



151 Farmington  
Ave  
Hartford, CT,  
06156

Re: Group Number 0284189

## We're sending you an electronic file with your plan documents

Thank you for doing business with Aetna. Enclosed are your plan documents. Here are a couple of other things to keep in mind as you review this material.

### **For your employees**

Members can always find their benefit information on their member website. They can go to [Aetna.com](https://www.aetna.com) to log in or register. They may also contact us for a free paper copy.

We offer free aids and services for anyone with disabilities. If a member needs these services, have them call the number on their member ID card.

### **Have questions?**

Contact your plan representative or account manager for help.

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).**

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3078250-01-01

# AETNA HEALTH INC.

## Group agreement

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The HMO group agreement is by and between

**AETNA HEALTH INC.** and  
**IOTA COMMUNITY SCHOOLS**  
**Contract holder**

Group agreement number: 0284189  
**Effective date:** July 01, 2024  
Contract situs: Tennessee

This HMO group agreement takes effect on the **effective date** if we have received your signed group application and the initial premium. It remains in force until terminated.

Term of the HMO group agreement:

- The initial term is the 12 consecutive months beginning on the **effective date**.
- Subsequent terms are the 12 consecutive months beginning with the **renewal date**.

**Premium due dates:** The **effective date** and the 1<sup>st</sup> day of each month after that

Signed at **Aetna's** Home Office, 1425 Union Meeting Road, Blue Bell, Pennsylvania 19422.

This group agreement is governed by applicable federal law and the laws of Tennessee.

By:   
\_\_\_\_\_  
Gregory S. Martino  
Vice President

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## The HMO group agreement

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The HMO group agreement consists of the following documents:

- This group agreement
- The certificate(s) of coverage
- The schedule of benefits
- Riders and amendments

## If you want to discuss your coverage

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If you have questions about your coverage under the group agreement, or if you wish to discuss it, contact your agent. If you have additional questions, you may contact us at:

### **Aetna**

1425 Union Meeting Road  
Blue Bell, Pennsylvania 19422  
1-800-445-5299

Please have your group agreement number available when you contact us. It is on the front page of this group agreement.

## Definitions

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You will see some words in bold type in the group agreement. The bold type means we have defined those words. The definitions are in this section and in the *Glossary* section of the certificate.

### **Contract holder**

IOTA COMMUNITY SCHOOLS and entities associated with it for purpose of coverage under this group agreement.

### **Covered person**

An employee or a dependent of an employee for whom all of the following applies:

- The person is eligible for coverage as defined in the certificate
- The person has enrolled for coverage and paid any required premium contribution
- The person's coverage has not ended

### **Effective date**

Date your coverage begins under this group agreement.

### **Premium due date**

The **effective date** and the 1<sup>st</sup> day of each month after that.

### **Renewal date**

Date that is 12 months after the **effective date** and each 12 months after that.

### **Termination date**

The date coverage ends according to the *Termination* section.

## Premium

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### Premium – rates and amount due

The premium rates will be on record with you and us. You will receive a new rate sheet when the premium rates change. Any rate sheet will state its **effective date**.

We charge premium based on the premium rates in effect on the **premium due date**.

The premium due on any **premium due date** is the total of the premium charges for your coverage. When we calculate premium due, we will use our records to determine who is a **covered person**.

You owe premium for a **covered person** starting with the first **premium due date** on or after the day the person's coverage starts. You stop paying premium for a **covered person** as of the first **premium due date** on or after the day the person's coverage ends.

### Premium – individual proration

Premium shall be paid in full for persons who are covered for an entire month beginning with the **premium due date**.

Premiums shall be adjusted as outlined below for persons whose:

- Coverage is effective on a day other than the first day of the billing month
- Coverage terminates on a day other than the last day of the billing month

If a person's coverage starts on the first of the month, the premium for the whole month is due. If the coverage starts after the first of the month, no premium for the month is due.

If a person's coverage ends on the first of the month, no premium for the month is due. If the coverage ends after the first of the month, the premium for the whole month is due.

### Premium – changes in rates

We may change the premium rates as of a **premium due date** during the initial term only if:

- There is a change in factors that materially affects the risk we assumed with this coverage. We will explain these changes in factors in our rate quote to you
- There is a change in law or regulation, or there is a judicial decision, that materially affects the cost of providing coverage

We may change the premium rates as of a **premium due date** during any following term.

We will let you know in writing of any change in premium rate 30 days before they take effect.

### Premium – experience credit

We may declare an experience credit at the end of a plan year. We do not have to declare any experience credit.

If we declare an experience credit, we may return the amount of the credit to you:

- By electronic fund transfer

- By applying the amount to the premium due in the current or next plan year
- By any other manner that we and you agree to

As a condition of us giving you an experience credit, we can require you to share it, in an agreed upon manner. We will require you to apply at least the excess experience credit for the sole benefit of the employees, if the sum of employee contributions for coverage exceeds the premium paid, less any experience credits.

### **Premium – when due**

Premium is due on the **premium due date**.

You have a payment grace period of 31 days immediately following the **premium due date**. The group agreement will remain in force during the grace period. If we have not received all premium due by the end of the grace period, it will automatically terminate at the end of the grace period. Refer to the *Termination* section of this group agreement.

### **Premium – how billed and paid**

We may bill you electronically. You shall pay premium due by electronic fund transfer, unless you choose to pay by check. Payment occurs when we receive good funds.

We may accept a partial payment but this does not waive our right to collect the entire amount due.

We may choose not to accept **premium** that is paid for you by someone else unless we are required to by law.

### **Premium – overdue amounts**

If you don't pay your premium on time, we will charge you interest on the total premium amount that is overdue. Overdue premium includes amounts due but not yet paid during the grace period. The interest rate will be up to 1 1/2% per month for each month or partial month an amount due remains unpaid.

We may also recover from you the costs of collecting any unpaid premium, including reasonable attorney fees and costs of suit.

We will not collect interest from you during the grace period or for any premium you pay before the grace period ends.

### **Premium – eligibility corrections**

We will retroactively drop a **covered person** from coverage and credit to your premium payments if:

- We billed you based on eligibility information you provided us
- The person did not pay the required premium contribution for the period
- The eligibility information included a person who was not eligible for coverage
- You request that we retroactively drop the person from coverage

Our credit of premium is limited to 2 months' credit for a person whose loss of eligibility occurred more than 60 days before the date you notified us. If we paid benefits on behalf of such a person, we may reduce the credit by the amount of benefit paid.

If you asked us to retroactively drop coverage, we will consider that as your statement that the person did not pay the required premium contribution for the period.

We will retroactively cover eligible persons who were not included in the eligibility information you provided us. We will cover them retroactively no more than 60 days before the date you both notify us and pay all applicable past premium.

## **Premium – waiver**

### **Payment of premiums**

We may waive up to 1 month's billed premium payments during any group agreement term.

The premium waiver will not apply for those employees who were added or removed from the plan after we billed you for that month's premium. For that month of coverage, additional premium will be due or credited.

### **Repayment of the waived premium**

We may require you to pay back the premium waived if you terminate the group agreement within 12 months of your **effective date** or **renewal date**. We will give 10 days prior written notice to you of the requirement for the repayment of the waived premium.

## **Fees for special services and assessments**

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### **Special services**

You may request that we provide special services beyond the routine administration of this group agreement. We will charge you a fee for each special service we provide.

The special services are:

- Us billing you for amounts due in a non-electronic medium.
- Us accepting payment of amounts due from you other than by electronic fund transfer. If you pay us by check, the check does not constitute payment until it is honored by a bank.
- Us handling your check returned to us due to insufficient funds. We may return the check to you without a second attempt to cash it.
- Reinstatement of the group agreement according to the *Termination* section.
- Any other special service you request and we agree to provide.

### **Special services – fees**

We may change any fee not already agreed to and included in your premium with 30 days advance notice to you.

### **Payment for third party technology provider**

We will pay a third-party technology provider you choose to provide services related to the administration for this group agreement. The fee we pay them will be an agreed upon amount between us and you. If we stop payment to the third party technology provider, we will give you 30 days advance notice.



## **Assessments**

We may charge you a pro rata allocation of any assessments we receive for state high risk pools and other state programs.

## **Fees and assessments – when due**

Fees and assessments are due on the **premium due date** upon invoice.

You have a payment grace period of 31 days immediately following the **premium due date**. The group agreement will remain in force during the grace period. If we have not received all fees and assessments due by the end of the grace period, this group agreement will automatically terminate at the end of the grace period.

## **Fees and assessments – how billed and paid**

We may bill you electronically. You shall pay fees and assessments by electronic fund transfer, unless you choose to pay by check. Payment occurs when we receive good funds.

We may accept a partial payment but this does not waive our right to collect the entire amount due.

## **Fees and assessments – overdue amounts**

You shall pay us interest on the total amount of fees and assessments that is overdue. Overdue fees and assessments include amounts due but not paid during the grace period. The interest rate will be up to 1 1/2% per month for each month or partial month an amount due remains unpaid.

We will not collect interest from you during the grace period or any fees and assessments you pay before the grace period ends.

We may also recover from you the costs of collecting any unpaid fees and assessments, including reasonable attorney fees and court costs.

## Some of our other responsibilities

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We will prepare the certificate and schedule of benefits that are part of the group agreement, as required by applicable federal and state laws. We will provide them to you in electronic form. We will also provide them to you in paper form if you request it.

We will provide the coverage stated in the certificate and schedule of benefits that are part of the group agreement. We will administer the coverage as required by the group agreement and applicable laws.

We will protect the personal health information of **covered persons** as required by laws. We will use it and share it with others as needed for their care and treatment. We will also use and share it to help us process **providers'** claims and otherwise help us administer the group agreement. For a copy of our Notice of Privacy Practices log on to <https://www.aetna.com/>.

Our duties in this section survive termination of the group agreement.

## Some of your other requirements and responsibilities

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### Participation and contribution

You must comply with our participation and contribution requirements we communicated to you in writing.

### Distribution – certain Patient Protection and Affordable Care Act (ACA) requirements

You shall distribute two documents required by the federal ACA:

- Summary of benefits and coverage (SBC)
- Notices of material modifications

You shall distribute them to your employees and their dependents, in accordance with the federal delivery, timing, and trigger requirements.

You shall certify to us on an annual basis and upon our request, that you have distributed them and will distribute them consistent with the ACA. You shall give us your certification within 30 calendar days of our request.

You shall give us information or proof upon our request, that you have distributed them and will distribute them consistent with the ACA. The information or proof must be in a form we will accept. You shall give us the information or proof within 30 calendar days of our request.

