Treatment for complications of pregnancy

- Prenatal screenings
  - Fetal screenings for genetic and/or chromosomal status of the fetus
  - Anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies
- Delivery and all inpatient **physician** and facility services for maternity care including:
  - Use of delivery room
  - Anesthesia
- Home delivery by a certified nurse midwife

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

- A minimum of 48 hours of inpatient care in a **hospital** after a vaginal delivery
- A minimum of 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier
- Newborn nursery care
  - **Hospital** services for routine nursery care for the newborn during the mother's normal stay
  - Initial newborn exam
    - Behavioral assessments and measurement
    - Blood pressure
    - Hearing screening
    - Hemoglobinopathies screening
    - Gonorrhea prophylactic medication
    - Hypothyroidism screening
    - PKU screening
    - Rh incompatibility testing
  - Circumcision of a covered male dependent
- Post-delivery home visits by a health care **provider** in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologist or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists.
- Care and treatment for the newborn to correct functional impairment caused by congenital defects and birth abnormalities including inpatient and outpatient dental, oral surgical, orthodontic services, and dental appliances that are **medically necessary** for the treatment of cleft lip, cleft palate or ectodermal dysplasia.

Behavioral health

Mental health treatment

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

- **Inpatient room and board** at the **semi-private room rate** (your policy will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility.** Coverage includes:

- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Counseling with family members to assist with the patient's diagnosis and treatment, and
- Convulsive therapy treatment

Professional charges in any **hospital** or facility required by state law

Eligible health services in a **residential treatment facility** licensed to provide a continuous, structured program of treatment and rehabilitation also include:

Treatment for eating disorders

24 hour-a-day nursing care

Individualized and intensive treatment which includes observation and assessment by a psychiatrist weekly or more often

Rehabilitation

Therapy

Education

- Recreational or social activities

- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Other outpatient mental health treatment such as:
    - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
    - Counseling with family members to assist with patient's diagnosis and treatment
    - Medication management visits to monitor and adjust drugs prescribed for a **mental health disorder**
    - Electro-convulsive therapy (ECT)
    - Mental health injectables
    - Transcranial magnetic stimulation (TMS)
    - Outpatient visits to providers as may be necessary and appropriate for diagnosis and treatment of psychiatric conditions, including:
      - Psychological diagnosis

        - Psychological testing
        - Individual psychotherapy
        - Group psychotherapy
    - Outpatient facility charges
    - Neuropsychological testing
    - Observation
    - Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

Substance use disorders treatment

Eligible health services include the treatment of **substance use 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 policy will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
    - Individual psychotherapy
    - Group psychotherapy
    - Psychological testing
    - Counseling with family members to assist with patient's diagnosis and treatment
    - Convulsive therapy treatment
    - **Detoxification**
    - Rehabilitation
    - Professional charges in any **hospital** or facility required by state law.

  Eligible health services in a **residential treatment facility** licensed to provide a continuous, structured program of treatment and rehabilitation also include:
    - Treatment for eating disorders
    - 24 hour-a-day nursing care
    - Individualized and intensive treatment which includes observation and assessment by a psychiatrist weekly or more often
    - Rehabilitation
    - Therapy
    - Education
    - Recreational or social activities
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
    - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker or licensed professional counselor (includes **telemedicine** consultation)
    - Other outpatient **substance use disorders** treatment such as:
        - Outpatient detoxification
        - **Partial hospitalization treatment** provided in a facility or program for **substance use disorders** treatment provided under the direction of a **physician**

- **Intensive outpatient program** provided in a facility or program for **substance use disorders** treatment provided under the direction of a **physician**
- Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other **substance use disorders**, including administration of medications
- Outpatient visits to providers as may be necessary and appropriate for diagnosis and treatment of psychiatric conditions, including:
  - Psychological diagnosis
  - Psychological testing
  - Individual psychotherapy
  - Group psychotherapy
- Outpatient facility charges
- Medication management visits to monitor and adjust drugs prescribed for a **substance use disorder**
- Treatment of withdrawal symptoms
- Observation
- Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

Oral surgery

Eligible health services include charges made by a physician, a dentist or hospital for:

- Maxillary or mandibular frenectomy when not related to a dental procedure
- Alveolectomy when related to tooth extraction
- Orthognathic surgery that is required to attain functional capacity of the affected part.
- Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses
- Cleft lip
- Cleft palate
- Ectodermal dysplasia

Reconstructive surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it even with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema, and prostheses. These can be done at the same time as the mastectomy or later. **Eligible health services** for reconstructive breast **surgery** include**:**
  - No less than 48 hours of inpatient care following a radical or modified radical mastectomy
  - No less than 24 hours of inpatient care after a total or partial mastectomy with lymph node dissection for treatment of breast cancer

- Your **surgery** corrects an accidental **injury**. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected. **Surgery** or a procedure to fix teeth injured due to an accident is covered when:
    - Teeth are sound natural teeth.
    - The **surgery** or procedure must be performed within 12 months or as soon after that as possible.
- Your **surgery** is needed to improve a significant functional impairment of a body part.
- Your **surgery** corrects a birth defect or other significant deformity caused by **illness**, **injury** or a previous treatment. The **surgery** will be covered if:
    - The defect results in facial disfigurement or functional impairment of a body part.
    - The purpose of the **surgery** is to improve function.
    - The **surgery** creates a more normal appearance, other than for orthognathic surgery.

Transplant services

Eligible health services include transplant services provided by a **physician** and **hospital** only when we **precertify** them.

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow, including autologous bone marrow transplants for breast cancer
- CAR-T and T-cell receptor therapy for FDA approved treatments
- Thymus tissue, for FDA-approved treatments

Eligible health services for both the living donor and member also include:

- Acquisition
- Mobilization
- Harvesting
- Storage of organs or tissue
- Preparatory myeloablative therapy or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies

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

Important note:

- If there are no Exchange IOE facilities for your transplant type in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your transplant services at the facility we designate, they will not be **eligible health services**.

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

Eligible health services include travel and lodging expenses for you and your companion to travel between your home and the IOE facility to receive services in connection with an approved transplant procedure or treatment. If the member receiving care is a minor, transportation and lodging may be allowed for two companions. Transportation and lodging costs for the donor are also covered when the donor is member.

The following are not covered under this benefit:

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

Treatment of infertility

Basic infertility services

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

- To diagnose and evaluate the underlying medical cause of **infertility**.
- To do **surgery** to treat the underlying medical cause of **infertility**. Examples are endometriosis surgery or, for men, varicocele surgery.
- Services to reverse non-elective sterilization caused by an **illness** or **injury**.

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

- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father. See the *Specific conditions - Maternity and related newborn care* section for more information on **eligible health services** for pregnancy services when the surrogate is a **covered person**.
  - Cryopreservation (freezing) of eggs, embryos or sperm.
  - Storage of eggs, embryos or sperm.
  - Thawing of cryopreserved (frozen) eggs, embryos or sperm.
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests and any charges associated with care of the donor required for donor egg retrievals or transfers.
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
- Home ovulation prediction kits or home pregnancy tests.
- Injectable **infertility** medication, including but not limited to menotropins, hCG and GnRH

agonists.

- The purchase of donor embryos, donor oocytes or donor sperm.
- Reversal of voluntary sterilizations, including follow-up care.
- Any charges associated with obtaining sperm from a person not covered under this plan for ART services.

6. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

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

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA)
- Computer tomographic angiography (CTA)
- Nuclear medicine imaging including positron emission tomography (PET) scans and PET/CT fusion scans
- Single photon emissions computed tomography (SPECT) scans
- Nuclear cardiology
- QCT bone densitometry
- Diagnostic CT colonography
- Other outpatient diagnostic imaging service where the billed charge exceeds $500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Eligible health services include diagnostic lab services, and pathology and other tests, including professional services to interpret the lab or test, but only when you get them from a licensed lab.

Diagnostic radiological services

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

- X-ray
- Mammogram
- Ultrasound
- Nuclear medicine
- EEG
- Echocardiogram
- EKG
- Professional services for test or lab interpretation and x-ray reading

Diagnostic sleep testing

Eligible health services include diagnostic sleep studies, sleep testing and sleep disorder treatments from a licensed **provider**.

