Exclusive Provider Organization (EPO) Medical Plan

Booklet-Certificate

[**Plan name:** **xxxxxxx**]
[**PPID:** **xxxxxxx**]

Underwritten by Aetna Life Insurance Company in the District of Columbia

Welcome

Thank you for choosing **Aetna**.

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

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

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

We agree with the **policyholder** to provide coverage for benefits through the DC Health Benefit Exchange (the Exchange), in agreement with the conditions and rights as set forth in this certificate and by the Exchange and/or the District of Columbia Department of Insurance, Securities and Banking and, if applicable, the Federal Department of Health and Human Services (the Department). Members covered under this certificate agree to all the requirements of the group policy.

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** plan for coverage.

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

Welcome to your **Aetna** plan.

Table of Contents

Let's get started!

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

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

What your plan does – providing covered benefits

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

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section. Coverage is not provided for any services received before coverage starts or after coverage ends.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

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

How your plan 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 plan won't always cover the services you want. Sometimes it doesn't cover health care services your doctor will want you to have.

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

- They appear in the *Eligible health services under your plan* section.
- They are not listed in the *What your plan doesn't cover – eligible health service exceptions and exclusions* section. (We will refer to this section as the "*Exceptions*" section in the rest

of this booklet-certificate.)
- 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 into your Aetna secure member website at www.aetna.com

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 plan 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 plan generally pays for **eligible health services** only within a specific geographic area, called a **service area**. There are some exceptions, such as for **emergency services** 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 services**, **urgent conditions**, and transplants for both medical and **pharmacy** services.

4. Paying for eligible health services– the general requirements

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

- The **eligible health service** is **medically necessary**
- You get the **eligible health service** from a **network provider**
- 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 plan and you will share the expense of your **eligible health services** when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense; and sometimes you will. For more information

see the *What the plan pays and what you pay* section, and see the schedule of benefits.

6. Disagreements

We know that people sometimes see things differently.

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

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

How to contact us for help

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

- Logging on to your Aetna secure member website at www.aetna.com.
- Register for our secure Internet access to reliable health information, tools and resources. Aetna online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

You can also contact us by:

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

Your member ID card

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

We will mail you your ID card. If you haven't received it before you need **eligible health services**, or if you've lost it, you can print a temporary ID card. Just log into your Aetna secure member website at www.aetna.com.

Who the plan covers

Coverage under this plan is provided because of your employer's application through the Exchange. The eligibility process and enrollment process are subject to any rules or other standards of the Exchange and/or the District of Columbia Department of Insurance, Securities and Banking.

You will find information in this section about:

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

Who is eligible

You can enroll if you:

- Live or work in the **service area**
- Meet all required eligibility requirements agreed upon by the **policyholder** and **Aetna**
- Are approved by the Exchange

When you can join the plan

As an employee you can enroll if you live or work in the **service area**:

- At the end of any waiting period your employer requires
- Once each **calendar year** during the annual enrollment period
- At other special times during the year (see the *Special times you can join the plan* section below)

If you do not enroll when you first qualify for health benefits, you may have to wait until the next annual enrollment period to join.

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

If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are your "dependents".)

- Your legal spouse
- [Your civil union partner]
- [Your domestic partner who meets eligibility rules set by your employer and requirements under state law]
- Your dependent children – your own or those of your [spouse, civil union partner, domestic partner]

  The children must be under 26 years of age and they include your:
  - Biological children
  - Stepchildren
  - Legally adopted children, including any children placed with you for adoption
  - 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 other child with whom you have a parent-child relationship]

- Any children approved by the Exchange

Effective date of coverage

The Exchange tells you when your coverage will be in effect.

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

You can't have coverage as an employee and a dependent and you can't be covered as a dependent of more than one employee on the plan.

Adding new dependents

If your plan includes coverage for dependents, you can add the following new dependents to your plan:

- A spouse - If you marry, you can put your spouse on your plan.
  - The Exchange must receive your completed enrollment information not more than 30 days after the date of your marriage.
  - Ask your employer when benefits for your spouse will begin:
    - If the Exchange receives your completed enrollment information by the 15th of the month, coverage will be effective no later than the first day of the following month.
    - If the Exchange receives your completed enrollment information between the 16th and the last day of the month, coverage will be effective no later than the first day of the second month.
- [A civil union partner – If you enter into a civil union, you can enroll your civil union partner on your plan.
  - The Exchange must receive your completed enrollment information not more than 30 days after the date of your civil union.
  - Ask your employer when benefits for your partner will begin. It will be either on the date your civil union is filed or the first day of the month following the qualifying event date.]
- [A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your plan. See *Who can be on your plan (Who can be your dependent)* section for more information.
  - The Exchange must receive your completed enrollment information not more than 30 days after the date you file a Declaration of Domestic Partnership, or not later than 30 days after you provide documentation required by your employer.
  - Ask your employer when benefits for your domestic partner will begin. It will be on the date your Declaration of Domestic Partnership is filed or the first day of the month following the qualifying event date.]
- A newborn child - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, the Exchange must receive your completed enrollment information within 30 days of birth.
  - You must still enroll the child within 30 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.

- If you miss this deadline, your newborn will not have health benefits after the first 31 days.

- An adopted child - You may put an adopted child on your plan 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.
  - You must complete your enrollment information and send it to the Exchange within 30 days after the adoption or the date the child was placed for adoption.
  - Ask your employer when benefits for your adopted child will begin. It is usually the date of the adoption (or placement) or the first day of the month following adoption (or placement).
- A foster child – You may put a foster child on your plan when you have obtained legal responsibility as a foster parent. A foster child is a child whose care, comfort, education and upbringing is left to persons other than the natural parents.
  - You must complete your enrollment information and send it to the Exchange within 30 days after the date the child is placed with you.
  - Ask your employer when benefits for your foster child will begin. It is usually the date you legally become a foster parent or the first day of the month following this event.
- A stepchild - You may put a child of your [spouse, civil union partner, domestic partner] on your plan.
  - You must complete your enrollment information and send it to the Exchange within 30 days after the date of your [marriage, civil union, declaration of domestic partnership] with your stepchild’s parent.
  - Ask your employer when benefits for your stepchild will begin. It is the date of your [marriage, civil union, declaration of domestic partnership] or the first day of the month following the qualifying event date.
- Court order – You can put a child you are responsible for under a qualified medical support order or court order on your plan.
  - You must complete your enrollment information and send it to the Exchange within 30 days after the date of the court order.
  - Ask your employer when benefits for the child will begin. It is usually the date of the court order or the first day of the month following the qualifying event date.