Your duties and our rights in the ACA requirements provision survive termination of the group agreement.

## **Distribution – certain Employee Retirement Income Security Act (ERISA) of 1974 requirements**

You are responsible for creating and distributing all reports and disclosures required by ERISA. These include:

- Summary plan descriptions
- Summary of material modifications
- Summary annual reports

## **Distribution – certificate and schedule of benefits**

You will distribute as required by applicable laws, the certificate and schedule of benefits that we provide you.

## **Information – access**

You shall make payroll and other records directly related to a person's coverage under this group agreement available to us for inspection. This will occur:

- Upon our reasonable advance request
- At our expense
- At your office
- During regular business hours

Your duties and our rights in the *Information – access* provision survive termination of the group agreement.

## **Information – enrollment**

You shall send us enrollment information we request to administer the group agreement. We will request the information monthly or as otherwise required. You will send us the information on our form, or through such other means as we require.

The enrollment information includes but is not limited to data needed to:

- Enroll your employees and their dependents
- Process terminations
- Make changes in family status

We can and will rely on the information that you send and that it is correct.

You shall:

- Maintain a complete record of the information you send us for at least seven years, and until the final rights and duties under the group agreement have been resolved
- Send us information you sent us before, upon request

We will not start covering a person under the group agreement until you send us the information to enroll that person. Subject to applicable laws and the group agreement, we will not stop covering a person until you send us the information to terminate coverage.

You shall notify us within 15 business days of the date in which:

- An employee's employment ends

- A dependent loses eligibility under the group agreement

You must notify us when a request for retroactive termination is a result of either a **covered person**:

- Performing an act or omission that constitutes fraud
- Making an intentional misrepresentation of material fact to get coverage or to get a benefit under the group agreement

Your duties and our rights in this *Information – enrollment* provision survive termination of the group agreement.

### **90 day waiting period limitation**

Your plan can't have a waiting period of more than 90 days. That means employees and their dependents must be able to begin health coverage within 90 days. This is a requirement of the ACA. It applies both to you and to us.

You will give us **effective dates** for your employees and their dependents that take into account all state and federal waiting period requirements. You acknowledge that we will rely on this information. You will inform us immediately if this information changes.

We will use this **effective date** information to enroll eligible employees and their dependents into the group plan.

### **Notices – termination of coverage**

You shall notify **covered persons** in writing, of their rights when coverage stops.

In particular, you shall notify all eligible **covered persons** of their right to continue coverage pursuant to the *Special coverage options after your plan coverage ends* provisions in the certificate and applicable federal and state laws. Your notification will include:

- A description of plans available
- Premium rates
- Application forms

You will give the notification within 60 calendar days to a person becoming eligible for continuation coverage.

Your duties and our rights in this provision survive termination of the group agreement.

## **Workers' compensation coverage**

You must comply with workers' compensation coverage laws applicable to your employees covered by the group agreement. Prior to the **effective date** and upon our request after the **effective date** you will provide us reasonable proof of that compliance.

You will provide us with monthly reports of all workers' compensation coverage cases. The report will list:

- Each case
- The employee name
- Identifying number
- Date of loss
- Diagnosis

## Termination

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### Automatic termination

The group agreement and all coverage end as of the last day of the grace period if you have not paid us all premiums and fees and assessments due as of the beginning of the grace period. The *Premium* section has a description of the grace period.

### Termination by you

You may end coverage under this group agreement if you give us 30 days advance written notice. Your termination notice may apply to all classes or any class of your employees covered under the group agreement. You can send us a termination notice during a period for which you have paid premium, but your **termination date** must be after that period.

### Termination by us

We may end the group agreement and all coverage it provides:

- Immediately upon notice to you:
  - If you perform any act or practice that constitutes fraud or if you make any intentional misrepresentation of a material fact relevant to the coverage
  - If you no longer have any employees under the plan who live, reside, or work in the service area
  - If you are a member of an association and your membership in the association ceases
  
- Upon 30 days written notice to you:
  - If you breach a provision of the group agreement and you do not cure the breach within the notice period
  - If you cease to be a group as defined under applicable state law
  - If you fail to meet our contribution or participation requirements applicable to this group agreement
  - If you do not certify your compliance with our policies and procedures upon request
  - If you change your eligibility or participation requirements without our consent
  
- Upon 90 days written notice to you (or such longer notice period as applicable laws require,) if we cease to offer the product provided by this group agreement
  
- Upon 180 days written notice to you (or such longer notice period as applicable laws require,) if we act as required by applicable federal and state laws for uniform termination of coverage

We may rescind the group agreement and all coverage it provides for fraud or intentional misrepresentation of material fact with 30 days advance written notice. The notice will state the **effective date** of rescission.

### Effective time of termination

The group agreement and its coverage end at 11:59 p.m. on the day of termination.

## **Effect of termination**

You, **covered persons**, and we continue to be responsible following termination for the duties we each incur prior to the termination of the group agreement. One of your duties includes payment of premium due for coverage through any grace period up to the day of termination. You, **covered persons**, and we also continue to be responsible for your, their, and our duties that the group agreement states are to occur following termination.

You, **covered persons**, and we have the rights and duties following termination of the group agreement, as stated specifically in the group agreement.

You shall notify **covered persons** of the termination of the group agreement. Your notice will comply with applicable federal and state laws. We have the right to notify employees of termination of the group agreement.

## **Reinstatement**

You may request that we reinstate the group agreement and coverage after we end it. You must make the request within 30 days of the **termination date**. We will reinstate the group agreement as of the **termination date** upon payment of all amounts due and you giving us reasonable assurances that you can and will fulfill all of your obligations under the group agreement.

## Intentional deception

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

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial or termination of benefits.
- Recovery of amounts we already paid.

We also may report fraud to law enforcement.

Rescission means you or a **covered person** loses coverage both going forward and going backward. If we paid claims for past coverage, we are entitled to receive the money back.

A **covered person** has special rights if we rescind coverage just for that individual:

- We will give the **covered person** 30 days advance written notice of any rescission of coverage
- The **covered person** has the right to an **Aetna** appeal
- The **covered person** has the right to a third party review conducted by an independent external review organization

## Responsibility for conduct

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### Employees and agents

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

We are not responsible to you for what is done by others, such as **providers**. They are not our employees or agents. **Providers** in our **network** are what the federal and state laws call our independent contractors. That simply means we have a business relationship with them and they are not our employees or agents.

### Indemnification – in general

We agree to indemnify and hold you harmless against that portion of your liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by our willful misconduct, criminal conduct or material breach of this group agreement.

You agree to indemnify and hold us harmless against that portion of our liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by your:

- Negligence
- Breach of the group agreement
- Breach of applicable federal and state laws
- Willful misconduct
- Criminal conduct
- Fraud
- Breach of a fiduciary responsibility in the case of an action under ERISA, related to or arising out of this group agreement or your role as employer or Plan Sponsor, as defined by ERISA.



These indemnification obligations end with the group agreement, except as to any matter concerning a claim that has been made in writing within 365 days after termination.

## **Indemnification – federal law requirements**

You shall indemnify us and hold us harmless for our liability that is directly caused by your:

- Negligence
- Breach of the group agreement
- Breach of federal or state laws that apply or
- Willful misconduct

and your act or failure to act was related to or arose out of your obligation to deliver the Summary of benefits and coverage and Notices of material modification.

Your and our rights and duties in this section survive termination of the group agreement.

## **General provisions**

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### **General provisions – content and interpretation of the group agreement**

#### **Applicable law**

Applicable law means all federal and state laws that apply to the matters covered by the group agreement. Federal and state law means statutes, regulations, official agency direction and guidance, and judicial decisions and orders, as they may be passed or issued, or as they may be amended, from time to time.

#### **Compliance with law**

You and we shall interpret the group agreement if possible so it complies with applicable federal and state laws.

If the group agreement omits or misstates any right or duty under applicable federal and state laws, you and we shall implement the group agreement as though the right or duty is stated correctly.

If any provision of the group agreement is invalid or illegal, you and we shall implement the group agreement as though the provision is not in the group agreement.

#### **Changes to the group agreement**

The group agreement may be amended by mutual consent and in writing.

We may change or end some or all coverage under this group agreement by notice, if we act as required by applicable laws for uniform modification of coverage and uniform termination of coverage.

We have to give you 90 days advance written notice, and you have to consent in writing to changes in the group agreement. Our amendment:

- Will not reduce benefits or coverage
- Will not eliminate benefits or coverage
- Will not increase benefits or coverage with a concurrent increase in premium during the current group agreement term, other than increased benefits or coverage required by federal and state laws

Payment of the applicable premium on the **effective date** of any amendment is your consent to any amendment requiring your consent.

Changes to the group agreement do not require the consent of any employee or of any other person.

### **Entire group agreement**

The group agreement replaces and supersedes:

- All other prior agreements of group coverage between us
- Any other prior written or oral understandings, negotiations, discussions or arrangements between us related to this group coverage

### **Waiver**

Only an officer of **Aetna** may waive a requirement of the group agreement.

We may fail to implement or fail to insist upon compliance with a provision of the group agreement at any given time or times. Our failure to implement or to insist on compliance is not a waiver of our right to implement or insist upon compliance with that provision at any other time or times.

## **General provisions – administration of the group agreement**

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### **Aetna name, symbols, trademarks and service marks**

We control the use of our name and of our symbols, trademarks and service marks presently existing or subsequently established. You shall not use any of them in advertising or promotional materials or in any other way without our prior written consent. You shall stop any and all use immediately upon our direction or upon termination of the group agreement.

### **Assignment and delegation**

You shall not assign any right or delegate any duty under the group agreement unless we approve it in writing in advance.

We may assign or delegate functions under the group agreement to third parties. For example, management or administration of prescription drug benefits will be performed by CaremarkPCS Health L.L.C. and/or its affiliates (CVS Caremark®), each of which is an affiliated, licensed pharmacy benefit manager. We may also change or end these delegations. We do not need to give you advance notice to enter into, change or end these arrangements, and we do not need your consent.

### **Claim determinations – ERISA claim fiduciary**

We are a fiduciary for the purpose of section 503 of Title 1 of the Employee Retirement Income Security Act of 1974. Where there is no legal action, we have authority to review all denied claims for benefits under this group agreement. In exercising this fiduciary responsibility, we have discretionary authority:

- To determine whether and to what extent **covered persons** are entitled to benefits
- To construe any disputed or doubtful terms under the group agreement. We shall be deemed to have properly exercised our authority unless we abuse our discretion by acting arbitrarily and capriciously.