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

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

Key Terms

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

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

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

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

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

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

GCIT **eligible health services** include:

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

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

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

Outpatient therapies

Chemotherapy
Eligible health services for chemotherapy depend on where treatment is received. In most cases,

chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**. **Eligible health services** include chemical or biological antineoplastic agents administered as part of a doctor's visit, home care visit, or at an outpatient facility for treatment of an **illness**. The criteria for establishing cost sharing applicable to orally administered cancer treatment drugs and cancer chemotherapy drugs that are administered intravenously or by injection shall be consistently applied.

Dialysis

Eligible health services to treat acute renal failure and chronic (end stage) renal disease in an inpatient, outpatient, office or home setting includes:

- Hemodialysis
- Peritoneal dialysis
    - Home intermittent peritoneal dialysis (IPD)
    - Home continuous cycling peritoneal dialysis (CCPD)
    - Home continuous ambulatory peritoneal dialysis (CAPD)
- Training for you and the person who will help you with home self-dialysis

When dialysis is provided in your home, it will not count toward any applicable home health care limits.

Outpatient infusion therapy

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

- A free-standing outpatient facility
- The outpatient department of a **hospital**
- A **physician's** office
- A home care **provider** in your home

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

Infusion therapy is nursing, durable medical equipment and the administration of prescribed medications or solutions through an IV, including:

- Total Parenteral Nutrition (TPN)
- Blood products
- Enteral nutrition therapy
- Antibiotic therapy
- Pain care
- Chemotherapy
- Injections (intra-muscular, subcutaneous, continuous subcutaneous)

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

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

Outpatient radiation therapy
Eligible health services include the following radiology services, materials and supplies, administration and treatment planning provided by a **health professional** to treat an **illness**:

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

This includes teletherapy, brachytherapy and interoperative radiation, photon or high energy particle sources.

Specialty prescription drugs

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

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

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

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

Cardiac and pulmonary rehabilitation services

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

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

Cardiac rehabilitation services include the following **eligible health services** after a cardiac event:

- Medical evaluation
- Training
- Supervised exercise
- Psychosocial support

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

Pulmonary rehabilitation services include:

- Introducing dry or moist gases into the lungs
- Nonpressurized inhalation treatment
- Intermittent positive pressure breathing treatment
- Air or oxygen, with or without nebulized medication
- Continuous positive pressure ventilation (CPAP)
- Continuous negative pressure ventilation (CNP)
- Chest percussion
- Therapeutic use of medical gases or aerosol drugs
- Equipment such as resuscitators, oxygen tents and incentive spirometers
- Broncho pulmonary drainage
- Breathing exercises

A course of outpatient short-term pulmonary rehabilitation following an **illness** or **injury** may also be eligible for coverage if it's:

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

Rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living.
Eligible health services include short-term rehabilitation services your **physician** prescribes. The services have to be performed by a:

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

Rehabilitation services have to follow a specific treatment plan ordered by your **physician**. They must involve goals you can reach in a reasonable period of time.

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

Outpatient cognitive rehabilitation, physical, occupational and speech therapy

Eligible health services include:

- Physical therapy, but only if it is expected to ease pain, restore health, and avoid disability after **illness**, **injury** or **surgical procedure** or loss of limb, or to treat lymphedema Including:
  - Hydrotherapy
  - Heat
  - Physical agents
- Bio-mechanical and neuro-physiological principles and devices
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Improve, develop or restore physical functions you lost as a result of an acute

illness, **injury** or **surgical procedure** such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing and job related activities.
    - Help you relearn skills so you can significantly regain your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to:
    - Improve or restore the speech function or correct a speech impairment as a result of an acute **illness**, **injury** or **surgical procedure**
    - Improve delays in speech function development caused by a gross anatomical defect present at birth
    - Identify, assess, and treat speech function, language, speech impairment and swallowing disorders in children and adults.
    - Treat communication or swallowing difficulties to correct a speech impairment

  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

Habilitation therapy services

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

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

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

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

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function.
- Occupational therapy (except for vocational rehabilitation or employment counseling or services provided in an educational or training setting), if it is expected to develop any impaired function.

- Speech therapy (except for services provided in an educational or training setting or to teach sign language), provided the therapy is expected to develop speech function as a result of delayed development. Speech function is the ability to express thoughts, speak words and form sentences.

Early intervention services

Eligible health services include speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for children from birth up to age 3.

Eligible health services include services that are:

- Certified by the Department of Behavioral Health and Developmental Services as eligible services under Part H of the Individuals with Disabilities Education Act; and
- Designed to attain or retain the capacity to function age appropriately within the child's environment or enhance functional ability without effecting a cure

No visit limit applies to occupational, physical or speech therapy services received under the Early Intervention Service benefit. **Eligible health services** are not limited by the exclusion of services that are not **medically necessary**.

7. Other services

Acupuncture

Eligible health services include manual or electro acupuncture.

The following is not covered under this benefit:

- Acupressure

Additional dental care for children and adults

Eligible health services include the following dental services and supplies provided by a **dental provider:**

- Removing, repairing, restoring or repositioning natural teeth damaged or lost due to accidental **injury**, including:
  - Dental work
  - Surgery
  - Dental appliances
  - Orthodontic treatment
- Repairing dental appliances damaged due to an accidental **injury** to the jaw, mouth, or face

Adult dental care

Eligible health services include the following dental services and supplies provided by a **dental provider:**

- Preparing the mouth for medical services and treatments such as radiation therapy to treat cancer and preparing for transplants, including:
  - Evaluation
  - Dental x-rays
  - Extractions, including surgical extractions
  - Anesthesia

Ambulance service

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

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

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

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

Your plan also covers emergency transportation to a **hospital** by fixed wing or rotary wing air transportation or by water **ambulance** services when your condition is unstable, and requires medical supervision and rapid transport.

The following are not covered under this benefit:

- **Ambulance** services, for routine transportation to receive outpatient or inpatient services
- Non-emergency fixed wing air **ambulance** transportation from an **out-of-network provider**

Clinical trial therapies (experimental or investigational)

Eligible health services include coverage for “routine patient costs” for an “approved clinical trial”.

An "approved clinical trial" is a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and the study or investigation is any of the following:

- A federally funded or approved trial
- Conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- A drug trial that is exempt from having an investigational new drug application

Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred by you from a **provider** in connection with participation in an "approved clinical trial" as a “qualified individual” for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

NOTE: This definition excludes the cost of:

- Services and supplies related to data collection and record keeping that is not used in the direct clinical management of the patient.
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- The cost of the investigational item, drug or device.

“Life threatening condition” means any disease or condition from which death is likely unless the course of disease or condition is interrupted.

“Qualified individual” means a covered person who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to treatment of cancer or other life-threatening disease or condition, and the referring health care professional has concluded that the individual’s participation in such trial is appropriate to treat the disease or condition, or the individual’s participation is based on medical and scientific information.

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

The following are not covered under this benefit:

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you

- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna**'s claim policies)

Durable medical equipment (DME)

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

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

Coverage includes:

- One item of **DME** for the same or similar purpose.
- Repair and maintenance of **DME** due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new **DME** item you need because your physical condition has changed. It also covers buying a new **DME** item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.
- Supplies and equipment needed for the use of the **DME**, for example, a battery for a powered wheelchair.

Covered **DME** includes the following items:

- Nebulizers
- Hospital-type beds
- Wheelchairs
- Traction equipment
- Walkers
- Crutches
- Home dialysis equipment and supplies
- Oxygen, and equipment to administer oxygen including oxygen concentrators and ventilators
- Urinary catheters and external urinary collection devices
- Leg braces, including attached or built-up shoes attached to the leg brace; molded therapeutic shoes for diabetics with peripheral vascular disease
- Arm, back and neck braces
- Head halters
- Catheters and related supplies
- Orthotics (braces, boots, splints), other than foot orthotics, including the cost of fitting, adjustment and repair
- Negative pressure wound therapy devices
- Cochlear implants

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

The following are not covered under this benefit:

- Appliances, devices, and medical supplies that have both a non-therapeutic and therapeutic use. Examples of these items are:
  - Whirlpools
  - Portable whirlpool pumps
  - Massage table
  - Sauna baths
  - Message devices (personal voice recorder)
  - Over bed tables
  - Elevators
  - Communication aids
  - Vision aids
  - Telephone alert systems

Hemophilia and congenital bleeding disorders

Eligible health services for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders include:

- Blood infusion equipment, including but not limited to, syringes and needles
- Blood and the administration of blood products, including but not limited to, Factor VII, Factor VIII, Factor IX and cryoprecipitate
- Training to provide infusion therapy at home

The home treatment must be supervised by a state approved hemophilia treatment center.