Inform the Exchange of any changes

If there are any changes which will affect you or your covered dependent’s eligibility, you must contact the Exchange within 30 days of the date of the change. This may include changes in:

- Address
- Phone number
- Marital status
- Dependent status

Special times you can join the plan

Federal law allows you and your dependents, if your plan includes coverage for dependents, to enroll at times other than your employer’s annual open enrollment period. This is called a special or limited enrollment period.

You can enroll in these situations when:

- You have lost minimum essential coverage.
- You have added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section for more information.
- You or your dependent's enrollment or non-enrollment in a plan through the Health Insurance Marketplace was not intended, by accident or a mistake, and is because of an error, false information or delay by the marketplace.
- [You or your dependent have proven to the marketplace that their plan did not honor or maintain an important provision of its contract with you or that you meet other unusual circumstances.]
- You or your dependent qualify for access to 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 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 did not enroll in this plan before because:
    - You were covered by another health plan, and now that other coverage has ended.
    - You had COBRA, and now that other coverage has ended .
- A court orders you to cover a current spouse[, civil union partner, domestic partner] or a child on your health plan.
- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan.
- 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.

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

- You lose your eligibility for enrollment in Medicaid or an S-CHIP plan Medicaid
- You 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

Effective date of coverage

Your coverage will be in effect based on when the Exchange receives your completed enrollment application:

- 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 plan is whether the services and supplies are **eligible health services**. See the *Eligible health services under your plan* and *Exceptions* sections plus the schedule of benefits.

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

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

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

Medically necessary; medical necessity

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

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

The fact that a **physician** may prescribe, authorize, or direct a service does not of itself make it **medically necessary** or covered by the group agreement.

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 *Eligible health services under your plan – 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 plan won't pay for it. You will find details on requirements in the *What the plan pays and what you pay - Important note – when you pay all* section.

Eligible health services under your plan

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

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

For example:

- **Physician** care generally is covered but **physician** care for **cosmetic surgery** is never covered. This is an exclusion.
- Home health care is generally covered but it is a **covered benefit** only up to a set number of visits a year. This is a limitation.

You can find out about exclusions in the *Exceptions* 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 plan when you are well.

Important notes:

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

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

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

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

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

Routine physical exams

Eligible health services include office visits to your **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 diseases
        - Human Immune Deficiency Virus (HIV) infections
    - Screening for gestational diabetes for women
    - High risk Human Papillomavirus (HPV) DNA testing for women
- Radiological services, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** checkup.

Preventive care immunizations

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

Preventive health care services for children

Eligible health services include:

- A review and written record of complete medical history
- Taking measurements and blood pressure
- Developmental and behavioral assessment
- Vision screening
- Hearing screening, including a newborn hearing screening before discharge from the hospital, by an audiologist, otolaryngologist, or other qualified person, and includes at least one of the following tests:
    - Auditory brain stem response
    - Otoacustic emissions
    - Other appropriate nationally recognized, objective physiological screening tests
- Immunizations
- Preventive help
- Other diagnostic screening tests including:

  - One set of hereditary and metabolic tests performed at birth;
  - Urinalysis, tuberculin test, and blood tests to screen for sickle hemoglobinopathy
- Instructions and help for the child and the parents or guardian on the results of the physical exam
- Necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and prematurity

Covered benefits will only include charges for:
- An exam at birth
- All exams during the first 12 years of the child's life
- 3 exams per year to age 22

Eligible health services do not include:
- Diagnosis or treatment of **injury** or **illness**
- Exams during a **hospital** or other facility stay, except as stated above
- Medicines, drugs, appliances, equipment or supplies, except as stated above
- Dental exams
- Exams for employment
- Exams before marriage

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

Preventive screening and counseling services

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

- **Obesity and/or healthy diet counseling**
  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling visits provided in connection with Hyperlipidemia (high

cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**
  Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment
- **Use of tobacco products**
  Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:
  - Preventive counseling visits
  - Treatment visits
  - Class visits

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

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms, baseline and annual
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure and a pathology exam on any removed polyp
- Lung cancer screenings

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

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

Prenatal care

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

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

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

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

Comprehensive lactation support and counseling services

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

Breast feeding durable medical equipment

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

Breast pump

Eligible health services include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**.
- The buying of either:
  - An electric breast pump (non-**hospital** grade). Your plan will cover this cost once every 36 months.
  - A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous 36 month period, the purchase of another electric breast pump will not be covered until one of these things happens:

- A 36 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.

[Drafting note: As permitted by regulation, the family planning services benefit below is removed for group health plans sponsored by certain religious employers and eligible organizations, and group health insurance coverage in connection with such plans that are exempt from the ACA requirement to cover contraceptive services.]

[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.]

[Drafting note: Remove third bullet below in important note when family planning services is not included under the plan.]

Important note:
See the following sections for more information:

- *Family planning services – other*
- *Maternity and related newborn care*
- *[Outpatient prescription drugs - preventive contraceptives]*
- *Treatment of basic infertility*

2. Physicians and other health professionals

Physician services

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

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

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

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

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

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

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

Physician surgical services

Eligible health services include the services of:

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

Alternatives to physician office visits

Walk-in clinic

Eligible health services include health care services provided at **walk-in clinics** for:

- Unscheduled, non-medical emergency **illnesses** and **injuries**
- The administration of immunizations administered within the scope of the clinic's license
- Individual screening and counseling services that will help you:
  - In weight reduction due to obesity and/or healthy diet
  - To stop the use of tobacco products

3. Hospital and other facility care

Hospital care

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

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

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

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 plan will pay only for **physician** services and not for a separate fee for facilities.

Home health care

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

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

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

for more information on the intermittent requirement.

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

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

Hospice care

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

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

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

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

- A **physician** for consultation or case management
- A physical or occupational therapist
- Bereavement counseling for the caregiver or immediate family for:
  - Six (6) months after member's death; or
  - Fifteen (15) visits, whichever occurs first
- A **home health care agency** for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient **prescription drugs**
  - Psychological counseling
  - Dietary counseling

Skilled nursing facility

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

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

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

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

- The **skilled nursing facility** admission will take the place of:
  - An admission to a **hospital** or sub-acute facility
  - A continued **stay** in a **hospital** or sub-acute facility
- There is a reasonable expectation that your condition will improve enough to go home within a reasonable amount of time

- The **illness** or **injury** is severe enough to require constant or frequent skilled nursing care on a 24-hour basis

4. Emergency services and urgent care

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

As always, you can get **emergency services** from **network providers**. However, you can also get **emergency services** from **out-of-network providers**. Your coverage for **emergency services** and urgent care from **out-of-network providers** ends when the attending **physician** and we determine that you are medically able to travel or to be transported to a **network provider** if you need more care.