Our review of claims for benefits may include the use of software and other tools to take into account factors such as:

- An individual's claim history
- A provider's billing patterns

- Complexity of the service or treatment
- Amount of time and degree of skill needed
- The manner of billing

### **Correcting our administrative errors**

A clerical error in keeping records or a delay in making an entry will not alone determine whether there is coverage. We will determine the facts and decide if coverage is in force and its amount. We will make a fair adjustment in premium if correction of the error or delay changes coverage.

We may correct, withdraw, or replace the group agreement, any certificate, any schedule of benefits and any other document issued with an error or issued in error.

### **Correcting your honest mistakes**

If you or any employee make an honest mistake of fact, we may make a fair change in premium. If the misstatement affects the existence or amount of coverage, we will use the true facts to determine whether coverage is or remains in effect and its amount.

### **Discrimination prohibited**

You shall not encourage or discourage enrollment in the coverage provided by the group agreement based on health status or health risk.

You shall act so as not to discriminate unfairly between persons in like situations at the time of the action.

### **Financial Sanctions Exclusions**

If coverage provided by this group agreement violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, we cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information, visit <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

### **Incontestability**

We will not use a statement you make to void this group agreement after it has been in force for 2 years from its **effective date**.

We will use only a statement in writing that you or a **covered person** makes, to do any of the following:

- To void coverage of the **covered person**
- To deny coverage of the **covered person**
- To deny a claim for benefits by the **covered person**

We will not use a statement by a **covered person** to deny a claim for benefit more than 2 years after the statement was made.

### **Notices**

The group agreement requires or permits notice to each other. These notices shall be in writing.

Notice may be delivered:

- In person, and is effective upon delivery
- By United States mail, sent first class, postage prepaid, and is effective three U.S. Postal Service delivery days following the date of mailing
- By commercial carriers UPS and FedEx, effective upon delivery
- By e-mail, fax or other electronic means, effective upon sending

Mail notices to us by mail and commercial carrier:

**Aetna Health Inc.**

1425 Union Meeting Road  
Blue Bell, Pennsylvania 19422

We will send notices to you by mail and commercial carrier:

**IOTA COMMUNITY SCHOOLS**

6000 POPLAR AVE, SUITE #250  
MEMPHIS, TN 38119

You and we must designate specific e-mail addresses, fax numbers or other electronic means in writing for purpose of notices.

### **Policies and procedures**

We have the right to adopt reasonable policies, procedures, rules, and interpretations of the group agreement in order to promote orderly and efficient administration. You and all **covered persons** are bound by and shall comply with them. You will certify your compliance with them upon our request or as required specifically by the group agreement.

### **Third party rights**

This group agreement does not give any rights or impose any duties on third parties except as specifically stated.

## **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

## **Smartphone or Tablet**

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

## **Non-Discrimination**

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

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

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-982-3862.

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

Civil Rights Coordinator,  
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),  
1-800-648-7817, TTY: 711,  
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

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

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





Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-982-3862. (Tongan)

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-982-3862. (Trukese)

Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-982-3862 numarayı arayın. (Turkish)

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862. (Ukrainian)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں۔ (Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862. (Vietnamese)

צו צוטריט שפראך באדינונגען אין קיין פרייז צו איר, רופן 1-888-982-3862. (Yiddish)

Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-888-982-3862. (Yoruba)



## **HMO**

### **Health maintenance organization (HMO) Certificate of coverage**

**Prepared for:**

Contract holder: IOTA COMMUNITY SCHOOLS

Contract holder number: 0284189

Group agreement effective date: July 01, 2024

Plan effective date: July 01, 2024

**Underwritten by Aetna Health Inc., in the State of Tennessee**



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Schedule of benefits

Issued with your certificate of coverage

# Welcome

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

Welcome to Aetna.

## Introduction

This is your certificate of coverage or "certificate." It describes your **covered services** – what they are and how to get them. It also describes how we manage the plan, according to our policies, federal and state laws and regulations. The schedule of benefits tells you how we share expenses for **covered services** and explains any limits. Along with the group agreement, they describe your Aetna plan. Each may have riders or amendments attached to them. These change or add to the document. This certificate takes the place of any others sent to you before.

It's really important that you read the entire certificate and your schedule of benefits. If you need help or more information, see the *Contact us* section below.

## How we use words

When we use:

- "You" and "your", we mean you and any covered dependents (if your plan allows dependent coverage)
- "Us," "we," and "our", we mean Aetna Health Inc. (Aetna)
- Words that are in bold, these are defined in the *Glossary* section

## Contact us

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

- Calling the toll-free number on your ID card
- Writing us at 1425 Union Meeting Road, Blue Bell, PA, 19422
- Visiting <https://www.aetna.com> to register and access your member website

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

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

## Your ID card

Show your ID card each time you get **covered services** from a **provider**. Only members on your plan can use your ID card. We will mail you your ID card. If you haven't received it before you need **covered services**, or if you lose it, you can print a temporary one using your member website.

## Wellness and other rewards

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

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

## Discount arrangements

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

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

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

## Coverage and exclusions

---

### Providing covered services

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

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

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

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

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

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

### Acupuncture

**Covered services** include manual or electro acupuncture.

The following are not **covered services**:

- Acupressure

## Ambulance services

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

## Emergency

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

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

The following are not **covered services**:

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

## Applied behavior analysis

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

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

## Autism spectrum disorder

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

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

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

## Behavioral health

### Mental health treatment

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

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group, and family therapies for the treatment of **mental health disorders**
  - Other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**

- Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
  - You are homebound
  - Your **physician** orders them
  - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
  - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- Observation
- Peer counseling support by a peer support specialist (including **telemedicine** consultation)

### **Substance related disorders treatment**

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

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group, and family therapies for the treatment of **substance related disorders**
  - Other outpatient **substance related disorders** treatment such as:
    - Partial hospitalization treatment provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - 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
    - Ambulatory or outpatient **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications

- Observation
- Peer counseling support by a peer support specialist including **telemedicine** consultation)

**Behavioral health important note:**

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

## Clinical trials

### Routine patient costs

**Covered services** include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

Coverage is limited to benefits for routine patient services provided within the network.

The following are not **covered services**:

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

Participation in a clinical trial will not be the sole reason to deny coverage.

### Experimental or investigational therapies

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

- Standard therapies have not been effective or are not appropriate
- We determine you may benefit from the treatment

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

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



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

**Covered services** include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Injection devices including syringes, needles and pens
  - Test strips - blood glucose, ketone and urine
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
  - Foot orthotic devices including orthopedic shoes and shoe inserts
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

## Durable medical equipment (DME)

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

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

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

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

**Covered services** also include:

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

The following are not **covered services**:

- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table

- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

## Emergency services

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

**Covered services** include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room. You can get **emergency services** from network or **out-of-network providers**.

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

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

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

## Non-emergency services

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

## Gender affirming treatment

**Covered services** include certain services and supplies for gender affirming treatment.

### Important note:

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

## Habilitation therapy services

Habilitation therapy services are services needed to keep, learn, or improve your skills and functioning for daily living (e.g., therapy for a child who isn't walking or talking at the expected age). The services must follow a specific treatment plan, ordered by your **physician**. The services 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**

## Outpatient physical, occupational, and speech therapies

**Covered services** include:

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

The following are not **covered services**:

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

## Hearing aids age 18 and under

Hearing aid means:

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

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

- Audiometric hearing visit and evaluation for a hearing aid **prescription** performed by:
  - A **physician** certified as an otolaryngologist or otologist
  - An audiologist who:
    - Is legally qualified in audiology
    - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
    - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not **covered services**:

- Replacement of a hearing aid that is lost, stolen or broken
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

## Home health care

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

- You are homebound
- Your **physician** orders them
- The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**, or you are unable to receive the same services outside your home
- The services are a part of a home health care plan

- The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker

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

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

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

The following are not **covered services**:

- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation

## Hospice care

**Covered services** include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

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

The following are not **covered services**:

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

## Hospital care

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

- Semi-private **room and board** (your plan will cover the extra expense of a private room when appropriate because of your medical condition)
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge
- Services of **physicians** employed by the **hospital**
- Administration of blood and blood derivatives, but not the expense of the donated blood or blood product

The following are not **covered services**:

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

## Infertility services

### Basic infertility

**Covered 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**.

The following are not **covered services**:

- All **infertility** services associated with or in support of an ovulation induction cycle while on injectable medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Intrauterine/intracervical insemination services.
- All **infertility** services associated with or in support of an Assisted Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, professional services
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers
  - Gestational carrier cycles
  - Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery)
- Cryopreservation (freezing), storage or thawing of eggs, embryos, sperm or reproductive tissue.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.

## Jaw joint disorder treatment

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

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

## Maternity and related newborn care

**Covered services** include pregnancy (prenatal) care, care after delivery and obstetrical services. This includes treatment of pregnancy complications when the mother's life is endangered.

After your child is born, **covered services** include:

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

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery
- No less than 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

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

## Nutritional support

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

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

The following are not **covered services**:

Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- Medical foods
- Other nutritional items

## Outpatient surgery

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

**Important note:**

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

The following are not **covered services**:

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

## Physician services

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

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

**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.

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

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

## Physician surgical services

**Covered services** include the services of:

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

The following are not **covered services**:

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

## Preventive care

Preventive **covered services** are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing, you may pay more as these services aren't preventive. If a **covered service** isn't listed here under

preventive care, it still may be covered under other **covered services** in this section. For more information, see your schedule of benefits.