Lymphedema

Eligible health services include the diagnosis evaluation, and treatment of lymphedema. Your plan will cover:

- Equipment
- Supplies
- Complex decongestive therapy
- Outpatient self-management training and education by a licensed health care professional
- Gradient compression garments:
  - Require a **prescription**
  - Are custom-fit for you
  - Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products

Medical and Surgical Supplies

Eligible health services include medical and surgical supplies that:

- Serve only a medical purpose
- Are used once
- Are purchased and not rented

Coverage includes:

- Syringes
- Needles
- Surgical dressings
- Splints

- Similar items that serve only a medical purpose

The following are not covered under this benefit:

- Items often stocked in the home for general use such as Band-Aids, thermometers, and petroleum jelly.

Nutritional support

Eligible health services include formula and enteral nutrition products for the treatment of an inherited metabolic disorder and severe protein or soy allergies.

An inherited metabolic disorder is an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids.

Eligible health services include:

- Formula and enteral nutrition products that:
  - Are liquid or solid formulas and enteral nutrition products for the partial or exclusive feeding by means of oral intake or enteral feeding by tube
  - A physician or other health care professional that is qualified for the management of an inherited metabolic disorder has issued a written order stating that the special food and supplement, formula or enteral nutrition product is medically necessary
  - Are a critical source of nutrition as certified by the physician by diagnosis, but do not need to be the covered individual's primary source of nutrition
  - Are proven effective as a treatment regimen for the covered individual
  - Are used under medical supervision which may include a home setting
- Medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products

The following are not covered under this benefit:

- Any other food item, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition if the item can be obtained over-the counter and without a written **prescription**

Prosthetic devices

Eligible health services include the initial provision and subsequent replacement of a prosthetic device and components that your **physician** orders and administers and are **medically necessary** for activities of daily living.

Prosthetic device means:

- An artificial device to replace, in whole or in part, a limb
- A medical device which replaces all or part of an internal body organ or an external body part lost or impaired as the result of disease, congenital defect or **injury**
- A breast prosthesis (internal or external) following a mastectomy
- Colostomy and needed ostomy supplies
- Restoration prosthesis (composite facial prosthesis)
- Wigs needed after cancer treatment

Component means:

- The materials and equipment needed to ensure the comfort and functioning of a prosthetic device

Limb means:

- An arm
- A hand
- A leg
- A foot
- Any portion of an arm, a hand, a leg, or a foot

Coverage includes:

- Fittings and adjustments
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- Instruction and other services (such as attachment or insertion) so you can properly use the device

The following are not covered under this benefit:

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

Sleep Treatment

Eligible health services include devices and supplies for sleep treatment such as:

- APAP
- CPAP
- BPAP
- Oral devices

Spinal manipulation

Eligible health services include spinal manipulation to correct a muscular or skeletal problem, but only if your **provider** establishes or approves a treatment plan that details the treatment, and specifies frequency and duration. Rehabilitative services must involve goals you can reach in a reasonable period of time and will end when progress toward the goal ends. It includes rehabilitative and habilitative therapy to treat problems of the bones, joints, and the back and surrounding muscles, tendons and ligaments.

Eligible health services also include habilitative services to help you keep or improve skills and functioning for daily living and includes services for people with disabilities in an inpatient or outpatient setting.

Vision care

Pediatric vision care

Routine vision exams

Eligible health services include a complete vision examination with dilation provided by an ophthalmologist or optometrist. The exam is used to check all aspects of your vision, including refraction and glaucoma testing.

Vision care supplies

We provide vision eyewear coverage that can help pay for **prescription** eyeglasses or **prescription** contact lenses. You have access to an extensive network of vision locations. If you have questions, see the *How to contact us for help* section.

Eligible health services include:

- Eyeglass frames
- **Prescription** lenses, including:
  - Choice of glass or plastic
  - All lens powers (single vision, bifocal, trifocal, lenticular and standard progressives)
  - Scratch resistant coating
- **Prescription** contact lenses including:
  - Elective contact lenses –chosen for comfort or appearance
  - Non-elective contact lenses – Only prescribed for certain eye conditions:
    - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
    - High ametropia exceeding -12D or +9D in spherical equivalent.
    - Anisometropia of 3D or more.
    - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: **Eligible health services** do not include non-elective contact lenses if you have undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

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

The following are not covered under this benefit:

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

Vision correction after surgery or for illness or accident

Eligible health services include prescribed eyeglasses or contact lenses only when required as a result of **surgery**, or for treatment of an accidental **injury**. Exams and replacement of these eyeglasses or contact lenses will be covered only if the **prescription** change is related to the **surgery**, **illness** or **injury** that required the original **prescription**. The purchase and fitting of eyeglasses or contact lenses or other services and supplies are covered if they are:

- Prescribed to replace the human lens lost due to **surgery** or **injury**
- "Pinhole" glasses that are prescribed for use after **surgery** for a detached retina
- Lenses prescribed instead of **surgery** in any of the following situations:
    - Contact lenses for the treatment of infantile glaucoma
    - Corneal or scleral lenses prescribed in connection with keratoconus
    - Scleral lenses prescribed to retain moisture when normal tearing is not possible or not adequate
    - Corneal or scleral lenses required to reduce a corneal irregularity other than astigmatism
- Low vision services and supplies, including prescribed optical devices, such as high-powered spectacles, magnifiers and telescopes.

8. Outpatient prescription drugs

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

Read this section carefully so that you know:

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

Some **prescription drugs** may not be covered or coverage may be limited. This does not keep you from getting **prescription drugs** that are not **covered benefits**. You can still fill your **prescription**, but you have to pay for it yourself. For more information see the schedule of benefits.

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

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

How to access network pharmacies

How to find a network pharmacy

You can find a **network pharmacy** online or by phone. See the *How to contact us for help* section for details. As defined in the *Glossary* section, **network pharmacies** include network **retail**, **mail order** or **specialty pharmacy** that has contracted with **Aetna**, an affiliate or a third party vendor to provide outpatient **prescription drugs** to you. **Network pharmacies** include out-of-network pharmacies or its intermediary that have agreed by fax or otherwise to accept our payment at our contracted level as payment in full.

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

If the pharmacy you have been using leaves the network

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

Eligible health services under your policy

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

- They are listed in the *Coverage and exclusions* section
- They are not listed in the *Exclusions* section

- They are not beyond any limits in the schedule of benefits

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

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

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

We will notify you in writing 30 days prior to a change to the **drug guide** that results in a **prescription drug** moving to a higher cost-sharing tier.

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

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

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

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

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

Prescription drug synchronization

If you are prescribed multiple medications, including **specialty prescription drugs**, and would like to have them each dispensed on the same fill date for your convenience, your **network pharmacy** may be able to coordinate that for you, provided that:

- Your **pharmacy** or **prescriber** tells us that the synchronization of the dates is in your best interest
- You request or agree to the synchronization

We will apply a prorated daily cost share rate, to a partial fill if needed, to synchronize your **prescription drugs**. We will not perform this proration more often than annually.

Retail pharmacy

Generally, **retail pharmacies** may be used for up to a 90 day supply of **prescription drugs**. You should show your ID card to the **network pharmacy** every time you get a **prescription** filled. The **network pharmacy** will submit your claim. You will pay any cost sharing directly to the **network pharmacy**.

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

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

Mail order pharmacy

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

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

Specialty pharmacy

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

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

All **specialty prescription drug** fills may be filled only at pharmacies that have agreed to accept our reimbursement terms for **specialty prescription drugs**. Pharmacies that have accepted our reimbursement terms are listed on our online **provider directory** at www.aetna.com/formulary. You can also call the toll-free number on your ID card to request a printed **directory**.