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

In case of a medical emergency

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

Emergency department HIV screening

Eligible health services include the cost of one annual voluntary HIV screening tests performed while receiving **emergency services**, other than HIV screening, in a **hospital** emergency room.

The cost associated with administering the HIV screening tests will include:

- Laboratory expenses to analyze the test
- Communicating to the patient the results of the test
- Any follow-up instructions for obtaining health care and supportive services

Coverage is not subject to any annual or coinsurance deductible or any co-payment other than the co-payment that the insured would have to pay for the applicable hospital emergency department visit.

Non-emergency condition

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits and the *Exceptions* and *Glossary* sections for specific information.

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

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

5. Pediatric dental care

Eligible health services include dental services and supplies provided by a **dental provider**. The **eligible health services** are those listed in the pediatric dental care section of the schedule of benefits. We have grouped them as Type A, B and C, and orthodontic treatment services in the schedule of benefits.

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

A dental emergency is any dental condition which:

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

The plan pays a benefit up to the dental emergency maximum shown in the schedule of benefits.

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

What rules and limits apply to dental care?

Several rules apply to the dental benefits. Following these rules will help you use the plan to your advantage by avoiding expenses that are not covered by the plan.

When does your plan cover orthodontic treatment?

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

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

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

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

When does your plan cover replacements?

The plan's "replacement rule" applies to:

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

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

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

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

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

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

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

An advance claim review

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

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

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

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

When to get an advance claim review

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

1. Ask your **dental provider** to write down a full description of the treatment you need. To do this, they must use an **Aetna** claim form or an American Dental Association (ADA) approved claim form.
2. Your **dental provider** should send the form to us before treating you.
3. We may request supporting images and other dental records.
4. Once we have received all the information we need, we will review your **dental provider's** plan. We will give you and your **dental provider** a statement of the benefits payable.
5. You and your **dental provider** can then decide how to proceed.

What is a course of dental treatment?

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

6. Specific conditions

Autism spectrum disorder

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

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

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

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

Important note:
Applied behavior analysis requires **precertification** by **Aetna**. The **network provider** is responsible for obtaining **precertification**.

Diabetic equipment, supplies and education

Eligible health services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Diabetic needles, syringes and pens
  - Test strips – blood glucose, ketone and urine
  - Injection aids for the blind
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Education
  - Self-management training and education provided by a health care **provider** certified in diabetes self-management training and education

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

[Drafting note: Remove the entire topic for groups with religious objections. For all other groups: 1.) include the topic; 2.) include the second bullet for plan designs that cover abortion services.]

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]]

Jaw joint disorder treatment

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

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- Involving the relationship between the jaw joint and related muscles and nerves such as myofascial pain dysfunction (MPD)
- Surgical treatment for temporomandibular joint dysfunction (TMJ) syndrome, when there is clear radiographic evidence of joint abnormality

Maternity and related newborn care

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

- A minimum of 48 hours of inpatient care in a **hospital** after a vaginal delivery
- A minimum of 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier
- Newborn hearing screening before being discharged from the hospital, by an audiologists, otolaryngologists, or other qualified person, which includes at least one of the following tests:
  - Auditory brain stem response
  - Otoacustic emissions
  - Other appropriate nationally recognized, objective physiological screening tests.

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

Mental health treatment

Eligible health services include the treatment of clinically significant **mental 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**, and other services and supplies related to your condition provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Other outpatient mental health treatment such as:
    - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound

        - Your **physician** orders them
        - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
        - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23 hour observation
    - Peer counseling support by a peer support specialist

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

Substance related disorders treatment

Eligible health services include the treatment of clinically significant **substance abuse** 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** and other services and supplies provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility**. Treatment of **substance abuse** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance abuse** section or unit, unless you are admitted for the treatment of medical complications of **substance abuse**.

As used here, "medical complications" include, but are not limited to, **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- 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 abuse** treatment such as:
        - Outpatient detoxification
        - **Partial hospitalization treatment** provided in a facility or program for **substance abuse** treatment provided under the direction of a **physician**
        - **Intensive outpatient program** provided in a facility or program for **substance abuse** treatment provided under the direction of a **physician**
        - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications
        - Treatment of withdrawal symptoms
        - 23 hour observation

- Peer counseling support by a peer support specialist

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

Reconstructive surgery and supplies

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

- Your **surgery** reconstructs the breast where a medically necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it even with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema, and prostheses.
- Your **surgery** corrects an accidental **injury**. The **surgery** must be performed as soon as medically feasible. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected. **Surgery** to fix teeth injured due to an accident is covered when:
  - Teeth are sound natural teeth. This means the teeth were stable, functional and free from decay or disease at the time of the **injury**.
  - The **surgery** returns the injured teeth to how they functioned before the accident.
- Your **surgery** is needed to improve a significant functional impairment of a body part.
- Your **surgery** corrects a gross anatomical defect present at birth or appearing after birth (but not the result of an **illness** or **injury**). The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - The purpose of the **surgery** is to improve function

Transplant services

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

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T-cell receptor therapy for FDA approved treatments

Network of transplant facilities

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

You must get transplant services from the IOE facility we designate to perform the transplant you need.

Important note:
Many pre and post transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant is being coordinated by the National Medical Excellence® (NME) program, all medical services must be managed through NME so that you receive the highest level of benefits at an appropriate facility. This is true even if the **eligible health service**

is not directly related to your transplant.

Treatment of infertility

Basic infertility

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.

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

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

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans
- Other outpatient diagnostic imaging service where the billed charge exceeds $500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

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

Diagnostic radiological services

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

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**.

Hormone replacement therapy

Eligible health services include:

- Hormone replacement therapy
- Hormone therapy
- Hormone blockers

When prescribed or ordered for treating symptoms and conditions of menopause or gender dysphoria when health care coverage is offered that also provides coverage for prescription drugs.

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** in his/her office
- A home care **provider** in your home

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

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

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

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

Outpatient radiation therapy

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

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

Specialty prescription drugs

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

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

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

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

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

Short-term cardiac and pulmonary rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

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

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

Short-term rehabilitation services

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

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

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

Outpatient cognitive rehabilitation, physical, occupational and speech therapy

Eligible health services include:

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

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

- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

Spinal manipulation

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

Your **provider** must establish or approve a treatment plan that details the treatment and specifies

frequency and duration.