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

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

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

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

**Important note:**

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

**Breast-feeding support and counseling services**

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

**Breast pump, accessories and supplies**

**Covered services** include renting or buying equipment you need to pump and store breast milk.

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

**Counseling services**

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

- Alcohol or drug misuse
  - Preventive counseling and risk factor reduction intervention
  - Structured assessment
- Genetic risk for breast and ovarian cancer
- Obesity and healthy diet
  - Preventive counseling and risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- Sexually transmitted infection



- Tobacco cessation
  - Preventive counseling to help stop using tobacco products
  - Treatment visits
  - Class visits

### **Family planning services – female contraceptives**

**Covered services** include family planning services as follows:

- Counseling services provided by a **physician** or other **provider** on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Contraceptive devices (including any related services or supplies) when they are prescribed, provided, administered, or removed by a **health professional**.
- Voluntary sterilization including charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

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

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

### **Immunizations**

**Covered services** include preventive immunizations for infectious diseases.

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

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

### **Prenatal care**

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

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

### **Routine cancer screenings**

**Covered services** include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp

- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms (including supplemental breast screening and diagnostic imaging)
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

### **Routine physical exams**

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

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the 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
  - High risk human papillomavirus (HPV) DNA testing for women

**Covered services** include:

- Office visit to a **physician**
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns, an initial **hospital** checkup

### **Well woman preventive visits**

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

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

### **Prosthetic device**

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

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

Coverage includes:

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

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

The following are not **covered services**:

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

## **Reconstructive breast surgery and supplies**

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prostheses

## **Reconstructive surgery and supplies**

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

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

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

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

These dental related services are limited to:

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

## Short-term cardiac and pulmonary rehabilitation services

### Cardiac rehabilitation

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

### Pulmonary rehabilitation

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

## Short-term rehabilitation services

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

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

**Covered services** include spinal manipulation to correct a muscular or skeletal problem. Your **provider** must establish or approve a treatment plan that details the treatment and specifies frequency and duration.

## Cognitive rehabilitation, physical, occupational, and speech therapy

**Covered services** include:

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

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

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

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

The following are not **covered services**:

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

## Skilled nursing facility

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

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

## Specialty prescription drugs

**Covered 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 freestanding outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in the office
  - A home care **provider** in your home

Certain injected and infused medications may be covered under the outpatient **prescription drug** benefit. Contact us to determine if coverage is under this **specialty prescription drug** or the outpatient **prescription drug** benefit.

## Telemedicine

**Covered services** include **telemedicine** consultations when provided by a **physician, specialist, behavioral health provider** or other **telemedicine provider** acting within the scope of their license.

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

The following are not **covered services**:

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

## Tests, images and labs – outpatient

### Diagnostic complex imaging services

**Covered services** include:

- Computed tomography (CT) scans, including for preoperative testing
- Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans

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

Complex imaging for preoperative testing is covered under this benefit.

### **Diagnostic lab work**

**Covered services** include:

- Lab
- Pathology
- Other tests

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

### **Diagnostic x-ray and other radiological services**

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

#### **Important note:**

Coverage for supplemental breast screening and diagnostic imaging will be considered the same as mammograms performed for routine cancer screenings as described in the *Preventive care* section.

## **Therapies – chemotherapy, GCIT, infusion, radiation**

### **Chemotherapy**

**Covered services** for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

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

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

### **Key Terms**

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

#### **Gene**

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

#### **Molecular**

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

#### **Therapeutic**

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

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

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

GCIT **covered services** include:

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

### **Facilities/providers for gene-based, cellular and other innovative therapies**

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

#### **Important note:**

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

### **Infusion therapy**

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

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

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

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

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

### **Radiation therapy**

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

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

### **Transplant services**

**Covered services** include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types:

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

### **Network of transplant facilities**

We designate facilities to provide specific services or procedures. They are listed as IOE facilities in your **provider** directory.

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

#### **Important note:**

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

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



The following are not **covered services**:

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

## **Urgent care services**

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

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

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

The following are not **covered services**:

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

## **Vision care**

### **Adult vision care**

**Covered services** include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not **covered services**:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

### **Pediatric vision care**

**Covered services** include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not **covered services**:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

### **Walk-in clinic**

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

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

## General plan exclusions

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

### Abortion

Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest, if it places the woman's life in serious danger or if pregnancy complications result in a non-viable fetus.

### Abortion drugs

Drugs used for elective termination of pregnancy except when the pregnancy is the result of rape or incest, if it places the woman's life in serious danger or if pregnancy complications result in a non-viable fetus.

### Behavioral health treatment

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

- **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation
- Sexual deviations and disorders except as described in the *Coverage and exclusions* section
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions-Preventive care* section

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

Examples of these are:

- The provision of donated blood to the **hospital**, other than blood derived clotting factors
- Any related services for donated blood including processing, storage or replacement expenses
- The service of blood donors, including yourself, apheresis or plasmapheresis
- The blood you donate for your own use, excluding administration and processing expenses

### Cosmetic services and plastic surgery

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

### Court-ordered services and supplies

This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a **covered service** under your plan

## Custodial care

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

Examples of these are:

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

## Educational services

Examples of these are:

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

## Examinations

Any health or dental examinations needed:

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

## **Experimental or investigational**

**Experimental or investigational** drugs, devices, treatments or procedures unless otherwise covered under clinical trials

## **Foot care**

Routine services and supplies for the following:

- Routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails
- Supplies (including orthopedic shoes), ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
- Treatment of calluses, bunions, toenails, hammertoes or fallen arches
- Treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes

## **Foot orthotic devices**

Foot orthotics or other devices to support the feet, such as arch supports and shoe inserts, unless required for the treatment of or to prevent complications of diabetes

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

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

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

See the *How your plan works – Medical necessity, referral, and precertification requirements* section.

## **Growth/height care**

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

## **Hearing exams**

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

## **Maintenance care**

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

## **Medical supplies – outpatient disposable**

Any outpatient disposable supply or device. Examples of these include:

- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages
- Bedpans
- Home test kits not related to diabetic testing
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

### **Missed appointments**

Any cost resulting from a canceled or missed appointment

### **Obesity surgery and services**

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

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

### **Other non-covered services**

- Services you have no legal obligation to pay
- Services that would not otherwise be charged if you did not have the coverage under the plan, unless the services provided by a non-governmental charitable research hospital because it bills patients for services provided but does not enforce by judicial proceedings collection from individual patients when there is no insurance coverage

### **Other primary payer**

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

### **Personal care, comfort or convenience items**

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

### **Private duty nursing**

## **Routine exams and preventive services and supplies**

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Coverage and exclusions* section

## **Services not permitted by law**

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

## **Services provided by a family member**

Services provided by a spouse, civil union partner, domestic partner, parent, child, stepchild, 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, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- **Surgery, prescription** drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape of a sex organ
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

## **Strength and performance**

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

## **Therapies and tests**

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

## **Treatment in a federal, state, or governmental entity**

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

## **Voluntary sterilization**

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

## **Wilderness treatment programs**

See *Educational services* in this section

## **Work related illness or injuries**

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

**Important note:**

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



## How your plan works

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### How your plan works while you are covered

Your HMO plan helps you get and pay for a lot of, but not all, health care services. The plan usually pays only when you get care from **network providers**.

#### Providers

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

You choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care. Your plan often will pay a bigger share for **covered services** 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.

#### Service area

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

### Who provides the care

#### Network providers

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

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

- **Emergency services** – see the description of **emergency services** in the *Coverage and exclusions* section.
- Urgent care – see the description of urgent care in the *Coverage and exclusions* section.
- **Network provider** not reasonably available – You can get services from an **out-of-network provider** if an appropriate **network provider** is not reasonably available. You must request approval from us before you get the care. Contact us for assistance.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

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

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

#### Your PCP

You must get **covered services** through your **PCP**.

### **How you choose your PCP**

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

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

### **What your PCP will do for you**

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

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

### **Changing your PCP**

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

### **If you do not select a PCP**

Because having a **PCP** is so important, we may choose one for you. You will get an ID card in the mail. We will tell you the name, address and telephone number of your **PCP**. If you wish, you can change the **PCP** by following the directions above for *Changing your PCP*.

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

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

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

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

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

If this situation applies to you, contact us for details. If you are undergoing treatment for an acute or chronic condition and the **provider** didn't leave the network based on fraud or lack of quality standards, you'll be able to receive transitional care from your **provider** for a period up to 120 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

#### **Important note:**

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

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

### **Medical necessity, referral and precertification requirements**

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

- The service is **medically necessary**

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

### Medically necessary, medical necessity

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

#### Important note:

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

### Referrals

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

### Precertification

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

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

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

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>

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

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

Step therapy is a type of **precertification** where you must try one or more prerequisite drugs before a step therapy drug is covered. A ‘prerequisite’ is something that is required before something else. Prerequisite drugs are FDA-approved, may cost less and treat the same condition. If you don’t try the prerequisite drugs first, the step therapy drug may not be covered.

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

### **Requesting a medical exception**

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

- Call the toll-free number on your ID card
- Log in to your member website at <https://www.aetna.com/>
- Submit the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road, Richardson, TX 75081

You, someone who represents you or your **provider** may seek a quicker medical exception when the situation is urgent. It’s an urgent situation when you have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug.

### **What the plan pays and what you pay**

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

#### **The general rule**

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

- You pay the **deductible**, when it applies.
- Then the plan and you share the expense. Your share is called a **copayment** or **coinsurance**.
- 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 the **negotiated charge** for a **network provider**.

#### **Negotiated charge**

*For health coverage:*

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

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

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

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

Some of these arrangements are called:

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

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

*For **prescription drug services**:*

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

### **Surprise bill**

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

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

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

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

Ancillary services mean any professional services including:

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

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

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers

- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory and imaging centers
- Rehabilitation facilities
- Other therapeutic settings

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

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

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

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

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

You may request external review if you want to know if the federal surprise bill law applies to your situation.

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

### **Paying for covered services – the general requirements**

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

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

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

You pay the entire expense when:

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

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

### **Where your schedule of benefits fits in**

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

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

### **Coordination of benefits**

Some people have health coverage under more than one health plan. If you do, we will work with your other plan 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 will help you understand this COB section.

Allowable expense means a health care expense that any of your health plans cover.

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

- 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 government benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

### **How COB works**

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
  - We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
  - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
  - Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
    - The amount that the secondary plan saved due to COB
    - Used to cover any unpaid allowable expenses
    - Erased at the end of the year

## Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information. A plan that does not contain a COB provision is always the primary plan.

COB rule	Primary plan	Secondary plan
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together	<ul style="list-style-type: none"> <li>• Plan of parent responsible for health coverage in court order</li> <li>• Birthday rule applies if both parents are responsible or have joint custody in court order</li> <li>• Custodial parent’s plan if there is no court order</li> </ul>	<ul style="list-style-type: none"> <li>• Plan of other parent</li> <li>• Birthday rule applies (later in the year)</li> <li>• Non-custodial parent’s plan</li> </ul>
Child – covered by individuals who are not parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

## How COB works with Medicare

If your other coverage is under Medicare, federal laws explain whether Medicare will pay first or second. COB with Medicare will always follow federal requirements. Contact us if you have any questions about this.

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. If you are eligible but not covered, and Medicare would be your primary payer, we may still pay as if you are covered by Medicare and coordinate with the benefits Medicare would have paid. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered.



