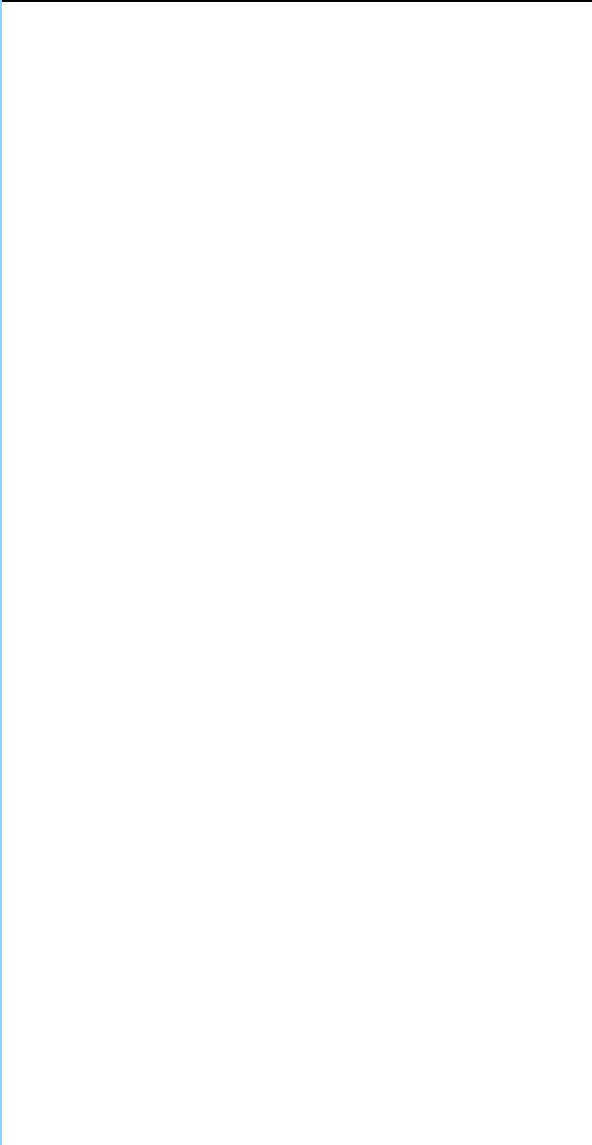


BENEFIT PLAN

**Prepared Exclusively for
Millard Public Schools**

Choice POS II

**What Your Plan
Covers and How
Benefits are Paid**





Choice POS II Medical Plan

Booklet

Prepared exclusively for:

Employer: Millard Public Schools

Contract number: MSA-737381

Booklet 1

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Third Party Administrative Services provided by Aetna Life Insurance Company

Welcome

Thank you for choosing **Aetna**.

This is your booklet. It is one of two documents that together describe the benefits covered by your Employer's self-funded health benefit plan for in-network and out-of-network coverage.

This booklet will tell you about your **covered benefits** – what they are and how you get them. It takes the place of all booklets describing similar coverage that were previously sent to you. The second document is the schedule of benefits. It tells you how we share expenses for **eligible health services** and tells you about limits – like when your plan covers only a certain number of visits.

Each of these documents may have amendments attached to them. They change or add to the documents they're part of.

Where to next? Flip through the table of contents or try the *Let's get started!* section right after it. The *Let's get started!* section gives you a thumbnail sketch of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your Employer's self-funded health benefit plan for in-network and out-of-network coverage.

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Schedule of benefits

Issued with your booklet-

Let's get started!

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

Some notes on how we use words

- When we say “you” and “your”, we mean both you and any covered dependents.
- When we say “us”, “we”, and “our”, we mean **Aetna** when we are describing administrative services provided by **Aetna** as Third Party Administrator.
- Some words appear in **bold** type. We define them in the *Glossary* section.

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

What your plan does – covered benefits

Your plan provides **covered benefits**. These are **eligible health services** for which your plan has the obligation to pay.

This plan provides in-network and out-of network coverage for medical, vision and pharmacy benefits.

What your plan doesn't do – exclusions

Your plan does not pay for benefits that are not covered under the terms of the plan. These are Exclusions and are described more in greater detail later in the document.

Many health care services and supplies are eligible for coverage under your plan in the *Eligible health services under your plan* section. However, some of those health care services and supplies have exclusions. For example, **physician care** is an eligible health service, but **physician care** for cosmetic surgery is never covered. This is an example of an exclusion.

The *What your plan doesn't cover - some eligible health service exclusions* section of this document also provides additional information.

The Plan does not cover any payments that are prohibited by the Federal Office of Foreign Asset Control.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

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

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

How your plan works while you are covered in-network

Your in-network coverage:

- Helps you get and pay for a lot of – but not all – health care services. These are called **eligible health services**.
- You will pay less cost share when you use a **network provider**.

1. Eligible health services

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

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

- They are listed in the *Eligible health services under your plan* section.
- They are not carved out in the *What your plan doesn't cover – some eligible health service exclusions* section. (We refer to this section as the "exclusions" section.)
- They are not beyond any limits in the schedule of benefits.

2. Providers

Aetna's network of doctors, **hospitals** and other health care **providers** are there to give you the care you need. You can find **network providers** and see important information about them most easily on our online **provider directory**. Just log into your Aetna Navigator® secure member website at www.aetna.com.