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

Other services

Preventive contraceptives

For females who are able to become pregnant, your outpatient **prescription drug** plan covers certain drugs and devices, including implants that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. This includes drugs, injectables, patches, rings and devices such as implants. Your outpatient **prescription drug** plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive drugs. See the *How to contact us for help* section for how.

We cover over-the-counter (OTC) and **generic prescription drugs** and devices, including implants for each of the methods identified by the FDA at no cost share. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drugs** or devices for that method at no cost share.

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

medical exception and submit the exception to us.

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

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

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

Immunizations

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

Injectables

Eligible health services include injectable drugs and injections administered at an authorized **pharmacy**, including flu shots and their administration.

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

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

Risk reducing breast cancer prescription drugs
Eligible health services include **prescription drugs** used to treat people who are at:

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

Tobacco cessation prescription and over-the-counter drugs

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

The following are not covered under this benefit:

- Abortion drugs
- Allergy serum and extracts administered by injection
- Any services related to the dispensing, injection or application of a drug
- Biological liquids and fluids unless specified on the **drug guide**
- **Cosmetic** drugs
    - Medications or preparations used for **cosmetic** purposes
- Compound **prescriptions** containing bulk chemicals that have not been approved by the FDA, including compounded bioidentical hormones
- Devices, products and appliances, except those that are specifically covered
- Dietary supplements including medical foods. See the *Coverage and exclusions – Other services* section
- Drugs or medications:
    - Which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written, except where stated above
    - That is therapeutically equivalent or a therapeutic alternative to a covered **prescription drug** unless a medical exception is approved
    - Provided under your medical benefits while an inpatient of a healthcare facility
    - That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
    - For which the cost is covered by a federal, state or government agency (for example: Medicaid or Veterans Administration)
    - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies
- Duplicative drug therapy (e.g. two antihistamine drugs)
- Genetic care
    - Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up or the expression of the body's genes except for the correction of congenital birth defects
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section.
- Implantable drugs and associated devices except where stated above
- **Infertility**
- **Prescription drugs** used primarily for the treatment of **infertility** Injectables:
    - Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by us.
    - Needles and syringes, except those used for insulin administration.
    - For any drug, which due to its characteristics, as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

- Off-label drug use except for:
  - Indications recognized through peer-reviewed medical literature.
  - A dosage of an FDA approved drug in excess of the recommended amount for use by a patient with intractable cancer pain.
- **Drugs and medications**:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition unless dental benefits are provided under the plan.
  - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **drug guide**.
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance or, drugs obtained for use by anyone other than the member identified on the ID card.
- Replacement of lost or stolen **prescriptions**
- Tobacco cessation drugs unless recommended by the United States Preventive Services Task Force (USPSTF). See the *Coverage and exclusions – Tobacco cessation prescription and over the counter drugs, Outpatient prescription drugs* section.
- Test agents except diabetic test agents
- A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide.**
- Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide.**

How you get an emergency prescription filled

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

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

Where your schedule of benefits fits in

You are responsible for paying your part of the cost sharing. The schedule of benefits shows any benefit limitations and any out-of-pocket costs you are responsible for. Keep in mind that you are responsible

for costs not covered under this policy.

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

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

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

What precertification requirements apply

Why some drugs need precertification

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

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

How to request a medical exception

Sometimes you or your **provider** may ask for a medical exception for drugs that are not covered or for **brand-name or specialty prescription drugs** or for which health care services are denied through **precertification** or **step therapy**. You may obtain coverage without additional cost sharing beyond that which is required of formulary **prescription drugs** for a non-formulary drug if:

- We determine, after consultation with the prescribing **provider**, that the formulary drugs are inappropriate for your condition; or
- You have been taking or using the non-formulary **prescription drug** for at least six months prior to its exclusion from the formulary; and
- The prescribing **provider** determines that either the formulary drugs are inappropriate therapy for your condition, or that changing drug therapy presents a significant health risk.

You, someone who represents you, or your **provider** can contact us. You will need to provide us with the required clinical documentation. We will make a coverage determination within 72 hours, including hours on weekends, after we receive your request and any information that supports it and will tell you and your **provider** of our decision. Any exception granted is based upon an individual and is a case by case decision. For directions on how you can submit a request for a review:

- Call us or contact us through our website. For details, see the *Contract us for help* section.
- Submit your request in writing to:
  CVS Health
  ATTN: Aetna PA
  1300 E Campbell Road
  Richardson, TX, 75081

You, someone who represents you, or your **provider** may seek a quicker medical exception when the situation is urgent. It's an urgent situation when you have a health condition that may seriously affect

your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug.

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

If you are denied a medical exception based on the above processes, you may have the right to a third party review by an independent external review organization. If our claim decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send you. That notice also will describe the external review process.

Prescribing units

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

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

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

General exclusions

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

In this section we tell you about the exceptions and exclusions that apply to your policy. And just a reminder, you'll find benefit and coverage limitations in the schedule of benefits.

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

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

Examples of these are:

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

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

This exception does not apply:

- If services are **medically necessary** and you incur a charge for the expense
- For treatment of hemophilia and congenital bleeding disorders. (See the *Other services - Hemophilia and congenital bleeding disorders* and *Specific therapies and tests - Outpatient infusion therapy* sections for more information.)

Clinical trial therapies (experimental or investigational)

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

Cosmetic services and plastic surgery

- Any treatment, **surgery** (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, except where described in the *Coverage and exclusions - Reconstructive surgery and supplies* section

Court-ordered testing

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

Custodial care

Except for Hospice care **eligible health services**, examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed.
- Administering oral medications.
- Care of a stable tracheostomy (including intermittent suctioning).
- Care of a stable colostomy/ileostomy.

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

Dental care

- Except for dental services related to accidental **injury,** dental services including services related to:
  - The care, filling, removal or replacement of teeth and treatment of diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Removal of soft tissue impactions
  - Alveolectomy except where described in the *Coverage and exclusions – Oral surgery* section
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth
  - Dental implants

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts and the **eligible health services** described in the *Coverage and exclusions - Additional dental care for children and adults* and *Adult dental care* sections.

Educational services

Examples of those services are:

- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution). This exclusion does not include therapy by a licensed therapist for behavioral health services if provided on an outpatient basis as part of a wilderness treatment program.
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

This exclusion does not include the **eligible health services** described in the *Coverage and exclusions - Preventive care and wellness, Mental health treatment, Lymphedema* and *Diabetic*

equipment, supplies and education sections.

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

- **Experimental or investigational** drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (**experimental or investigational**) or covered under clinical trials (routine patient costs)

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Except for Hospice care **eligible health services**, similar institutions serving as a person's main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Foot care

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies

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

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

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

See the *Medical necessity and precertification requirements* section.

Growth/Height care

Unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies:

- 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 aids

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 over-the-counter items

- Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Other home test kits
  - Compresses
  - Over-the-counter convenience and hygienic items

Obesity (bariatric) surgery and weight management

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

Other primary payer

- Payment for a portion of the charge that Medicare 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 policy 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 where described in the *Coverage and exclusions – Outpatient private duty nursing* section.

Services provided by a family member

- Services provided by an immediate family member

Services, supplies and drugs received outside of the United States

- Non-emergency medical services, outpatient **prescription drugs** or supplies received outside of the United States. They are not covered even if they are covered in the United States under this policy.

Sexual dysfunction and enhancement

- Any treatment, **prescription drug**, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - **Surgery**, **prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services

Strength and performance

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

Telemedicine

- Services given by **providers** that are not contracted with **Aetna**
- Services including:
  - Audio-only telephone
  - Electronic mail message
  - Facsimile transmission or online questionnaire
  - Telemedicine kiosks

Therapies and tests

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

Treatment in a federal, state, or governmental entity

Except where required by **applicable law**:

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

Vision care for adults

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

Wilderness treatment programs

- See *Educational services* in this section.

Work related illness or injuries

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

Who provides the care

Just as the starting point for coverage under your policy is whether the services and supplies are **eligible health services**, the foundation for getting covered care is the network. This section tells you about **network providers**.