You are eligible for Medicare if you are covered under it. You are also eligible for Medicare even if you are not covered if you refused it, dropped it, or didn't make a request for it.

### **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.

### **Our rights**

We have the right to:

- Release or obtain any information we need for COB purposes, including information we need to recover any payments from your other health plans
- Reimburse another health plan that paid a benefit we should have paid
- Recover any excess payment from a person or another health plan, if we paid more than we should have paid

### **Benefit payments and claims**

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

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

### **Claim type and timeframes**

#### **Urgent care claim**

An urgent claim is one for which the doctor treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 72 hours.

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. We will make a decision within 15 days.

#### **Post-service claim**

A post-service claim is a claim that involves health care services you have already received. We will make a decision within 30 days.

#### **Concurrent care claim extension**

A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let us know you need this extension 24 hours before the original approval ends. We will have a

decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

### **Concurrent care claim reduction or termination**

A concurrent care claim reduction or termination occur when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an 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 uphold 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.

### **Filing a claim**

When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider** must send us the bill within 12 months of the date you received services, unless you are legally unable to notify us. You must send it to us with a claim form that you can either get online or contact us to provide. You should always keep your own record of the date, **providers** and cost of your services.

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

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

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

## Complaints, claim decisions and appeal procedures

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### The difference between a complaint and an appeal

#### Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you 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.

#### Appeal

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

### Claim decisions and appeal procedures

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

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

### Appeal of an adverse benefit determination

#### Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

#### Any other claim appeal

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 by contacting us. You need to include:

- Your name
- The plan sponsor’s name

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

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 calendar days for a post-service claim.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 180 calendar days from the date you receive the notice of the first appeal decision.

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

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

### **Exhaustion of appeal process**

In most situations, you should complete the two levels of appeal with us before you can take these other actions:

- Contact the Tennessee Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Tennessee Department of Insurance
- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding

You do not have to complete the two levels of appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
- We did not follow all of the claim determination and appeal requirements of Tennessee. 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).

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

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

You may also request external review if you want to know if the federal surprise bill law applies to your situation.

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse 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 Aetna
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

We 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 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 give you 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 benefit determinations**

- Your **provider** tells us a delay in receiving health care services would:
  - Jeopardize your life, health or ability to regain maximum function
  - Be much less effective if not started right away (in the case of **experimental or investigational** treatment)

### **For final adverse determinations**

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

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment), or
- The 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.

## **Recordkeeping**

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

## **Fees and expenses**

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

## **Eligibility, starting and stopping coverage**

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### **Eligibility**

#### **Who is eligible**

The contract holder decides and tells us who is eligible for health coverage.

#### **When you can join the plan**

You must live or work in the service area to enroll in this plan.

You can enroll:

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

You can enroll eligible family members (these are your “dependents”) at this time too.

If you don’t enroll when you first qualify for benefits, you may have to wait until the next annual enrollment period to join.

#### **Who can be a dependent on this plan**

You can enroll the following family members:

- Your legal spouse
- Your domestic partner who meets contract holder rules and requirements under state law
- Dependent children – yours or your spouse’s or partner’s
  - Dependent children must be:
    - under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including those placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court order

### **Adding new dependents**

You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

You must provide a completed enrollment form not more than 31 days after the event date.

### **Special times you can join the plan**

You can enroll in these situations:

- You didn't enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan

We must receive the completed enrollment information within 31 days the date when coverage ends.

You can also enroll in these situations:

- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You are now eligible for state premium assistance under Medicaid or S-CHIP which will pay your premium contribution under this plan

We must receive the completed enrollment information within 60 days of the date when coverage ends.

### **Notification of change in status**

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

- Change of address
- Dependent status change

- Dependent who enrolls in Medicare or any other health plan

### **Starting coverage**

Your coverage under this plan has a start and an end. You must start coverage after you complete the eligibility and enrollment process. You can ask your contract holder to confirm your effective date.

### **Stopping coverage**

Your coverage typically ends when you leave your job; but it can happen for other reasons. Ending coverage doesn't always mean you lose coverage with us. There will be circumstances that will still allow you to continue coverage. See the *Special coverage options after your coverage ends* section.

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends.

### **When will your coverage end**

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The contract holder asks to end coverage
- You are no longer eligible for coverage, including when you move out of the service area
- Your work ends
- You stop making required contributions, if any apply
- We end your coverage
- You start coverage under another medical plan offered by your employer

### **Why would we end your coverage?**

We may immediately end your coverage if you commit fraud or you intentionally misrepresented 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 prepayment for periods after the date your coverage ended.

### **Special coverage options after your coverage ends**

#### **When coverage may continue under the plan**

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have. Contact the contract holder to see what options apply to you.

In some cases, premium payment is required for coverage to continue. Your coverage will continue under the plan as long as the contract holder and we have agreed to do so. It is the contract holder's responsibility to let us know when your work ends. If the contract holder and we agree in writing, we will extend the limits.



## **Consolidated Omnibus Budget Reconciliation Act (COBRA)**

The federal COBRA law usually applies to employers of group sizes of 20 or more and gives employees and most of their covered dependents the right to keep their health coverage for 18, 29 or 36 months after a qualifying event. The qualifying event is something that happens that results in you losing your coverage. The qualifying events are:

- Your active employment ends for reasons other than gross misconduct
- Your working hours are reduced
- 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 dependents under the plan
- You die
- You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy

Talk with your employer if you have questions about COBRA or to enroll.

### **When you are not eligible for COBRA coverage**

If you lost coverage because of termination due to gross misconduct, the COBRA wouldn't be offered. In that case you will be covered for the remaining month after your termination plus another 3 months, after paying your monthly premium.

### **How you can extend coverage because of death or divorce from your covered spouse**

Your coverage may be extended if it ends because of divorce or death of your covered spouse. Your coverage will continue for the month remaining after your coverage ends plus up to 15 months upon advance payment to your employer every month for the full month's premium.

### **How you can extend coverage if you are pregnant when coverage ends**

Your coverage may be extended if your coverage is terminated during pregnancy. Your coverage will continue for the remaining month at termination, plus no less than 6 months after the pregnancy ends.

### **Continuation of coverage for other reasons**

To request an extension of coverage, just contact us

### **How you can extend coverage if you are totally disabled when coverage ends**

Your coverage may be extended if you are totally disabled when coverage ends.

Only the medical condition which caused the total disability is covered during your extension.

You are "totally disabled" if you cannot work at your occupation or any other occupation for pay or profit.

Your covered dependent is "totally disabled" if they can't engage in most normal activities like a healthy person of the same age and gender.

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:

- When you or your dependent are no longer totally disabled
- When you become covered by another health benefits plan

- 36 months of coverage

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

You have the right to extend coverage for your dependent child beyond plan age limits, if the child is not able to self-sustain employment because of mental or physical disability and depends mainly (50% or more of their income) on you for support.

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

We may ask you to send us proof of the disability within 31 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

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

### **How you can extend coverage when getting inpatient care when coverage ends**

Your coverage may be extended if you are getting inpatient care in a **hospital** or **skilled nursing facility** when coverage ends.

Benefits are extended for the condition that caused the **hospital** or **skilled nursing facility stay** or for complications from the condition. Benefits aren't extended for other medical conditions.

You can continue to get care for this condition until the earliest of:

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

### **How your dependent can extend coverage after you die**

Your dependents can continue coverage after your death if:

- You were covered at the time of your death
- The request is made within 30 days after your death, and
- Payment is made for coverage

Your dependent's coverage will end on the earliest date:

- The end of the 12 month period after your death
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- The date your spouse remarries

To request extension of coverage, the dependent, or their representative, can contact us.

## General provisions – other things you should know

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### Administrative provisions

#### How you and we will interpret this certificate

We prepared this certificate according to ERISA and other federal and state laws that apply. You and we will interpret it according to these laws. Also, we have the right to make determinations on matters such as eligibility for services, denials of benefits, and other terms of this certificate at our discretion, subject to the terms of this certificate.

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

### Coverage and services

#### Your coverage can change

Your coverage is defined by the group agreement. This document may have amendments and riders too. Under certain circumstances, we, the contract holder 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 the contract holder or **provider**, can do this.

#### Physical examination and evaluations

At our expense, we have the right to have a **physician** of our choice examine you. This will be done at reasonable times while certification or a claim for benefits is pending or under review.

#### Records of expenses

You should keep complete records of your expenses. They may be needed for a claim. Important things to keep are:

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

### Honest mistakes and intentional deception

#### Honest mistakes

You or the contract holder 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 consequences for your coverage. These serious consequences include, but are not limited to:

- Rescission of coverage
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to criminal authorities. See the *Benefit payments and claims, Filing a claim* section for information about rescission.

You have special rights if we rescind your coverage:

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

## **Some other money issues**

### **Legal action**

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

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

### **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.

### **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 **covered services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting <https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

### **Recovery of overpayments**

We sometimes pay too much for **covered services** or pay for something that this 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 up to 18 months after the overpayment was received, except in cases of fraud.

### **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 whom the money comes from – for example, the other driver, the contract holder, or another insurance company.

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

- Agreeing to repay us from money you receive because of your injury when you are fully compensated or “made whole” for your loss.
- Giving us the 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.
- 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.
- 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.

Once you are made whole, 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 will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your plan.

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

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

## Glossary

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### Behavioral health provider

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

### Brand-name prescription drug

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

### Coinsurance

This is the percentage of **covered services** you pay after your **deductible**.

### Copay, copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit. In **prescription** drug plans, it is the amount you pay for covered drugs.

### Covered service

The benefits, subject to varying cost shares, covered under the plan. These are:

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

### Deductible

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

### Detoxification

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

### Drug guide

A list of **prescription** and OTC drugs and devices established by us or an affiliate. It does not include all **prescription** and OTC drugs and devices. This list can be reviewed and changed by us or an affiliate. A copy is available at your request. Go to <https://www.aetna.com/individuals-families/find-a-medication.html>.

### Emergency medical condition

An acute, severe medical condition that:

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

- Danger to the health of an unborn baby

## Emergency services

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

## Experimental or investigational

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

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

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

## Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product, that is considered to be as effective as the brand-name product. It offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance

## Health professional

A person who is authorized by law to provide health care services to the public; for example, **physicians**, nurses and physical therapists.