Habilitation therapy services

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

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

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

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

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function
- Occupational therapy (except for vocational rehabilitation or employment counseling or services provided in an educational or training setting), if it is expected to develop any impaired function
- Speech therapy (except for services provided in an educational or training setting or to teach sign language), provided the therapy is expected to develop speech function as a result of delayed development

Speech function is the ability to express thoughts, speak words and form sentences.

Habilitative services for children

Eligible health services include congenital or genetic birth defects existing at or from birth, including a hereditary defect. "Congenital or genetic birth defect" includes:

- Autism or an **autism spectrum disorder**; and
- Cerebral palsy

Except for habilitative services provided in early intervention or school programs, **eligible health services** include:

- The treatment of congenital or genetic birth defects to improve a child's ability to function;
- Occupational therapy, physical therapy and speech therapy; and
- Health care services that help a person keep, learn or improve skills and functioning for daily living, including, but not limited to, applied behavioral analysis (ABA) for the treatment of **autism spectrum disorder**

Applied behavioral analysis is an educational service that is the process of applying interventions:

- That systematically change behavior; and
- That are responsible for the observable improvement in behavior

We must precertify habilitative services.

8. Other services

Accidental dental injury

Eligible health services include dental work needed to treat **injuries** to the jaw, sound natural teeth, mouth or face as a result of an accident. An **injury** that results from chewing or biting is not considered an accidental dental **injury** under this plan. Treatment must begin within 12 months of the **injury**, or as soon after that as possible to be an **eligible health service** under this plan.

Acupuncture

Eligible health services include acupuncture services provided by a **physician**, if the service is provided as a form of anesthesia in connection with a covered **surgical procedure**.

Ambulance service

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

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

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

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

Clinical trial therapies (experimental or investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** that are provided as part of an “approved clinical trial” undertaken for the purposes of the prevention, early detection, treatment or monitoring of cancer, a chronic disease or life-threatening **illnesses** and all of the following conditions are met:

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

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

- The FDA has approved the drug, device, treatment or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial is approved by an Institutional Review Board that will oversee the investigation.

- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

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

- Federally funded trials:
  - The study or investigation is approved or funded by one or more of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare & Medicaid Services
    - A clinical trial cooperative group or center of any of the entities described in the entities listed above, including the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trial Group, and the Community Programs for the Clinical Research in AIS, or the Department of Defense or the Department of Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy
  - For those approved by the Departments of Veterans Affairs, Defense or Energy, the study or investigation must have been reviewed and approved through a system of peer review that the federal Secretary of Health and Human Services determines:
    - To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health
    - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application
- A study or investigation approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46

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 plan will cover either buying or renting the item, depending

on which we think is more cost efficient. If you purchase **DME**, that purchase is only eligible for coverage if you need it for long-term use.

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

Coverage includes:

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

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

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

Nutritional support

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

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

Prosthetic devices

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

Prosthetic device means:

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

Coverage includes:

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

Vision care

Pediatric vision care

Routine vision exams

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

Vision care supplies

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

Eligible health services include:

- Eyeglass frames, **prescription** lenses or **prescription** contact lenses

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

Adult vision care

Routine vision exams

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

9. 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 plan
- Other services
- How you get an emergency **prescription** filled
- Where your schedule of benefits fits in
- What **precertification** requirements apply
- How can I request a medical exception
- Prescribing units

Some **prescription 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.

How to access network pharmacies

How do you find a network pharmacy?

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

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

What 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 plan

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

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

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

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

Your outpatient **prescription drug** plan is based on the drugs in the **drug guide**. The **drug guide** includes

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

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

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

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

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

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

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

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

Retail pharmacy

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

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

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

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

Mail order pharmacy

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

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

Specialty pharmacy

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

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

The initial **prescription** for **specialty prescription drugs** may be filled at a network **retail pharmacy**.

All **specialty prescription drug** fills after the initial fill must be filled at a network **specialty pharmacy** except for urgent situations.

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

[Drafting note: This language will not print for religious employers and group health insurance coverage in connection with such plans that are exempt from the requirement to cover contraceptive services.]

[Preventive contraceptives

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

We cover over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA at no cost share. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drugs** or devices for that method at no cost share. When prescribed female contraceptives, you will be dispensed up to a 12-month supply of the **prescription** contraceptive at one time.

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

Diabetic supplies

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

- Diabetic needles, syringes and pens
- Test strips – blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs

See the *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**.

Off-label use

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

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

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

Orally administered anti-cancer drugs, including chemotherapy drugs

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

Over-the-counter drugs

Eligible health services include certain over-the-counter medications, as determined by the plan. Coverage of the selected over-the-counter medications requires a **prescription**. You can access the list by logging on to your Aetna secure member website at www.aetna.com.

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.

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 plan'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 plan.

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

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

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

What precertification requirements apply

Why do some drugs need precertification?

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

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 can I request a medical exception?

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

You, someone who represents you or your **prescriber** may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a **non-preferred drug**. You, someone who represents you or your **prescriber** may submit a request for a quicker review for an urgent situation by:

- Contacting our Precertification Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716
- Submitting the request in writing to [CVS Health ATTN: **Aetna** PA, 1300 E Campbell Road Richardson, TX 75081]

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

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

after we receive your request. If the quicker medical exception is approved, coverage will be provided for the entire time you have an urgent situation.

Prescribing units

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

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

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

What your plan doesn't cover – eligible health service exceptions and exclusions

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

In this section we tell you about the exceptions and exclusions that apply to your plan.

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

Exceptions and exclusions

The following are not **eligible health services** under your plan except as described in the *Eligible health services under your plan* section of this certificate or by a rider or amendment included with this certificate:

Acupuncture, **acupressure and acupuncture therapy**, except where described in the *Eligible health services under your plan* section.

Ambulance services

- **Ambulance** services, for routine transportation to receive outpatient or inpatient services
- Fixed wing air **ambulance** transportation from an **out-of-network provider**, except where described in the *Eligible health services under your plan - Ambulance service* section.

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

Examples of these are:

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

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

Clinical trial therapies (experimental or investigational)

- Your plan does not cover clinical trial therapies (**experimental or investigational**), except where described in the *Eligible health services under your plan - Clinical trial therapies (experimental or investigational)* section.