Network providers

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

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

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

You may select a **network provider** from the **directory** through our website. See the *How to contact us for help* section. You can search our online **directory**, for names and locations of **providers**.

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

Your PCP

We encourage you to access **eligible health services** through a **PCP**. They will provide you with primary care.

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

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

How to choose your PCP

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

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

What your PCP will do for you

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

Your **PCP** can also:

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

How to change your PCP

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

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

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

- The **provider** you have now is not in the network
- You are already a member of **Aetna** and your **provider** stops being in our network

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

	If you are a new enrollee and your provider is an out-of-network provider	**When your provider stops participation with us**
Request for approval	You need to complete a Transition of Coverage Request form and send it to us. You can get this form by calling the number on your ID card.	You or your **provider** should call us for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, at least 90 days if you are in an active course of treatment, but this may vary based on your condition.	Care will continue during a transitional period, at least 90 days if you are in an active course of treatment, but this may vary based on your condition. This date is based on the date the **provider** terminated their participation with us.

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

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

If you are determined to be terminally ill, the transitional period will continue for the remainder of your life for care directly related to the treatment of your terminal illness.

For the transitional period for a **provider** that stops participating in our network, we will authorize coverage for the transitional period in accordance with our agreement with the **provider** existing immediately before the provider stops participating. The transitional period does not apply if the **provider** has been terminated for cause.

For the transitional period for a **provider** that is not in our network, we will authorize coverage for the transitional period only if the **provider** agrees to our usual terms and conditions for contracting **providers**.

What the policy pays and what you pay

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

- Your **deductible**
- Your **copayments/coinsurance**
- Your **maximum out-of-pocket limit**

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

The general rule

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

- You pay for the entire expense up to any **deductible** limit, when a **deductible** applies.
- Then, the policy and you share the expense up to any **maximum out-of-pocket limit**. Your share is called a **copayment** or **coinsurance**.
- Then, the policy pays the entire expense after you reach your **maximum out-of-pocket limit**.

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

Important note – when your policy pays all

Your policy pays the entire expense for all **eligible health services** under the preventive care and wellness benefit.

Important note – when you pay all

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

- When you get a health care service or supply that is not **medically necessary**. See the *Medical necessity and precertification requirements* section.
- When your policy requires you or your **provider** to request **precertification**, it was requested, we refused it, and you get an **eligible health service** without **precertification**. See the *Medical necessity and precertification requirements* section.
- Usually, when you get an **eligible health service** from someone who is not a **network provider**. See the *Balance billing protection for out-of-network services* provision below and the *Who provides the care* section.

In all these cases, after all appeals have been exhausted under the *When you disagree – claim decisions and appeal procedures* section, the **provider** may require you to pay the entire charge. And any amount you pay will not count towards your **deductible** or towards your **maximum out-of-pocket limit**.

Balance billing protection for out-of-network services

You are protected from balance billing by an **out-of-network provider** for certain services.

What is balance billing?

You're responsible for certain cost-sharing amounts such as **deductibles**, **copayments** and **coinsurance** for covered services. An **out-of-network provider** may have a billed charge that exceeds the amount paid by us plus your cost-sharing amounts. A balance bill occurs if the provider bills you for payment of this balance.

When you cannot be balance billed

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

- **Emergency services** provided by an **out-of-network provider including independent freestanding emergency departments**. Your final diagnosis will not determine whether services are **emergency services**.
- Non-emergency surgical or ancillary services provided by an **out-of-network provider** at an in-network facility. This includes professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and lab services.
- Out-of-network emergency air ambulance services

We will:

- Pay the **out-of-network provider** based on a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area
- Base your in-network cost sharing requirement on what we usually pay an i**n-network provider**
- Count any amounts you are responsible for under this protection toward the in-network **maximum out-of-pocket limit**

If you pay an amount that exceeds this, the provider must refund that amount with interest. If you are billed an amount that exceeds your payment responsibility stated on your explanation of benefits or you believe you've been wrongly billed, you can file a complaint with the State Corporation Commission's Virginia Bureau of Insurance at https://scc.virginia.gov/pages/File-Complaint-Consumers or call 1-877-310-6560.

When you can be balance billed:

If you receive services from an **out-of-network provider** or facility in any other situation, you may be required to pay the entire expense. See the *Who provides the care - Network providers* section for more information.

Special financial responsibility

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

Neither you nor we are responsible for charges, expenses or costs in excess of the **negotiated charge** for **covered benefits**.

Where your schedule of benefits fits in

The schedule of benefits shows any benefit limitations that apply to your policy. It also shows any out-of-pocket costs you are responsible for when you receive **eligible health services**. And any **maximum out-of-pocket limits** that apply. We will notify you that you have met your **maximum out-of-pocket** no later than 30 days after we have paid enough claims to make that determination. You will not be required to pay cost share for eligible **covered services** for the rest of the plan year. Any amounts over your **maximum out-of-pocket** will be promptly refunded to you.

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

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

When you disagree - claim decisions and appeal procedures

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

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

Claim procedures

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

Notice	Requirement	Deadline
Notice of claim	• You should notify and request a claim form from us	• You must notify us within 20 days after a covered loss or as soon as reasonably possible.
Claim forms	• When we receive notice of claim, we will send you a claim form • The claim form will provide instructions on how to complete and where to send the form(s).	• We will send you a claim form within 15 days of receiving notice • If we don't send you a claim form within 15 days or if you are unable to complete a claim form, you must send us: – A description of services – Bill of charges – Any medical documentation you received from your **provider**
Proof of loss (a claim) When you have received a service from an eligible **provider**, you will be charged. The information you receive for that service is your proof of loss.	• A completed claim form and any additional information required by us.	• You or your **provider** must send us proof of loss within 90 days or as soon as reasonably possible. • If it was not reasonably possible, we won't void or reduce your claim if you send us notice and proof of loss as soon as reasonably possible. • In any event, unless you are legally unable to notify us, you your **provider** must send us notice and proof no later than 1 year after the 90 day deadline.

Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of claims and communicating our claim decisions

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

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

Urgent care claim

An urgent claim is one for which the doctor treating you decides prompt medical care is needed.

Pre-service claim

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

Post-service claim

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

Concurrent care claim extension

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

Concurrent care claim reduction or termination

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

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

The chart below shows the different types of claims and how much time we have to tell you about our decision.

We may need to tell your **physician** about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the **hospital**.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial decision by us	72 hours (24 hours for appeals that relate to a **prescription** to alleviate cancer pain)	15 days	15 days	24 hours for urgent request, or 72 hours if clinical information is required and received more than 24 hours after request^ 15 days for non-urgent request
Extensions	Not applicable	15 days	15 days	
If we request more information	24 hours	15 days	15 days	
Time you have to send us additional information	48 hours	45 days	45 days	

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

Adverse benefit determinations

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

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

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

The difference between a complaint and an appeal

A complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call the number on your ID card or write us. See the *How to contact us for help* section. For complaints about things handled by the Exchange, such as enrollment, you can call or write the Exchange to complain. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

An appeal

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

Appeals of adverse benefit determinations

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

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination. Or you can call the number on your ID card. You need to include:

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

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

You can appeal one time under this policy.

Urgent care or pre-service claim appeals

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

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

Timeframes for deciding an appeal

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	36 hours (24 hours for appeals that relate to a **prescription** to alleviate cancer pain)	15 days	30 days	As appropriate to type of claim
Extensions	None	None	None	

Exception request for prescription drugs

See the *Outpatient prescription drugs, How to request a medical exception* section for information on requesting and gaining access to clinically appropriate **prescription drugs** that are not covered under this plan.

Exhaustion of appeals process

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

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

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

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

The Virginia Bureau of Insurance is also available to help you at any time during the appeal process. You are not required to complete the appeals process with us before you contact them. See the *Managed Care Ombudsman* provision below for additional information.

External 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 external review only if:

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

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

You must submit the Request for External Review Form:

- To the Virginia Bureau of Insurance
- Within 120 calendar days of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

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

The Virginia Bureau of Insurance will contact the IRO that will conduct the review of your claim.

The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

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 tell you of 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 external review decision. You or your **provider** must submit a request for external review to the Virginia Bureau of Insurance.