## Home health care agency

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

## Hospital

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

## Infertility

A disease defined by the failure to become pregnant:

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

## Jaw joint disorder

This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

## Mail order pharmacy

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

## Medically necessary, medical necessity

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

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

Generally accepted standards of medical practice mean:

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

### Important note:

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



## Mental health disorder

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

## Negotiated charge

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

## Network provider

A **provider** listed in the directory for your plan. A NAP **provider** listed in the NAP directory is not a **network provider**.

## Out-of-network provider

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

## Physician

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

## Precertification, precertify

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

## Prescription

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

## Primary care physician (PCP)

A **physician** who:

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

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

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

## Provider

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

## Psychiatric hospital

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

## Referral

This is a written or electronic authorization made by your **PCP** to direct you to a **network provider** for **medically necessary** services and supplies.

## Residential treatment facility

An institution specifically licensed by applicable laws to provide residential treatment programs for **mental health disorders**, **substance related disorders**, or both. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

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

In addition to the above requirements, an institution must meet the following:

For residential treatment programs treating **mental health disorders**:

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

For residential treatment programs treating **substance related disorders**:

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

For **detoxification** programs within a residential setting:

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

## Retail pharmacy

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

## Room and board

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

## Semi-private room rate

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

## Skilled nursing facility

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

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

**Skilled nursing facility** does not include institutions that provide only:

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

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

## Specialist

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

## Specialty prescription drug

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

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

## Specialty pharmacy

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

## Stay

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

## Substance related disorder

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

## Surgery, surgical procedure

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

- Cutting
- Abrading

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

### **Telemedicine**

A consultation between you and a **physician, specialist, or behavioral health provider or telemedicine provider** who is performing a clinical medical or behavioral health service by means of electronic communication.

### **Terminal illness**

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

### **Value prescription drugs**

A group of medications determined by us that may be available at a reduced **copayment** or **coinsurance** and are noted on the **drug guide**.

### **Walk-in clinic**

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

- Drug store
- Pharmacy
- Retail store
- Supermarket

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

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

## **Important Information about the Affordable Care Act (ACA)**

### **Non-discrimination Rule**

The Office of Civil Rights recently issued a Non-discrimination Rule in response to Section 1557 of the Affordable Care Act (ACA). Section 1557 prohibits discrimination because of race, color, national origin, sex, age or disability in health-related insurance or other health-related coverage. This applies to Aetna. Changes to health insurance plans are effective on the first day of the policy or plan year beginning on or after January 1, 2017.

Some language changes may not be in the enclosed certificate of coverage or policy. This may be because the language is still under official review for approval. See the *Important note* below for how this affects your policy or plan.

**Important note:**

We will comply with the requirements of the Rule for all new and renewing policies or plans with an effective date on or after January 1, 2017.

Below is a summary of some of the recent Non-discrimination Rule changes.

An insurer covered by the Rule that provides or administers health-related insurance or other health-related coverage:

- Shall not:
  - Cancel, limit or refuse to issue or renew a policy or plan
  - Deny or limit coverage of a claim
  - Apply additional cost sharing

to a person because of race, color, national origin, sex, age, or disability.

- Shall not:
  - Deny or limit coverage
  - Deny or limit coverage of a claim
  - Apply additional cost sharing

to a transgender person, if it results in discrimination against that person.

- Shall not exclude or limit health services related to gender transition.

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates. Aetna companies that receive funds from the federal Department of Health and Human Services are subject to the Rule.**

**NOTICE CONCERNING COVERAGE UNDER  
THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. **This summary does not cover all provisions of the law, or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

- (1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);
- (2) the insurer was not authorized to do business in this state;
- (3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

- (1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- (2) any policy of reinsurance (unless an assumption certificate was issued);
- (3) interest rate yields that exceed an average rate;
- (4) dividends;
- (5) credits given in connection with the administration of a policy by a group contractholder;
- (6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- (7) unallocated annuity contracts (which give rights to group contractholders, not individuals).

#### LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- \$300,000 for policies and contracts of all types, except as described in the next point
- \$500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - \$300,000
- life insurance cash surrender value - \$100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - \$100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - \$250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - \$100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
  - \$100,000 for limited benefits and supplemental health coverages
  - \$300,000 for disability and long term care insurance
  - \$500,000 for basic hospital, medical and surgical insurance or major medical insurance

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The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Insurance Guaranty Association  
150 Third Avenue South  
Suite 1600  
Nashville, TN 37201

Tennessee Department of Commerce and Insurance  
500 James Robertson Parkway  
Nashville, TN 37243

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# AETNA HEALTH INC. Rider

## Obesity surgery

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Rider effective date: July 01, 2024

This obesity surgery rider is added to your certificate. It describes your obesity **surgery** benefit. Obesity **surgery** is also known as bariatric and weight loss **surgery**. This rider is subject to all other requirements described in your certificate, including general exclusions and defined terms.

### What you need to know about obesity surgery benefit

Read this rider carefully so you will know:

- How to find an obesity **surgical** facility
- Coverage and exclusions
- What **precertification** requirements apply
- Where your schedule of benefits fits in
- How to read your schedule of benefits

### How to find an obesity surgical facility

You may go to any network facility that performs obesity **surgery**. Contact us to find a network facility.

### Coverage and exclusions

#### Covered services

Obesity **surgery** is a type of procedure performed on people who are morbidly obese for the purpose of losing weight. Your **physician** will determine whether you qualify for obesity **surgery**.

**Covered services** include:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient **prescription** drugs included under the **prescription** drug rider when **prescription** drugs are covered under the plan
- One obesity **surgical** procedure
- A multi-stage procedure when planned and approved by us
- Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

#### Exclusions

The following are not **covered services**:

- Weight management treatment
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate or this rider
- Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:
  - 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

## What precertification requirements apply

Your **provider** will request approval from us before your obesity **surgery**. See the *Medical necessity, referral and precertification* section of the certificate for more information.

## Where your schedule of benefits fits in

### How you share in the cost

This schedule of benefits lists the **deductibles**, limits and **copayments** or **coinsurance**, if any apply to the **covered services** you receive under this rider. This rider is subject to the requirements described in your plan schedule of benefits unless otherwise noted below.

### How your cost share works

- The **deductibles**, **copayments** and **coinsurance**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- You are responsible to pay any **deductibles**, **copayments** and **coinsurance**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

#### Important note:

**Covered services** are subject to the calendar year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **coinsurance** described in the medical plan schedule of benefits unless otherwise noted below.

## Covered services

### Obesity surgery

Description	In-network
Inpatient services – <b>room and board</b>	\$100 per day for 3 days per admission then 0% thereafter

	after <b>deductible</b>
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### Outpatient obesity surgery services

Description	In-network
At <b>specialist</b> office	\$40 per visit
	no <b>deductible</b> applies
At <b>hospital</b> outpatient department	\$0 per visit after <b>deductible</b>
At facility that is not a <b>hospital</b>	\$0 per visit after <b>deductible</b>

# Aetna Health Inc. Rider

## Prescription drug plan

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Rider effective date: July 01, 2024

This **prescription** drug plan rider is added to your certificate. It describes your **prescription** drug benefits. This rider is subject to all other requirements described in your certificate, including general exclusions and defined terms.

### What you need to know about the prescription drug plan

Read this rider carefully so you will know:

- How to access your benefit
- How to access network pharmacies
- How to get an emergency **prescription** filled
- Coverage and exclusions
- Where your schedule of benefits fits in
- **Precertification** requirements that apply
- Utilization review
- Requesting a medical exception
- How to read your schedule of benefits

### How to access your benefit

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

#### **Important note:**

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

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

**Covered services** are based on the drugs in the **drug guide**. We exclude **prescription** drugs listed on the formulary exclusions list unless we approve a medical exception. The formulary exclusions list is a list of **prescription** drugs not covered under the plan. This list is subject to change. If it is **medically necessary** for you to use a **prescription** drug that is not on this **drug guide**, you or your **provider** must request a medical exception. See the *Requesting a medical exception* section for more information.

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

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

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

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

### **Prescription drug synchronization**

If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, your network pharmacy may be able to coordinate that for you. This is called synchronization. We will apply a prorated daily cost share rate, to a partial fill of a maintenance drug, if needed, to synchronize your **prescription** drugs.

### **How to access network pharmacies**

A network pharmacy will submit your claim. You will pay your cost share to the pharmacy. You can find a network pharmacy online or by phone. See the *Contact us* section in your certificate for how. You may go to any of our network pharmacies.

### **Pharmacy types**

#### **Retail pharmacy**

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

#### **Mail order pharmacy**

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

#### **Specialty pharmacy**

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

### **When the pharmacy you use leaves the network**

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

### **How to get an emergency prescription filled**

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

<b>Type of pharmacy</b>	<b>Your cost share will be</b>
A network pharmacy	The plan cost share
An out-of-network pharmacy	The full cost of the <b>prescription</b>

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

- You will fill out and send a **prescription** drug refund form to us, including all itemized pharmacy receipts
- Coverage will be limited to items obtained in connection with the out-of-area emergency or urgent situation

- Submission of the refund form doesn't guarantee a refund. If approved, you will be reimbursed the cost of the **prescription** less your network cost share

## Other covered services

### Anti-cancer drugs taken by mouth

**Covered services** include any drug prescribed for cancer treatment, including chemotherapy drugs. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

### Contraceptives (birth control)

For females who are able to become pregnant, your **prescription** drug plan covers certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at a network pharmacy. At least one form of each FDA-approved contraception methods is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for how.

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

#### Preventive contraceptives important note:

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

## Diabetic supplies

**Covered services** include items such as:

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

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

## Immunizations

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

## Infertility drugs

**Covered services** include oral ovulation induction **prescription** drugs used to treat the underlying medical cause of **infertility**.

## Over-the-counter (OTC) drugs

**Covered services** include certain OTC medications when you have a **prescription** from your **provider**. You can see a list of covered OTC drugs by logging on to your member website.

## Preventive care drugs and supplements

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

## Risk reducing breast cancer prescription drugs

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

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

## Sexual dysfunction or enhancement drugs

**Covered services** include **prescription** drugs for the treatment of sexual dysfunction or enhancement. See the *Contact us* section for how to find the most up-to-date information on dosing.