Clinical trial therapies (routine patient costs)

- 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)

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, whether or not for psychological or emotional reasons, except where described in the *Eligible health services under your plan - Reconstructive surgery and supplies* section

Counseling

- Marriage, religious, family, career, social adjustment, pastoral, or financial counseling

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding

Custodial care

Examples are:

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

Durable medical equipment (DME)

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

Early intensive behavioral interventions
Examples of those services are:

- Early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions

Educational services
Examples of those services are:

- Any service or supply for education, training or retraining services or testing
- Special education, remedial education, wilderness treatment program, job training and job hardening programs

Emergency services and urgent care

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

Examinations
Any health or dental examinations needed:

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

Experimental or investigational

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

Facility charges
For care, services or supplies provided in:

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

[Drafting note: This exclusion will print for plans that do not cover contraceptive counseling, devices and voluntary sterilization services.]

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

Examples of these are:

- Over-the-counter (OTC) contraceptive supplies, such as male and female condoms, spermicides and sponges

- OTC emergency contraceptives
- Any drug, or supply to prevent or terminate pregnancy, including birth control pills, patches and implantable **prescription drug** contraceptives
- Contraceptive devices such as inter-uterine devices (IUDs) and diaphragms, including initial fitting and insertion even if for a medical condition other than birth control
- Tubal ligation and other forms of voluntary sterilization, along with related services and supplies, follow-up care and treatment
- Services related to prescribing, monitoring and/or administration of the **prescription drug** contraceptive devices
- Contraception services during a **stay** in a **hospital** or other facility for medical care
- Male contraceptive methods]

[Drafting note: This exclusion will print for plans that cover contraceptive counseling, devices and voluntary sterilization services under the Preventive care and wellness benefit.]

[**Family planning services – female contraceptives counseling and devices**

- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods]

[Drafting note: Include the second bullet for groups with religious objections/plan designs that exclude abortion services. For these groups, standard is to include the entire bullet. Remove the second bullet for plan designs that do not exclude abortion services.]

Family planning services - other

- [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]

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

Growth/Height care

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

Hearing aids

Home health 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

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

Jaw joint disorder

- Non-surgical treatment of **jaw joint disorder**

Maintenance care

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

Medical supplies – outpatient disposable

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

Mental health treatment

- Mental health services for the following categories (or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)):
  - Stay in a facility for treatment for dementias or amnesia without a behavioral disturbance that necessitates mental health treatment
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders, except where stated in the eligible health services under your plan – *Preventive care and wellness* section
  - Pathological gambling, kleptomania, pyromania
  - School and/or education service, including special educational, remedial education, wilderness treatment programs or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities

- Transportation

Nutritional support

- Any food item, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible health services under your plan – Other services* section

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 *Eligible health services under your plan – 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 or another party is responsible for as the primary payer

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions and blood products

Outpatient prescription drugs

- 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
- **Cosmetic** drugs
  - Medications or preparations used for **cosmetic** purposes
- Compound **prescriptions** containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA), including compounded bioidentical hormones
- Devices, products and appliances, except those that are specifically covered
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place it is prescribed or

dispensed
  - Which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written, except where stated in the *Eligible health services under your plan – Outpatient prescription drugs* section
  - That includes the same active ingredient or a modified version of an active ingredient
  - That is therapeutically equivalent or a therapeutic alternative to a covered **prescription drug** unless a medical exception is approved
  - That is therapeutically equivalent or a therapeutic alternative to an over-the-counter (OTC) product unless a medical exception is approved
  - Provided under your medical benefits while an inpatient of a healthcare facility
  - Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by **Aetna's** Pharmacy and Therapeutics Committee
  - That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - For which the cost is covered by a federal, state or government agency (for example: Medicaid or Veterans Administration)
  - Not approved by the FDA or not proven to be safe and effective
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies
- Duplicative drug therapy (e.g. two antihistamine drugs)
- Genetic care
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up or the expression of the body's genes except for the correction of congenital birth defects
- Immunizations related to travel or work
- Immunization or immunological agents
- Implantable drugs and associated devices except where stated in the *Eligible health services under your plan – Preventive care and wellness* and *Outpatient prescription drugs* section
- **Infertility**
  - **Prescription drugs** used primarily for the treatment of **infertility** [except where stated in the *Eligible health services under your plan – Treatment of infertility* section]
- Injectables:
  - Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by us.
  - Needles and syringes, except those used for self-administration of an injectable drug.
  - 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.]
- Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps. See the *Eligible health services under your plan – Diabetic equipment, supplies and education* section.
- **Prescription drugs**:
  - Dispensed by other than a network **retail**, **mail order** and **specialty pharmacies**.

- Dispensed by an out-of-network **mail order pharmacy**, except in a medical emergency or urgent care situation.
- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.
- Filled prior to the effective date or after the end date of coverage under this plan.
- Dispensed by a **mail order pharmacy** that includes **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
- That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug as determined by the plan.
- 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 **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **drug guide** or the product on the **drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
- That are not covered or related to a non-covered service.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary** or otherwise improper and drugs obtained for use by anyone other than the member identified on the ID card.

- Refills
  - Refills dispensed more than one year from the date the latest **prescription** order was written
- Replacement of lost or stolen **prescriptions**
- Tobacco use
  - Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). See the *Eligible health services under the plan – Outpatient prescription drugs* section.
- Test agents except diabetic test agents

Outpatient surgery

- The services of any other **physician** who helps the operating **physician**.
- A **stay** in a **hospital**. (A **hospital stay** is an inpatient **hospital** benefit. See *the 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.

Pediatric dental care

In addition to the exclusions that apply to health coverage:

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

- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a **dental provider**

Dental care for adults

- Dental services for adults, including services related to:
  - The care, filling, removal or replacement of teeth due to diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Removal of soft tissue impactions
  - Alveolectomy
  - 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.

Personal care, comfort or convenience items

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

Physician surgical services

- The services of any other **physician** who helps the operating **physician**.
- 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.

Private duty nursing

Prosthetic devices

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

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

- Non-emergency medical services, outpatient **prescription drugs** or supplies received outside

of the United States. They are not covered even if they are covered in the United States under this certificate.

Sexual dysfunction and enhancement

- Any treatment, **prescription drug**, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, except as stated in D.C. Bulletin pertaining to gender identity/dysphoria including:
  - **Surgery**, **prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services

Strength and performance

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

[Telemedicine

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

Therapies and tests

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

Tobacco cessation

Except where described in this certificate:

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

Transplant services

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

Treatment in a federal, state, or governmental entity

Except where required by law:

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

Treatment of infertility

All charges associated with the treatment of infertility, except as described under the *Eligible health services under your plan – Treatment of infertility – Basic infertility* section. This includes:

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

Vision care

Vision care services and supplies

Your plan does not cover vision care services and supplies, except as described in the *Eligible health services under your plan – Other services* section.