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

Initial adverse determinations

Your treatment is for cancer or your **provider** tells the Virginia Bureau of Insurance that a delay in your receiving health care services for your medical condition would:

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

Final adverse determinations

- Your treatment is for cancer or your **provider** tells the Virginia Bureau of Insurance that a delay in your receiving health care services for your medical condition would:
  - Jeopardize your life, health or ability to regain maximum function
  - Be much less effective if not started right away (**experimental or investigational** treatment)
- The final adverse determination concerns an admission, availability of care, continued **stay** or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of the IRO's receipt of the request.

Managed Care Ombudsman

If you have any questions regarding an **appeal** or grievance concerning the health care services that you have been provided, which have not been satisfactorily addressed by us, you may contact the Office of the Managed Care Ombudsman for assistance.

Office of the Managed Care Ombudsman
Bureau of Insurance - SCC
P.O. Box 1157
Richmond, VA 23218

Toll-free: (877) 310-6560
Richmond Metropolitan Area: (804) 371-9741
E-Mail: ombudsman@scc.virginia.gov
Fax: (804) 371-9944

Virginia Department of Health, Office of Licensure and Certification

You or your **provider** can contact the Office of Licensure and Certification to file a complaint regarding quality of care, choice and accessibility of **providers**, or network adequacy. The contact information is shown below.

Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Richmond, Virginia 23233-1463

Toll free: 1-800-955-1819
Richmond Metropolitan Area: (804) 367-2104
E-mail: OLC-Complaints@vdh.virginia.gov
Fax: (804) 527-4503

Recordkeeping

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

Fees and expenses

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

Coordination of benefits (COB)

This policy does not coordinate benefits with any other policies, except for any Medicare coverage or plan you may have. That means that this policy pays benefits regardless of whatever other coverage you might have.

The Department of Medical Assistance Services is the payor of last resort.

When coverage ends

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

When coverage will end

Your coverage under this policy will end if:

- You voluntarily stop your coverage by notifying the Exchange. See the *Cancellation by the policyholder* provision below for more information.
- You no longer meet the eligibility requirements of the Exchange including moving out of the **service area**
- You do not pay the required **premium** payment by the end of the grace period
- This product is discontinued in the state, if approved by the insurance department of the state where this policy was issued
- We withdraw from the individual market in the state, if approved by the insurance department of the state where this policy was issued
- We rescind your coverage, as permitted under this policy

Cancellation by the policyholder

You may cancel this policy at any time by notifying the Exchange in writing. The cancellation will be effective on the later of the date the notice is received or the date you requested. We will promptly refund to you the prorated premium for periods after the date coverage ended. The cancellation will not affect any claims for dates of service prior to the cancellation date.

When coverage will end for any dependents

Dependent coverage will end if:

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

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

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

Notice of coverage ending

The Exchange 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 except as described below in the *Why would we end coverage* section.

When we would end coverage

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

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

Special coverage options after your coverage ends

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

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

Extending coverage for your disabled child beyond the policy age limits

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

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

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

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

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year after the 2-year period following your child's reaching the limiting age. You must send it to us within 31 days of our request. If you don't, we can end coverage for your dependent child.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this policy

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

How we administer this policy

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

Who's responsible to you

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

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

Coverage and services

Your coverage can change

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

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

Entire contract; changes

This policy, including the amendments, inserts or riders, and any attached papers, if any, forms the entire contract of insurance. No change in this policy will be valid until approved by an executive officer of the Company and is attached. No agent has authority to change this policy or to waive any of its provisions.

Financial sanctions exclusions

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

If you become eligible for Medicare

If you are eligible for Medicare Parts A, B or D, we will base our payment for **eligible health services** on the benefits covered by the Medicare part that you're eligible for. We will do this even if you are not enrolled in Medicare unless you are only eligible for Medicare due to End Stage Renal Disease (ESRD). Medicare will be the primary payor for the **eligible health 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") from your employer or your workers' compensation insurance carrier equal to the amount we paid.

You agree that you will notify us of any workers' compensation claim you make.

Legal action

No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No legal action may be brought after three years from the time written proof of loss is required to be given.

Benefits not transferable

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

Following the law

If, on the policy's effective date, language in the policy is different from the laws of the state in which the Insured resides, the policy will follow **applicable law**.

When you are no longer the policyholder

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

Child-only coverage

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

Effect of benefits under other policies

Non-duplication of benefits

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

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

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

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

Physical examinations and evaluations
At our expense, we have the right to have a **physician** of our choice examine you. This may be done as often as reasonably necessary while a claim is pending.

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

Things that would be important to keep are:

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

Honest mistakes and intentional misrepresentation
Honest mistakes
If a misstatement is made regarding a covered person's age, **eligible health services** will be based on the correct age.

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

- Loss of coverage, starting at the effective date of coverage
- Loss of coverage going forward
- Denial of benefits
- Recovery of amounts we already paid

You have special rights if you lose coverage. We will give you 30 days advanced written notice of any loss of coverage. The notice will:

- Cleary identify the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact
- Explain why the act, practice, or omission was fraud, an omission or an intentional misrepresentation of a material fact
- Advise you that you or your authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission
- Describe the internal appeal process for rescissions, including any time limits
- Include the date when date when the advance notice ends and provide the date back to which the coverage will be rescinded
- We will refund you all premiums you paid.

You have the right to an **Aetna** appeal. See *When you disagree - claim decisions and appeal procedures* for information on how to submit an appeal.

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. If services are related to balance

billing protection, we will always pay the **out-of-network provider** and not require an assignment of benefits. If we pay you, you are responsible for applying any payment to the claim from the **out-of-network provider**. Except for dental, oral surgery or **ambulance** services, we will not accept an assignment to an **out-of-network provider**.

Recovery of overpayments

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

Your health information

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

Glossary

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

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

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

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

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

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

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

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

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

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

Custodial care
Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be **custodial care** even if it is prescribed by a **physician** or given by trained medical personnel. Custodial care does not include Hospice care **eligible health services.**

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

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

Dental provider
A **physician**, **dentist**, specialty **dentist**, person, or facility licensed by **applicable law** to provide dental care services.

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

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

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

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

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

You can also call the toll-free number on your ID card to request a printed directory.

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

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

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

Effective date of coverage
The date the policyholder's coverage begins under this policy.

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

Emergency medical condition
Regardless of the final diagnosis, a severe medical condition showing itself by severe symptoms including severe pain that would lead a prudent layperson to reasonably believe that the condition, **illness**, or **injury** is of an urgent nature. And that if you don't get immediate medical care it could result in:

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

Emergency services
A medical screening examination given in a **hospital's** emergency room or a freestanding emergency facility to evaluate an **emergency medical condition**. This includes any additional medical examination and treatment to stabilize the patient.

Stabilize means providing treatment that guarantees the condition will not get worse as a result of or during the transfer of the individual from a facility. For a pregnant woman, stabilize also means that the woman has delivered, including the placenta.

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

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

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

- Dosage
- Safety

- Strength
- Quality
- Performance

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

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

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

Hospice care
Supportive care designed to provide physical, psychological, psychosocial or other health care services to people who have been diagnosed with a **terminal illness** and whose medical prognosis is death within six month. The focus of care is on comfort and quality of life, rather than cure.

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

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

Hospice facility
An institution specifically licensed, certified or otherwise authorized by **applicable law** to provide **hospice care**.

Hospital
An institution licensed as a **hospital** by **applicable law** and accredited as a **hospital** by The Joint Commission (TJC).

Hospital does not include a:
- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility** behavioral health

- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

Illness
A sickness or disease of the body or mind.

Infertile, infertility
A disease defined by the failure to become pregnant:

- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart
- Because an individual or their partner has been clinically diagnosed with gender identity disorder

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

Intensive outpatient program (IOP)
Services designed to address a **mental health disorder** or **substance use disorder** issue and may include group, individual, family or multi-family group psychotherapy, psycho-educational services, and adjunctive services such as medication monitoring. Clinical treatment provided must be a minimum of 3 hours each treatment day. Services must be **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials.

A adverse medical necessity determination is subject to our appeals procedure. See the *When you disagree – claim decisions and appeal procedures* section of this policy.