## Tobacco cessation prescription and OTC drugs

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

## Exclusions

The following are not **covered services**:

- Abortion drugs used for elective termination of pregnancy except when the pregnancy places the woman's life in serious danger
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a **covered service**
- Drugs or medications
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a **prescription** by law, even if a **prescription** is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered **prescription** drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a **covered service**

- That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
- That are drugs or growth hormone 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, for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body’s genes, genetic makeup or the expression of the body’s genes unless listed as a **covered service**
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule or the certificate
- **Infertility:**
  - Injectable **prescription** drugs used primarily for the treatment of **infertility**
- Injectables including:
  - Any charges for the administration or injection of **prescription** drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription** drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or **prescription** drugs for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan’s **drug guide**
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- Tobacco cessation drugs unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer’s product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan’s **drug guide**
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan’s **drug guide**

## Where your schedule of benefits fits in

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **coinsurance**, if any apply to the **covered services** you receive under the **prescription** drug plan. You should review this schedule to become aware of these and any limits that apply to these services.

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

- The type of **prescription** you're prescribed
- Where you fill the **prescription**

The plan may make some **brand-name prescription drugs** available to you at the **generic prescription drug** cost share.

## Precertification requirements that apply

For certain drugs, your **provider** 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 certain drugs and makes sure they are **medically necessary**.

Step therapy is a type of **precertification** where you must try one or more prerequisite drugs before a step therapy drug is covered. A 'prerequisite' is something that is required before something else. Prerequisite drugs are FDA-approved, may cost less and treat the same condition. If you don't try the prerequisite drugs first, the step therapy drug may not be covered.

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

## Utilization review

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

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

## Requesting a medical exception

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

- Call the toll-free number on your ID card
- Log in to your member website at <https://www.aetna.com/>
- Submit the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road, Richardson, TX 75081

You, someone who represents you or your **provider** may seek a quicker medical exception when the situation is urgent. It's an urgent situation when you have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug.

## How to read your schedule of benefits

### How your cost share works

- The **deductibles, copayments** and **coinsurance**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- You are responsible to pay any **deductibles, copayments** and **coinsurance**, if they apply and before the plan will pay for any **covered services**.



- Your **copayment** or **coinsurance** is the amount you pay for each **prescription** fill or refill. The schedule of benefits shows you the cost share you need to pay for a specific **prescription** fill or refill.
- This plan doesn't cover every **prescription** drug. You pay the full amount of any **prescription** drug you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **provider** or contact us if you have a question about what your cost share will be.

**Important note:**

All **covered services** are subject to the calendar year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **coinsurance** described in the medical plan schedule of benefits unless otherwise stated in this schedule.

## Plan features

### **Deductible and cost share waiver for risk reducing breast cancer prescription drugs**

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

### **Deductible and cost share waiver for contraceptives (birth control)**

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

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

### **Deductible and cost share waiver for tobacco cessation prescription and OTC drugs**

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

## **General coverage provisions**

### **Prescription drug maximum out-of-pocket limit provisions**

**Covered services** that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

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

- All costs for non-**covered services**

## Covered services

### Preferred generic prescription drugs

Description	In-network
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30 day supply at a <b>retail pharmacy</b> or <b>mail order pharmacy</b>	\$20
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90 day supply at a <b>retail pharmacy</b> or <b>mail order pharmacy</b>	\$40
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### Preferred brand-name prescription drugs

Description	In-network
-------------	------------

30 day supply at a <b>retail pharmacy</b> or <b>mail order pharmacy</b>	\$40
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90 day supply at a <b>retail pharmacy</b> or <b>mail order pharmacy</b>	\$80
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### Non-preferred generic prescription drugs

Description	In-network
-------------	------------

30 day supply at a <b>retail pharmacy</b> or <b>mail order pharmacy</b>	\$70
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90 day supply at a <b>retail pharmacy</b> or <b>mail order pharmacy</b>	\$140
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### Non-preferred brand-name prescription drugs

Description	In-network
-------------	------------

30 day supply at a <b>retail pharmacy</b> or <b>mail order pharmacy</b>	\$70
---	------

90 day supply at a <b>retail pharmacy</b> or <b>mail order pharmacy</b>	\$140
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### Specialty prescription drugs

Description	In-network
-------------	------------

30 day supply at a <b>specialty pharmacy</b> or a <b>retail pharmacy</b> or <b>mail order pharmacy</b>	20% but no more than \$250
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### Anti-cancer drugs taken by mouth

Description	In-network
-------------	------------

30 day supply or <b>mail order pharmacy</b>	\$0
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90 day supply or <b>mail order pharmacy</b>	\$0
---	-----

### Contraceptives (birth control)

**Brand-name prescription drugs** and devices are covered at 100% when a generic is not available

Description	In-network
90 day supply of generic and OTC drugs and devices	\$0
90 day supply of <b>brand-name prescription drugs</b> and devices	Paid based on the tier of drug in the schedule

### Diabetic supplies, drugs and insulin

Description	In-network
30 day supply at a <b>retail pharmacy</b> or <b>mail order pharmacy</b>	Paid based on the tier of drug in the schedule
90 day supply at a <b>retail pharmacy</b> or <b>mail order pharmacy</b>	Paid based on the tier of drug in the schedule

### Preventive care drugs and supplements

Description	In-network
Preventive care drugs and supplements	\$0
Limits	<p>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF).</p> <p>For a current list of covered drugs and supplements or more information see the <i>Contact us</i> section.</p>

### Risk reducing breast cancer prescription drugs

Description	In-network
Risk reducing breast cancer <b>prescription drugs</b>	\$0
Limits	<p>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF.</p> <p>For a current list of covered risk reducing breast cancer drugs or more information, see the <i>Contact us</i> section.</p>

### Tobacco cessation prescription and OTC drugs

Description	In-network
Tobacco cessation <b>prescription</b> and OTC drugs	\$0
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF.  For a current list of covered tobacco cessation drugs or more information, see the <i>Contact us</i> section.

## **Schedule of benefits**

If this is an ERISA plan, you may have certain rights under this plan. ERISA may not apply to a church or government group. Please contact the contract holder for additional information.

### **Prepared for:**

Contract holder: IOTA COMMUNITY SCHOOLS

Contract holder number: 0284189

HMO group agreement effective date: July 01, 2024

Plan name: HMO

Plan effective date: July 01, 2024



## Schedule of benefits

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This schedule of benefits (schedule) lists the **deductibles, copayments** or **coinsurance**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

### How your cost share works

- The **deductibles, copayments** and **coinsurance**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- You are responsible to pay any **deductibles, copayments** and **coinsurance** if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits.  
See the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at <https://www.aetna.com/>.

#### **Important note:**

**Covered services** are subject to the calendar year **deductible**, maximum out-of-pocket, limits, **copayment** or **coinsurance** unless otherwise stated in this schedule. The *Surprise bill* section in the certificate explains your protections from a surprise bill.

### How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay.

This is in addition to any **copayment** or **coinsurance** you pay when you get **covered services** from an in-network **provider**.

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

### How your PCP or physician office visit cost share works

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

### How your maximum out-of-pocket works

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

## Contact us

We are here to answer questions. See the *Contact us* section in your certificate.

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

## Plan features

### Deductible

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

Deductible type	In-network
Individual	\$250 per calendar year
Family	\$500 per calendar year

### Deductible waiver

There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

### Maximum out-of-pocket limit

Includes the **deductible**

Maximum out-of-pocket type	In-network
Individual	\$3,000 per calendar year
Family	\$9,000 per calendar year



## General coverage provisions

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

### Deductible provisions

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **coinsurance**, if any, for these **covered services**.

### Individual deductible

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

### Family deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

### Copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit. In **prescription** drug plans, it is the amount you pay for covered drugs.

### Coinsurance

This is the percentage of **covered services** you pay after your **deductible**.

### Maximum out-of-pocket limit

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

### Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

### Family maximum out-of-pocket limit

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

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

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

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-covered services which are identified in the certificate and the schedule

### **Your financial responsibility and decisions regarding benefits**

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

## Covered services

### Acupuncture

Description	In-network
Acupuncture	\$20 per visit
	no <b>deductible</b> applies
Visit limit per year	20

### Ambulance services

Description	In-network
Emergency services	\$0 per trip
	no <b>deductible</b> applies
Non-emergency services	Not covered

### Applied behavior analysis

Description	In-network
Applied behavior analysis	\$0 per visit
	no <b>deductible</b> applies

### Autism spectrum disorder

Description	In-network
Diagnosis and testing	\$40 per visit
	no <b>deductible</b> applies
Treatment	\$40 per visit
	no <b>deductible</b> applies
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	\$0 per visit
	no <b>deductible</b> applies

## Behavioral health

### Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services- <b>room and board</b> including <b>residential treatment facility</b>	\$100 per day up to 3 days per admission, then 0% thereafter
	after <b>deductible</b>
Other inpatient services and supplies Other <b>residential treatment facility</b> services and supplies	No charge
Outpatient office visit to a <b>physician</b> or <b>behavioral health provider</b>	\$40 per visit no <b>deductible</b> applies
<b>Physician</b> or <b>behavioral health provider</b> <b>telemedicine</b> consultation	\$40 per visit no <b>deductible</b> applies
Outpatient <b>mental health disorders telemedicine</b> cognitive therapy consultations by a <b>physician</b> or <b>behavioral health provider</b>	\$0 per visit no <b>deductible</b> applies
Other outpatient services including: <ul style="list-style-type: none"> <li>Behavioral health services in the home</li> <li>Partial hospitalization treatment</li> <li>Intensive outpatient program</li> </ul> <p>The cost share doesn't apply to in-network peer counseling support services</p>	\$0 per visit
	no <b>deductible</b> applies
<b>Telemedicine provider mental health disorders</b> consultation	Covered based on type of service and <b>provider</b> from which it is received

### Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services – <b>room and board</b> during a <b>hospital stay</b>	\$100 per day up to 3 days per admission, then 0% thereafter
	after <b>deductible</b>

Other inpatient services and supplies during a <b>hospital stay</b>	No charge
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Outpatient office visit to a <b>physician</b> or <b>behavioral health provider</b>	\$40 per visit no <b>deductible</b> applies
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<b>Physician</b> or <b>behavioral health provider</b> <b>telemedicine</b> consultation	\$40 per visit no <b>deductible</b> applies
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Outpatient <b>telemedicine</b> cognitive therapy consultations by a <b>physician</b> or <b>behavioral health provider</b>	\$0 per visit no <b>deductible</b> applies
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Other outpatient services including: <ul style="list-style-type: none"> <li>Behavioral health services in the home</li> <li>Partial hospitalization treatment</li> <li>Intensive outpatient program</li> </ul> <p>The cost share doesn't apply to in-network peer counseling support services</p>	\$0 per visit
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	no <b>deductible</b> applies
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<b>Telemedicine provider substance related disorders</b> consultation	Covered based on type of service and <b>provider</b> from which it is received
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**Clinical trials**