- 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

Wilderness treatment programs

- Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

Work related illness or injuries

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

Who provides the care

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

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 *Eligible health services under your plan* section.
- Urgent care – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section and to the schedule of benefits.
- **Network provider not reasonably available** – You can get **eligible health services** under your plan 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 *Eligible health services under your plan* section.

You may select a **network provider** from the **directory** through your Aetna secure member website at www.aetna.com. You can search our online **directory**, DocFind®, for names and locations of **providers**.

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

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 plan:

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

How do you 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 will your PCP 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 do I change my PCP?

You may change your **PCP** at any time. You can call us at the number on your ID card or log on to your Aetna secure member website at www.aetna.com to make a change.

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

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

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

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.

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

What the plan pays and what you pay

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

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

- You pay for the entire expense up to any **deductible** limit, when a **deductible** applies.

And then

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

And then

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

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

Important note – when your plan pays all

Your plan 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 plan requires **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 *Who provides the care* section.

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

Special financial responsibility

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

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

charge for **covered benefits**.

Where your schedule of benefits fits in

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

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

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

When you disagree - claim decisions and appeal procedures

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

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

Notice of claim

You must tell us in writing within 20 days after you have paid for a service covered under group policy. If you do not tell us within 20 days, you must do so as soon as possible. Written notice is not required more than one year from when you paid for the services.

Claim forms

Claim forms may be obtained from us or your employer. If we don't send you the forms within 15 days, your request for the claim forms will be enough for us to process your request for reimbursement.

Proof of loss

If you are paying for services over a period of time, you must provide proof of payment no later than 90 days after the last date of service. If you are unable to do so, you must provide proof as soon as possible, but no later than 12 months after the last day of service.

Claim procedures

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

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

	• 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.	the claim is received.

Types of claims and communicating our claim decisions

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

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

Urgent care claim

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

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

Pre-service claim

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

Post-service claim

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

In this section, health care services means services or supplies provided by a **physician** or other **health professional** for the prevention, care, diagnosis, or treatment of disease, pain, injury, deformity or other physical or mental condition including services mandated under Chapter 31 of Title 31 (coverage for the medical and psychological treatment of drug abuse, alcohol abuse, and mental illness).

Concurrent care claim extension

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

Concurrent care claim reduction or termination

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

During this continuation period, you are still responsible for your share of the costs, such as **copayments**/**coinsurance** and **deductibles** that apply to the service or supply. If we support our decision

at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

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

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

Type of notice	**Urgent care claim**	**Pre-service claim**	**Post-service claim**	**Concurrent care claim**
Initial decision by us	72 hours	15 days	30 days	24 hours for urgent request^, or 72 hours if clinical information is required and received more than 24 hours after request^ 15 days for non-urgent request
Extensions	Not applicable	15 days	15 days	
If we request more information	Not applicable	15 days	15 days	
Time you have to send us additional information	48 hours	45 days	45 days	

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

Adverse benefit determinations

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

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

An adverse benefit determination may also be based on:

- Your eligibility for coverage
- Whether the service or supply is **experimental or investigational**
- The **medical necessity**, appropriateness, or level of care, or health care setting
- Whether a wellness incentive has been properly applied
- Whether you were was given a reasonable alternate option for satisfying a wellness plan when required

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

We will reimburse you for any payment you have made for services once we receive your proof of payment. If we will only pay a portion of a claim that you have paid, that portion will be paid once we receive your proof of payment.

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 resulting in a rescission, denial, termination, or other limitation of a benefit. 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
- Your employer's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by calling 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 two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Urgent care or pre-service claim appeals

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

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

Timeframes for deciding an appeal

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	36 hours	15 days	30 days	As appropriate to type of claim
Extensions	None	None	None	

Exhaustion of appeals process

You have the option to contact the District of Columbia Department of Insurance, Securities and Banking to request an investigation or file a complaint with the Department at any time during the internal claims and appeal process.

In most situations, you must complete the two levels of appeal with us before you can pursue arbitration or litigation.

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

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

External review

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

You have a right to external review only if:

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

If our claim decision is one for which you can seek external review, we will say that in the notice of

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

You must submit the Request for External Review Form:

- To District of Columbia Department of Insurance, Securities and Banking
- 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 ERO. We will pay for information we send to the ERO plus the cost of the review.

The District of Columbia will contact the ERO that will conduct the review of your claim.

The ERO will:

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

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

How long will it take to get an ERO decision?

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

Sometimes you can get a faster external review decision. Your **provider** must call us or send us a Request for External Review Form.

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

For initial adverse determination

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

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

For final adverse determination

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

from a facility

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

If you are dissatisfied with the resolution reached through our internal grievance system regarding medical necessity, you may contact the [Director, Office of the Health Care Ombudsman and Bill of Rights] at the following:

For **medically necessary** cases:
[District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
One Judiciary Square
441 4th St. N.W., 900 South
Washington, D.C. 20001
1 (877) 685-6391, (202) 724-7491
Fax: (202) 442- 6724]

In this section, Director means the Director of the Department of Health Care Finance.

If you are dissatisfied with the resolution reached through our internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

For non–**medically necessary** cases:
[[Commissioner]
Department of Insurance, Securities and Banking
1050 First Street, NE, Suite 801
Washington, D.C. 20002
(202) 727-8000
Fax: (202) 354-1085]

In this section, grievance means a written request by a member or a member representative for review of a decision of an insurer to deny, reduce, limit, terminate or delay a benefit to a member, including regarding:

- A determination about the **medical necessity**, appropriateness, or level of care, health-care setting, or effectiveness of a treatment
- A determination as to whether treatment is **experimental**
- An insurer's decision to rescind coverage
- The failure to provide or make payment that is based on a determination of your eligibility to participate in a plan
- Whether a wellness incentive has been properly applied
- Whether you were given a reasonable alternate option for satisfying a wellness plan when required

In this section, a grievance decision means a determination accepting or denying the basis or requested remedy of the grievance.

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

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

Key terms

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

Allowable expense means:

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

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

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

Here's how COB works

- The primary plan pays first. When this is the primary plan, we will pay your claims first as if the other plan does not exist.
- The secondary plan pays after the primary plan. When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.

We will never pay an amount that, when combined with payments from your other coverage, adds up to more than 100% of the allowable expenses.