Jaw joint disorder
This is:

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

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

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

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

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

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease
- Not primarily for the convenience of the patient, **physician** or other health care **provider**

Generally accepted standards of medical practice means:

- Standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Consistent with the standards set forth in policy issues involving clinical judgment

An adverse medical necessity determination is subject to our appeals procedure. See the *When you disagree – claim decisions and appeal procedures* section of this policy.

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

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

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

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

Negotiated charge
For health coverage, this is either:

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

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

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

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

Some of these arrangements are called:

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

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

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

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

Network provider

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

Network pharmacy

A **retail**, **mail order** or **specialty pharmacy** that has contracted with us, an affiliate or a third party vendor to provide outpatient **prescription drugs** to you. **Network pharmacies** include **out-of-network** pharmacies or its intermediary that have agreed by fax or otherwise to accept our payment at our contracted level as payment in full.

Non-preferred drug

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

Out-of-network provider

A **provider** who is not a **network provider**.

Partial hospitalization treatment

Clinical treatment provided must be a minimum of 6 hours each treatment day in a licensed or approved day or evening treatment program. Services must be **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental health disorder** or **substance use disorders** issue and may include:

- Diagnostic evaluation
- Medical, psychiatric and psychological care
- Group, individual, family or multi-family group psychotherapy
    - Mental, emotional or nervous disorders
    - Alcohol or other drug dependence
    - Rendered by a :
    - Hospital
    - Alcohol or drug rehabilitation facility
    - Intermediate care facility
    - Mental health treatment facility
    - Physician
    - Psychologist
    - Clinical psychologist
    - Licensed clinical social worker
    - Licensed professional counselor
    - Licensed substance abuse treatment practitioner
    - Licensed marriage and family therapist
    - Clinical nurse specialist
- Psycho-educational services
- Adjunctive services such as medication monitoring
- Counseling and rehabilitation for the treatment of physiological or psychological dependence on alcohol or other drugs

Partial hospitalization treatment also includes intensive outpatient programs for the treatment of alcohol or other drug dependence provided over a period of 3 or more continuous hours per day to individuals or groups.

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

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

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

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

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

Premium

The amount you are required to pay to us for your coverage.

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

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

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

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

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

Primary care physician (PCP)
A **physician** who:

- The **directory** lists as a **PCP**
- Supervises, coordinates and provides initial care and basic medical services to a person as a general practitioner, family care **physician**, an internist, pediatrician or an OB, GYN and OB/GYN
- Is shown on our records as your **PCP**

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

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

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

R.N.
A registered nurse.

Remote patient monitoring

The delivery of home health services using telecommunications technology to enhance the delivery of home health care, including:

- Monitoring of clinical patient data such as:
  - Weight
  - Blood pressure
  - Pulse
  - Pulse oximetry
  - Blood glucose
  - Other condition-specific data
- Medication adherence monitoring
- Interactive video conferencing with or without digital image upload

Residential treatment facility (mental health disorders)

An institution specifically licensed as a **residential treatment facility** by **applicable law** to provide for mental health residential treatment programs. And is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

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

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

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

Residential treatment facility (substance use disorders)

An institution specifically licensed as a **residential treatment facility** by **applicable law** to provide for **substance use disorders** residential treatment programs. And is credentialed by us or accredited by one of the following agencies, commissions or committees for the services being provided:

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

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

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

residential treatment facility or otherwise licensed institution)

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

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

Retail pharmacy

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

Room and board

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

Room and board includes the following **eligible health services**:

- Bed
- Meals
- Special diets
- **Semi-private room rate**
- Private room when **medically necessary**

Semi-private room rate

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

Service area

The geographic area where **network providers** for this policy are located. The **service area** for your plan includes Amelia, Chesterfield, Goochland, Hanover, Henrico, New Kent and Powhatan counties and Richmond City Botetourt, Franklin, Montgomery, Radford and Roanoke counties and Roanoke City and Salem. Please call the toll-free number on your ID card to request a printed copy of the **service area**.

Skilled nursing facility

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

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

Except for **hospice care**, **skilled nursing facility** does not include institutions that provide only:

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

Skilled nursing services

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

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

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

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

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

Step therapy
A form of **precertification** where you must try one or more prerequisite drug(s) before a step therapy drug is covered. The prerequisite drugs have FDA approval, may cost less and treat the same condition. If you don't try the appropriate prerequisite drug first, you may need to pay full cost for the step therapy drug. You will find the **step therapy prescription drugs** on the **drug guide**. For the most up-to-date information, call us or go online. See the *How to contact us for help* section for details.

Substance use disorder
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association.

Surgery center
A facility specifically licensed as a freestanding ambulatory surgical facility by **applicable law** to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

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

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

It also includes:

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

Telemedicine

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

- Diagnosing or treating a patient
- **Remote patient monitoring** services for delivery of home health services
- Consulting with other health care **providers** regarding a patient's diagnosis or treatment

Services can be provided by:

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

Terminal illness

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

Urgent care facility

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

Urgent condition

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

Walk-in clinic

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

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

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

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

Wellness and other incentives

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

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

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health status.

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

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

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

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

Notice Regarding Women's Health and Cancer Rights Act

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

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

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

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

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

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

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

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

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

Confidentiality Notice

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

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

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

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

Exclusive provider organization (EPO)
Medical policy

Schedule of benefits

Underwritten by Aetna Life Insurance Company in the Commonwealth of Virginia

Schedule of benefits

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

How to read your schedule of benefits

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

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

How your deductible works

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

How your maximum out-of-pocket limit works

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

How to contact us for help

We are here to answer your questions.

- Log in to the Aetna website at **Aetna.com**
- Call the number on your ID card

Aetna Life Insurance Company's policy provides the coverage described in this schedule of benefits**.** This schedule replaces any schedule of benefits previously in use. Keep it with your policy.

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

Deductible

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

Deductible	In-network
Individual	$3,300
Family	$6,600

Deductible waiver

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

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

Maximum out-of-pocket limit

Maximum out-of-pocket limit	In-network
Individual	$6,800
Family	$13,600

General coverage provisions

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

Deductible provisions

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

Individual deductible

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

Family deductible

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

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

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

Deductible credit

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

Maximum out-of-pocket limit provisions

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

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

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

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

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

If the **maximum out-of-pocket limit** does not apply to a **covered benefit**, your cost share for that **covered benefit** will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-covered services
- Any out of pocket costs incurred for non-urgent use of an urgent care **provider**

Your financial responsibility and decisions regarding benefits

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

Eligible health services

1. Preventive care and wellness

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

Preventive care and wellness includes:

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

Preventive care and wellness limits

Routine physical exams

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

Preventive care immunizations

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

Well woman preventive visits

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

Preventive screening and counseling services
Limits are per 12 months unless stated below:

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

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

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

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

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

Comprehensive lactation support and counseling services

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

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

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

2. Physicians and other health professionals

Physician services

Description	In-network
Office hours visits (non-surgical) non preventive care	$20 **copay**, no **deductible** applies
Telemedicine consultation by a **physician**	Covered based on the type of service and where it is received

Specialist office visits

Description	In-network
Office hours visit (non-surgical)	$50 **copay**, no **deductible** applies

Telemedicine

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

Allergy injections

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

Allergy testing and treatment

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

Immunizations that are not considered preventive care

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

Medical injectables

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

Physician surgical services

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

Alternatives to physician office visits

Walk-in clinic visits

Description	Designated in-network	Non-designated in-network
Non-emergency services	0%, no **deductible** applies	$20 **copay**, no **deductible** applies
Telemedicine consultation for non-emergency services through a **walk-in clinic**	0%, no **deductible** applies	$20 **copay**, no **deductible** applies
Preventive care immunizations	0%, no **deductible** applies	0%, no **deductible** applies

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

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

Preventive screening and counseling services at a walk-in clinic
Includes obesity and/or healthy diet counseling, use of tobacco products

Description	Designated in-network	Non-designated in-network
Preventive screening and counseling services	0%, no **deductible** applies	0%, no **deductible** applies
Telemedicine consultation for preventive screening and counseling services through a **walk-in clinic**	0%, no **deductible** applies	0%, no **deductible** applies

Limits

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

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

3. Hospital and other facility care

Hospital care

Description	In-network
Inpatient **hospital**	40% after **deductible**
Inpatient **physician** services	40% after **deductible**

Alternatives to hospital stays

Outpatient surgery

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

Home health care

Description	In-network
Outpatient	40% after **deductible**
Visit limit per year	Coverage is limited to 100 visits per **calendar year**

Important note:
Limited to 3 intermittent visits per day provided by a participating **home health care agency**. 1 visit equals a period of 4 hours or less. Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow coverage for up to12 hours with a daily maximum of 3 visits.