Description	In-network
<b>Experimental or investigational</b> therapies	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received

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

Description	In-network
Diabetic services	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received
Diabetic equipment	Covered based on type of service and where it is received
Diabetic self-care programs	Covered based on type of service and where it is received

### Durable medical equipment (DME)

Description	In-network
DME	\$0 per item

	no <b>deductible</b> applies
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### Emergency services

Description	In-network
Emergency room	\$200 per visit

	no <b>deductible</b> applies
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#### Emergency services important note:

**Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

### Habilitation therapy services

#### Outpatient physical (PT), occupational (OT) therapies

Description	In-network
PT, OT therapies	\$0 per visit no <b>deductible</b> applies

#### Outpatient speech therapy (ST)

Description	In-network
ST therapy	\$0 per visit no <b>deductible</b> applies

### Hearing aids age 18 and under

Description	In-network
Hearing aids	20% per item no <b>deductible</b> applies

Age limit	Covered persons through age 18
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Limit	One per ear every 36 months
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Limit every 36 months	\$1,000
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## Home health care

A visit is a period of 4 hours or less

Description	In-network
Home health care	\$40 per visit no <b>deductible</b> applies
Limit per year	120

### Home health care important note:

Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

## Hospice care

Description	In-network
Inpatient services - <b>room and board</b>	\$100 per day up to 3 days per admission, then 0% thereafter (waived if you are transferred from a <b>hospital</b> to a hospice care facility, and the maximum has been satisfied in the <b>hospital</b> )
	after <b>deductible</b>
Other inpatient services and supplies	No charge
Outpatient services	\$0 per visit
	no <b>deductible</b> applies

### Hospice important note:

This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

## Hospital care

Description	In-network
Inpatient services – <b>room and board</b>	\$100 per day up to 3 days per admission, then 0% thereafter
	after <b>deductible</b>
Other inpatient services and supplies	No charge

### Infertility services

Description	In-network
Treatment of basic <b>infertility</b>	Covered based on type of service and where it is received

### Jaw joint disorder

Includes TMJ

Description	In-network
<b>Jaw joint disorder</b> treatment	\$40 per visit

	no <b>deductible</b> applies
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### Maternity and related newborn care

Includes complications

Description	In-network
Inpatient services – <b>room and board</b>	\$0 per admission

	no <b>deductible</b> applies
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Other inpatient services and supplies	No charge
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Services performed in <b>physician</b> or <b>specialist</b> office or a facility	\$0 per visit
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	no <b>deductible</b> applies
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Other services and supplies	Covered based on type of service and where it is received
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#### **Maternity and related newborn care important note:**

Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the certificate. It will give you more information about coverage for maternity care under this plan.



## Nutritional support

Description	In-network
Nutritional support	\$0 per item

	no <b>deductible</b> applies
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## Outpatient surgery

Description	In-network
At <b>hospital</b> outpatient department	\$200 per visit after <b>deductible</b>
At facility that is not a <b>hospital</b>	\$200 per visit after <b>deductible</b>

At the <b>physician</b> office	Covered based on type of service and where it is received
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## Physician and specialist services

Including surgical services

### Your PCP

Description	In-network
<b>Physician</b> office hours (not surgical, not preventive)	\$20 per visit no <b>deductible</b> applies

Immunizations that are not considered preventive care	Covered based on type of service and where it is received
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<b>Physician</b> visit during inpatient <b>stay</b>	\$20 per visit no <b>deductible</b> applies
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<b>Physician</b> home visit (not preventive)	\$20 per visit no <b>deductible</b> applies
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<b>Physician</b> surgical services	\$20 per visit no <b>deductible</b> applies
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<b>Physician telemedicine</b> consultation	\$20 per visit no <b>deductible</b> applies
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<b>Telemedicine provider</b> consultation Basic medical services	Covered based on type of service and <b>provider</b> from which it is received
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## Specialist

Description	In-network
<b>Specialist</b> office hours (not surgical, not preventive)	\$40 per visit no <b>deductible</b> applies

<b>Specialist</b> home visit (not preventive)	\$40 per visit no <b>deductible</b> applies
<b>Specialist</b> surgical services	\$40 per visit no <b>deductible</b> applies
<b>Specialist telemedicine</b> consultation	\$40 per visit no <b>deductible</b> applies
<b>Telemedicine provider</b> consultation <b>Specialist</b> services	Covered based on type of service and <b>provider</b> from which it is received

### Preventive care

Description	In-network
Preventive care services	\$0 no <b>deductible</b> applies
Breast feeding counseling and support limit	6 visits in a group or individual setting  Visits that exceed the limit are covered under the <b>physician</b> services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy  Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump
Counseling for alcohol or drug misuse visit limit per day	1
Counseling for alcohol or drug misuse visit limit	5 visits/12 months
Counseling for obesity, healthy diet visit limit per day	1
Counseling for obesity, healthy diet visit limit	Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Counseling for tobacco cessation visit limit per day	1
Counseling for tobacco cessation visit limit	8 visits/12 months
Family planning services (female contraception and counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting  Counseling that exceeds this limit covered as a <b>physician</b> services office visit

Description	In-network
Immunizations limit	<p>Covered persons age 0-99</p> <p>Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</p> <p>For details, contact your <b>physician</b></p>
Routine cancer screening limits	<p>Subject to any age, family history and frequency guidelines as set forth in the most current:</p> <p>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF</p> <p>The comprehensive guidelines supported by the Health Resources and Services Administration</p> <p>For more information contact your <b>physician</b> or see the <i>Contact us</i> section of your certificate</p>
Routine lung cancer screening limit	<p>1 screening every 12 months</p> <p>Screenings that exceed this limit covered as outpatient diagnostic testing</p>
Routine physical exam limits	<p>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents</p> <p>Limited to</p> <p>7 exams from age 0-1 year  3 exams every 12 months age 1-2  3 exams every 12 months age 2-3 and 1 exam every 12 months after that age, up to age 22  1 exam every 12 months after age 22</p> <p>High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months</p>
Well woman routine GYN exam limit	<p>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration</p>

### Prosthetic devices

Includes medical wigs

Description	In-network
Prosthetic devices	\$0 per item
	no <b>deductible</b> applies

## Reconstructive surgery and supplies

Including breast surgery

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

## Short-term rehabilitation services

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

### Cardiac rehabilitation

Description	In-network
Cardiac rehabilitation	\$40 per visit no <b>deductible</b> applies

### Pulmonary rehabilitation

Description	In-network
Pulmonary rehabilitation	\$40 per visit no <b>deductible</b> applies

### Cognitive rehabilitation

Description	In-network
Cognitive rehabilitation	Covered based on type of service and where it is received

## Physical, occupational and speech therapies

Description	In-network
At the <b>physician</b> office	\$40 per visit no <b>deductible</b> applies
At facility that is not a <b>hospital</b>	\$40 per visit no <b>deductible</b> applies
At <b>hospital</b> outpatient department	\$40 per visit no <b>deductible</b> applies

Visit limit per year	60
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## Spinal manipulation

Description	In-network
At the <b>physician</b> office	\$40 per visit no <b>deductible</b> applies
At facility that is not a <b>hospital</b>	\$40 per visit no <b>deductible</b> applies
At <b>hospital</b> outpatient department	\$40 per visit no <b>deductible</b> applies

## Skilled nursing facility

Description	In-network
Inpatient services – <b>room and board</b>	\$100 per day up to 3 days per admission, then 0% thereafter (waived if you are transferred from a <b>hospital</b> to a <b>skilled nursing facility</b> , and the maximum has been satisfied in the <b>hospital</b> )

	after <b>deductible</b>
Day limit per year	unlimited
Other inpatient services and supplies	No charge

## Tests, images and labs - outpatient

### Diagnostic complex imaging services

Description	In-network
At facility that is not a <b>hospital</b>	\$40 per visit no <b>deductible</b> applies
At <b>hospital</b> outpatient department	\$40 per visit no <b>deductible</b> applies

### Diagnostic lab work

Description	In-network
At facility that is not a <b>hospital</b>	\$40 per visit no <b>deductible</b> applies
At <b>hospital</b> outpatient department	\$40 per visit no <b>deductible</b> applies

### Diagnostic x-ray and other radiological services

Description	In-network
At facility that is not a <b>hospital</b>	\$40 per visit no <b>deductible</b> applies
At <b>hospital</b> outpatient department	\$40 per visit no <b>deductible</b> applies

## Therapies

### Chemotherapy

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

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

Description	In-network (GCIT-designated facility/provider)	Non-designated network facility/provider (Including <b>providers</b> who are otherwise part of Aetna's network but are not GCIT-designated facilities/ <b>providers</b> )
Services and supplies	Covered based on type of service and where it is received	Not covered

## Infusion therapy

### Outpatient services

Description	In-network
In <b>physician</b> office	\$40 per visit
	no <b>deductible</b> applies
At an infusion location	\$200 per visit
	after <b>deductible</b>
In the home	\$40 per visit
	no <b>deductible</b> applies
At <b>hospital</b> outpatient department	\$200 per visit
	after <b>deductible</b>
At facility that is not a <b>hospital</b>	\$200 per visit
	after <b>deductible</b>

## Radiation therapy

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

## Transplant services

Description	Network (IOE facility)	Network non-IOE facility (Including <b>providers</b> who are otherwise part of Aetna's network but are non-IOE <b>providers</b> )
Inpatient services and supplies	\$100 per day up to 3 days per admission, then 0% thereafter	Not covered
	after <b>deductible</b>	

## Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

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

Description	In-network
Urgent care facility	\$25 per visit
	no <b>deductible</b> applies
Complex imaging, lab and radiology services	No charge

## Vision care

Performed by an ophthalmologist or optometrist and includes refraction

### Adult vision care

Description	In-network
Adult vision exam	\$0 per visit
	no <b>deductible</b> applies
Limit	Limited to covered persons age 19 and older
Visit limit	1 every 24 months

### Pediatric vision care

Description	In-network
Pediatric vision exam	\$0 per visit
	no <b>deductible</b> applies
Limit	Limited to covered persons through the end of the month in which the person turns 19
Visit limit	1 every 24 months

## Walk-in clinic

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

Description	In-network
Non-emergency services	\$20 per visit
	no <b>deductible</b> applies
Preventive care immunizations	\$0 per visit no <b>deductible</b> applies
Preventive care immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your <b>physician</b>
Preventive screening and counseling services	\$0 per visit no <b>deductible</b> applies
Preventive screening and counseling limits	See the <i>Preventive care services</i> section of the SOB