Determining who pays

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

If you are:	Primary plan	Secondary plan
Covered under the plan as an employee, retired employee or dependent	The plan covering you as an employee or retired employee.	The plan covering you as a dependent.
Eligible for Medicare	If you or a dependent have Medicare coverage, the rule above may be reversed. See the *How to contact us for help* section if you have questions.	
COB rules for dependent children		

Child of: • Parents who are married or living together	The "birthday rule" applies. The plan of the parent whose birthday[+] (month and day only) falls earlier in the **plan year**. [+]Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)[+]. [+]Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together • With court-order	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other spouse's plan.	The plan of the other parent. But if that parent has no coverage, then his/her spouse's plan is primary.
Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
Child of: • Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parent pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
Child covered by: • Individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination: See *Child of* content above.	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree, or the dependent of an employee or	COBRA or state continuation coverage is secondary to the plan that covers the person as an

	retiree, is primary to COBRA or state continuation coverage.	employee or retiree, or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.
Benefit reserve each family member has a separate benefit reserve for each **plan year**	The benefit reserve: • Is made up of the amount that the secondary plan saved due to COB • Is used to cover any unpaid allowable expenses • Balance is erased at the end of each year

How COB works with Medicare

This section explains how the benefits under this plan work with benefits available under Medicare.

When we say Medicare, we mean the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you meet the criteria for coverage because of:

- Your age
- A disability
- End stage renal disease (ESRD)

You are also eligible for Medicare even if you are not enrolled because you:

- Refused it
- Dropped it
- Did not make a proper request for it

When you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. In the case of someone who is eligible but not covered, the plan may pay as if you are covered by Medicare and coordinate benefits with the benefits Medicare would have paid had you enrolled in Medicare. Sometimes, this plan is the primary plan, which means that the plan pays benefits

before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid if you were covered.

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	**Primary plan**	**Secondary plan**
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan
If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.	Medicare Your plan
A disability other than ESRD and your employer has more than 100 employees	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

[Drafting note: This table and statement below should be selected when the plan's COB is 100% Allowable. If COB is not 100% Allowable then remove this text from the form. This option is the SG standard.]

[How are benefits paid?

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

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

[Drafting note: This table below should be selected when COB is Maintenance of Benefits. If COB is not MOB then remove the table from the form.]

[How are benefits paid?

We are primary	We pay your claims as if there is no Medicare coverage.
Medicare is primary	We calculate the amount we would pay if there were no Medicare coverage. If the Medicare

	payment is equal to or more than what we would pay, we make no payment. If Medicare paid less than what we would pay, we pay the difference between our payment and the Medicare payment.]

[Drafting note: This table and the statement below should be selected when COB is Government Exclusion. If the plan's COB is not Government Exclusion then the table and statement should be removed from the form.]

[**How are benefits paid?**

We are primary	We pay your claims as if there is no Medicare coverage.
Medicare is primary	We calculate our benefit based on any remaining charges after Medicare has paid. Any member cost share under the plan will be applied to the remaining charges before the plan will pay.

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

Other health coverage updates – contact information

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

Right to receive and release needed information

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

Right to pay another carrier

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

Right of recovery

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

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

When coverage ends

Decisions to end coverage are subject to any rules or other standards of the Exchange and/or the District of Columbia Department of Insurance, Securities and Banking. In this section, "we" and "us" mean the Exchange for some activities and decisions.

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

When will your coverage end?

Your coverage under this plan will end if:

- The group policy ends
- You voluntarily stop your coverage
- You are no longer eligible for coverage including moving out of the **service area**
- Your employment ends
- You no longer meet the eligibility requirements of the Exchange
- You become covered under another health plan offered by your employer

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent no longer meets the eligibility requirements of the Exchange by turning age 26, in which case coverage will end December 31st of that year.
- The group policy ends
- Your coverage ends for any of the reasons listed above
- You enroll under a group Medicare plan that we offer and your coverage ends under that plan

[In addition, coverage for your domestic partner or civil union partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners or civil unions.
- The date the domestic partnership or civil union ends. For domestic partnerships, you should provide your employer a completed and signed Declaration of Termination of Domestic Partnership.]

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your coverage ends* section for more information.

Why would we end coverage?

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

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

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because: • Your job has been eliminated • You have been placed on severance • This plan allows former employees to continue their coverage	You may be able to continue coverage. See the *Special coverage options after your coverage ends* section.
Your employment ends because of a military leave of absence.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage may continue until stopped by the **policyholder** but not beyond 24 months from the start of the absence.

It is your **policyholder's** responsibility to let us know when your employment ends. The limits above may be extended only if we and the **policyholder** agree in writing to extend them.

Special coverage options after your coverage ends

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

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

COBRA gives some people the right to keep their health coverage for 18, 29 or 36 months after a "qualifying event". COBRA usually applies to employers of group sizes of 20 or more. Talk with your employer if you have questions about this.

Here are the qualifying events that trigger COBRA continuation, who is eligible for continuation and how long coverage can be continued.

Qualifying event causing loss of coverage	Covered persons eligible for continued coverage	Length of continued coverage (starts from the day you lose current coverage)
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy	You and your dependents	18 months

When do I receive COBRA information?

The chart below lists who is responsible for giving the notice, the type of notice they are required to give and when.

Employer/Group health plan notification requirements		
Notice	**Requirement**	**Deadline**
General notice – employer or **Aetna**	Notify you and your dependents of COBRA rights	Within 90 days after active employee coverage begins
Notice of qualifying event – employer	• Your active employment ends for reasons other	Within 30 days of the qualifying event or the loss of

	than gross misconduct • Your working hours are reduced • You become entitled to benefits under Medicare • You die • You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy	coverage, whichever occurs later
Election notice – employer or **Aetna**	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA – employer or **Aetna**	Notify you and your dependents if you are not entitled to COBRA coverage	Within 14 days after notice of the qualifying event
Termination notice **–** employer or **Aetna**	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period	As soon as practical following the decision that continuation coverage will end

You/your dependents notification requirements		
Notice of qualifying event – qualified beneficiary	Notify your employer if: • You divorce or legally separate and are no longer responsible for dependent coverage • Your covered dependent children no longer qualify as a dependent under the plan	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify your employer if: • The Social Security Administration determines that you or a covered dependent qualify for disability status	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends
Notice of qualified	Notify your employer if:	Within 30 days of the Social

beneficiary's status change to non-disabled	• The Social Security Administration decides that the beneficiary is no longer disabled	Security Administration's decision
Enrollment in COBRA	Notify your employer if: • You are electing COBRA	60 days from the qualifying event. You will lose your right to elect, if you do not: • Respond within the 60 days • And send back your application

How can you extend the length of your COBRA coverage?

The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
You were disabled during the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
• You die • You divorce or legally separate and are no longer responsible for dependent coverage • You become entitled to benefits under Medicare • Your covered dependent children no longer qualify as dependent under the plan	You and your dependents	Up to 36 months

How do you enroll in COBRA?