Hospice care

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

Skilled nursing facility

Description	In-network
Inpatient facility	40% after **deductible**
Day limit per year	Coverage is limited to 100 days per admission

Private duty nursing

Description	In-network coverage
Outpatient private duty nursing	50% after **deductible**
Limit per year	Coverage is limited to 16 hours per **calendar year**

4. Emergency services and urgent care

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

Description	In-network
Hospital emergency room	40% after **deductible**
Non-emergency care in a **hospital** emergency room	40% after **deductible**

Important note:

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

Description	In-network coverage
Urgent medical care at an urgent care facility	$50 **copay**, no **deductible** applies
Non-urgent use of an urgent care **provider**	Not covered

6. Specific conditions

Autism spectrum disorder

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

Diabetic equipment, supplies and education

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

Family planning services - other

Inpatient services

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

Outpatient services

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

Jaw joint disorder treatment

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

Maternity and related newborn care

Prenatal care services

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

Delivery services and postpartum care services

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

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

Behavioral health

Mental health treatment

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

Description	In-network
Inpatient **mental health** treatment Inpatient **residential treatment facility**	40% after **deductible**
Other inpatient mental health treatment services and supplies Other inpatient **residential treatment facility** services and supplies	40% after **deductible**
Outpatient mental health treatment visits to a **physician** or **behavioral health provider**	$20 **copay**, no **deductible** applies
Outpatient mental health **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	$0 **copay**, no **deductible** applies
Outpatient mental health **telemedicine** visit	Covered based on the type of service and where it is received

Description	In-network
Other outpatient mental health treatment or skilled behavioral health services in the home, **partial hospitalization treatment** and **intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services, after you meet your **deductible**	40% after **deductible**

Substance use disorders treatment
Coverage provided under the same terms, conditions as any other **illness**.

Description	In-network
Inpatient **substance use disorders detoxification** Inpatient **substance use disorders** rehabilitation Inpatient **substance use disorders** treatment in **residential treatment facility**	40% after **deductible**
Other inpatient **substance use disorders detoxification** services and supplies Other inpatient **substance use disorders** rehabilitation services and supplies Other inpatient **substance use disorders residential treatment facility** services and supplies	40% after **deductible**
Outpatient **substance use disorders** treatment visits to a **physician** or **behavioral health provider**	$20 **copay**, no **deductible** applies
Outpatient **substance use disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	$0 **copay**, no **deductible** applies
Outpatient **substance use disorders telemedicine** visit	Covered based on the type of service and where it is received
Other outpatient **substance use disorders** services or **partial hospitalization treatment** and **intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services, after you meet your **deductible**	40% after **deductible**

Reconstructive breast surgery

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

Reconstructive surgery and supplies

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

Transplant services

Description	Network (Exchange IOE facility)	Out-of-network (Includes providers who are otherwise part of Aetna's network but are non-Exchange IOE providers)
Services and supplies	Coverage limited to IOE only Covered based on the type of service and where it is received	Not covered

Treatment of infertility

Basic infertility services

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

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

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

Diagnostic lab work

Description	In-network
Performed at a facility	$25 **copay**, no **deductible** applies
Performed at **physician** office	40% after **deductible**
Performed at **specialist** office	40% after **deductible**

Diagnostic radiological services (X-ray)

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

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

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

Outpatient therapies

Chemotherapy

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

Outpatient infusion therapy

Description	In-network
Performed in a **physician** office or in a person's home	$50 **copay**, no **deductible** applies
Performed in outpatient facility	40% after **deductible**

Radiation therapy

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

Specialty prescription drugs

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

Cardiac and pulmonary rehabilitation services

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

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

Rehabilitation therapy services

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

Outpatient physical therapy

Description	In-network
Physical therapy	40% after **deductible**
Visit limit per year	Coverage is limited to 30 visits per calendar year PT and OT combined, separate from habilitation and includes all outpatient places of service for PT and OT

Outpatient occupational therapy

Description	In-network
Occupational therapy	40% after **deductible**
Visit limit per year	Coverage is limited to 30 visits per calendar year PT and OT combined, separate from habilitation and includes all outpatient places of service for PT and OT

Outpatient speech therapy

Description	In-network
Speech therapy	40% after **deductible**
Visit limit per year	Coverage is limited to 30 visits per calendar year, separate from habilitation and includes all outpatient places of service for ST.

Habilitation therapy services

Description	In-network
Physical, occupational, speech and chiropractic/ osteopathic/ manipulation therapies	40% after **deductible**
Visit limit per year	None

Early intervention services

Description	In-network
Early intervention services for children from birth up to age 3	$50 **copay**, no **deductible** applies

8. Other services

Acupuncture

Description	In-network
Acupuncture	$20 **copay**, no **deductible** applies
Visit limit per year	Coverage is limited to 10 visits per **calendar year**

Ambulance service

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

Clinical trial therapies (experimental or investigational)

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

Durable medical equipment (DME)

Description	In-network
DME	50% after **deductible**
Limit per year	None

Nutritional support

Description	In-network
Formula and enteral nutrition products	0%, no **deductible** applies

Prosthetic devices

Description	In-network
Prosthetic devices	30% after **deductible**

Spinal manipulation

Description	In-network
Spinal manipulation	40% after **deductible**
Visit limit per year	Coverage is limited to 30 visits per calendar year, separate from habilitation and includes all outpatient places of service for Chiro.

Important note:
See the *Habilitation therapy services* benefit described above for the cost share and limits that apply to habilitative chiropractic /osteopathic/ manipulation therapy.

Vision care

Pediatric vision care

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

Routine vision exams (including refraction)

Description	In-network
Performed by an ophthalmologist or optometrist	50% after **deductible**
Visit limit per year	Coverage is limited to 1 visit every 12 months

Vision care services and supplies

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

Limits

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

Important note:

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

9. Outpatient prescription drugs

Plan features - maximums and limits

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

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

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

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

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

Per prescription cost share

Tier 1 -- preferred generic prescription drugs

Description	In-network
For each 30 day supply filled at a retail pharmacy	$10 copay no deductible applies
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a retail pharmacy or mail order pharmacy	$25 copay no deductible applies

Tier 2 -- preferred brand-name prescription drugs

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

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

Description	In-network
For each 30 day supply filled at a retail pharmacy	40% after deductible
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a retail pharmacy or mail order pharmacy	40% after deductible

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

Tier 4 -- Specialty prescription drugs

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

Diabetic supplies and insulin

Description	**In-network**
For each 30 day supply filled at a **retail pharmacy**	Paid according to the tier of drug in the schedule of benefits, above
Description	**In-network**
For each 30 day supply filled at a **specialty network pharmacy**	50% after **deductible**

Important note:
Your cost share will not exceed $50 per 30 day supply of a covered **prescription** insulin drug filled at a **network pharmacy**.

Orally administered anti-cancer medications

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

Outpatient contraceptive prescription drugs and devices

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

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

Preventive care drugs and supplements

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

Risk reducing breast cancer prescription drugs

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

Tobacco cessation prescription and over-the-counter drugs

Description	In-network
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill, no **deductible** applies
Limit	• **Two, 90-day treatment programs only. Any additional treatment programs will be paid according to the tier of drug per the schedule of benefits, above.** • **Coverage only includes generic prescription drug when there is also a brand-name drug available.** • **Coverage is subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, see the How to contact us for help section.**

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

If you or your **prescriber** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the cost share that applies to **brand-name prescription drugs**. The cost difference does not apply toward your **deductible** or **maximum out-of-pocket limit**, if you have one.