You enroll by sending in an application and paying the **premium**. Your employer has 14 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the **premium**. If this is completed on time, you have enrolled in COBRA.

When is your first premium payment due?

Your first **premium** payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?

For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% covers administrative fees. If you apply for COBRA because of a disability, the total due will change to 150% of the plan costs in your 19th month of COBRA.

Can you add a dependent to your COBRA coverage?
You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent
- You notified your employer within 31 days of their eligibility
- You pay the additional required **premiums**

When does COBRA coverage end?
COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become entitled to benefits under Medicare.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Continuation of coverage for other reasons
To request an extension of coverage, just call the number on your ID card.

How can you extend coverage when getting inpatient care when coverage ends?
Your coverage may be extended if you or your dependents are getting inpatient care in a **hospital** or **skilled nursing facility** when coverage ends.

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

Benefits will be extended until the earliest of:

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

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

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

Ordered means:

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

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

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

- Is not able to be self-supporting because of mental or physical disability
- Depends 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 coverage under the group policy remains in effect.

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

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

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet-certificate

We prepared this booklet-certificate according to ERISA and according to other federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet-certificate when we administer your coverage, so long as we use reasonable discretion.

How we administer this plan

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

Who's responsible to you

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

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

Coverage and services

Your coverage can change

Your coverage is defined by the group policy. This document may have amendments or riders too. Under certain circumstances, we or your employer or the law may change your plan. 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 plan. No other person – including your employer or **provider** – can do this.

If a service cannot be provided to you

Sometimes things happen that are 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 services you need even if these things happen. But if we can't, we may refund you or your employer any unearned **premium**.

Financial sanctions exclusions

If coverage provided under this certificate 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 http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Legal action

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

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

Physical examinations[, evaluations,] and autopsy
At our expense, we have the right to have a **physician** of our choice examine you. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. We also have the right to make an autopsy in case of death where it is not forbidden by law.

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

Things that would be important to keep are:

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

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

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

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

We also may report fraud to criminal authorities.

You have special rights if we rescind your coverage:

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

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

Recovery of overpayments
We sometimes pay too much for **eligible health services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid – you or your **provider** – to return what we paid. If

we don't do that we have the right to reduce any future benefit payments by the amount we paid by mistake.

When you are injured

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

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

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

We don't have to reduce the amount we're due for any reason, even to help pay your lawyer or pay other costs you incurred to get a recovery.

Your health information

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

Glossary

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

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

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

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

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

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 plan.

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

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

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

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 jurisdiction in which it is located.

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

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

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 your and your dependents' coverage, if your plan includes coverage for dependents, begins under this booklet-certificate as noted in our records.

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

Emergency medical condition

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

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

Emergency services

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

Experimental or investigational

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

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

Generic prescription drug, generic drug

A **prescription drug** with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Health professional

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

Home health care agency

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

Home health care plan

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

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

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

Hospice care program
A program prescribed by a **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 state and federal laws to provide **hospice care**.

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

Hospital does not include a:

- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility** for **substance abuse**
- **Residential treatment facility** for **mental disorders**
- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

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

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

- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older

- For a male without a female partner, after:
    - At least 2 abnormal semen analyses obtained at least 2 weeks apart

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

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

Jaw joint disorder
This is:

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

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

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

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

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

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

Generally accepted standards of medical practice means:

- Standards based on credible scientific evidence published in peer-reviewed medical literature

generally recognized by the relevant medical community
- Consistent with the standards set forth in policy issues involving clinical judgment

The fact that a **physician** may prescribe, authorize, or direct a service does not of itself make it **medically necessary** or covered by the group policy.

Mental disorder

Mental 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 disorders**. In general, a **mental disorder** is a serious disturbance in a person's thought process, emotions or behavior that causes problems in mental functioning. **Mental 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 plan members. This does not include **prescription drug** services from a **network pharmacy**.

The **negotiated charge** does not reflect any amount an affiliate or we may receive under a rebate arrangement between us or an affiliate and a drug manufacturer for any **prescription drug**.

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

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

The **negotiated charge** does not reflect any amount an affiliate or we may receive under a rebate arrangement between us, an affiliate or a third party vendor and a drug manufacturer for any

prescription drug, including **prescription drugs** on the **drug guide**.

We may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network provider
A **provider** listed in the **directory** for your plan. However, a National Advantage Program (NAP) **provider** listed in the NAP **directory** is not a **network provider**.

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

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

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

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

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

Physician
A skilled health care professional trained and licensed to practice medicine under the 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)**.

Plan Year
A consecutive 12 month period during which the plan provides coverage for **covered benefits**.

Policyholder

An employer or organization who agrees to remit the **premiums** for coverage under the group policy payable to **Aetna**. The **policyholder** shall act only as an agent of **Aetna members** in the employer group, and shall not be the agent of **Aetna** for any purpose.

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 or your employer is required to pay to **Aetna** 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 family care **physician**, an internist or a pediatrician
- 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 state and federal 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 state and federal laws to provide a program for the diagnosis, evaluation and treatment of alcoholism, drug abuse, **mental disorders** (including substance related disorders) or mental **illnesses**.

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

Qualified individual
A member who is receiving treatment in a clinical trial therapy for the purposes of prevention, early detection, treatment or monitoring of cancer, a chronic disease or life-threatening illnesses.

R.N.
A registered nurse.

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

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

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

In addition to the above requirements, an institution must meet the following for residential treatment programs treating **mental 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 abuse)
An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for **substance abuse** residential treatment programs. And is credentialed by **Aetna** or accredited by one of the following agencies, commissions or committees for the services being

provided:

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

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

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

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

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

Retail pharmacy

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

Room and board

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

Semi-private room rate

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

Service area

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

Skilled nursing facility

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

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

Skilled nursing facility does not include institutions that provide only:

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

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

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 drugs
These are **prescription drugs** that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

You can access the list of these **specialty prescription drugs**. See the *How to contact us for help* section for details.

Specialty pharmacy
This is a **pharmacy** designated by **Aetna** as a network **pharmacy** to fill **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** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.aetna.com/formulary.

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

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

Surgery, surgical procedure

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

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

It also includes:

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

Telemedicine

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

Services can be provided by:

- Two-way audiovisual teleconferencing
- Telephone calls
- Any other method required by state law

Terminal illness

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

Urgent care facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition**.

Urgent condition

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

Walk-in clinic

A free-standing health care facility. Neither of the following is considered a **walk-in clinic**:

- An emergency room
- The outpatient department of a **hospital**

Discount programs

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

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

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

Wellness and other incentives

We may encourage and incent you to access certain medical services, 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.