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

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

3. Paying for eligible health services– the general requirements

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

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

You will find details on **medical necessity** and **precertification** requirements in the *Medical necessity and precertification requirements* section.

4. Paying for eligible health services– sharing the expense

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

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

5. Disagreements

We know that people sometimes see things differently.

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

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

How your plan works while you are covered out-of-network

The section above told you how your plan works while you are covered in-network. You also have coverage when you want to get your care from **providers** who are not part of the **Aetna** network. It’s called out-of-network or **other health care** coverage.

Your out-of-network coverage:

- Means you can get care from **providers** who are not part of the **Aetna** network.
- Means you will have to pay for services at the time that they are provided. You will be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible health services** that you paid directly to a **provider**.
- Means that when you use out-of-network coverage, it is your responsibility to start the **precertification** process with **providers**.
- Means you will pay a higher cost share when you use an **out-of-network provider**.

You will find details on:

- **Precertification** requirements in the *Medical necessity and precertification requirements* section.
- **Out-of-network providers** and any exceptions in the *Who provides the care* section.
- Cost sharing in the *What the plan pays and what you pay* section, and your schedule of benefits.
- Claim information in the *When you disagree - claim decisions and appeals procedures* section.

How to contact us for help

We are here to answer your questions. Your plan of benefits includes the **Aetna** Concierge program. The program provides immediate access to healthcare resource consultants who have been specifically trained in the details of your plan. To contact an **Aetna** Concierge for questions on your plan, wherever you see the term Member Services within this booklet-certificate or your schedule of benefits, this is your **Aetna** Concierge team.

Register for Aetna Navigator®, our secure internet access to reliable health information, tools and resources. Aetna Navigator® online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

You can contact us by:

- Calling your **Aetna** Concierge at the toll-free number on your ID card from 8:00 a.m. to 6:00 p.m. Monday through Friday
- Logging onto Aetna Navigator® at www.aetna.com

Your member ID card

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

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

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

Who the plan covers

You will find information in this section about who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, “you” means the employee.

Who is eligible

Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an “eligible class,” as defined below; and
- You will need to meet the “eligibility date criteria” described below.

Determining if you are in an eligible class

You are in an eligible class if:

- You are an active part-time, full-time or retired employee, as defined by your employer as a:
 1. Full-time Active Employee of the Employer who is regularly and consistently scheduled to work at least thirty (30) hours per week and is on the regular payroll of the Employer for that week.
 2. Part-time Active Employee of the Employer. An Employee is considered to be part-time if he or she normally works at least twenty (20) hours per week and is on the regular payroll of the Employer for that work or actually works at least thirty (30) hours per week or more during the measurement period of August 1 through July 31.
 3. Retired Employee of the Employer who is at least fifty-five (55) years of age, but less than sixty-five (65) years of age, with twenty (20) years of active service and sixty (60) months of continuous coverage under the Plan.

Determining when you become eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the effective date of the plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the effective date of the plan

If you are hired after the effective date of this plan, your coverage eligibility date is the date you are hired.

If you enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you enter the eligible class.

Obtaining coverage for dependents

Your dependents can be covered under this Plan. You may enroll the following dependents:

- Your legal spouse.
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under this Plan. This determination will be conclusive and binding upon all persons for the purposes of this Plan.

Coverage for dependent children

To be eligible for coverage, a dependent child must be under 26 years of age. A dependent child may also be covered from age 26, if unmarried, to age 30 for medical coverage.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records, or initiation of legal proceedings serving parental rights.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legal separated or divorced former Spouse of the Employee; foster Children; grandchildren who live with You and are dependent on You for support; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums.

Coverage will end on the last day of the Plan month.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren; as long as a natural parent remains married to the employee;
- Your legally adopted children;
- Any children placed with you for adoption;
- Any children for whom you are responsible under court order;

The term "placed" means the assumption and retention by such Employee of the legal obligation for total or partial support of the Child in anticipation of adoption of the Child. The Child must be available for adoption and the legal process must have commenced.

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

Eligibility

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. Employees who meet eligibility requirements during a measurement period, as described in the Affordable Care Act (ACA) regulations, will have been deemed to have met the eligibility requirements for the appropriate month (if using a monthly measurement period) or the resulting stability period (if using a look-back period and continuing coverage through the stability period regardless of actual hours worked), as determined by the Plan Sponsor.

Rehire/Reinstatement of coverage

If Your coverage ends due to termination of employment, leave of absence, reduction of hours or lay-off and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended under this Plan, Your coverage will be reinstated based on the rehire provisions of the Affordable Care Act.

If Your coverage ends due to termination of employment, leave of absence, reduction of hours or lay-off and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended under this Plan, and You did not perform any hours of service that were credited within the 13-week period, You will be treated as a new hire and will be required to meet all of the requirements of a new Employee including satisfaction of a new waiting period.

Important Reminder

Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

How and when to enroll

Initial enrollment in the plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.

Late enrollment

If you do not enroll during the Initial Enrollment Period, or a subsequent annual enrollment period, you and your eligible dependents may be considered **Late Enrollees** and coverage may be deferred until the next annual enrollment period. If, at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered **Late Enrollees**.

You must return your completed enrollment form before the end of the next annual enrollment period as described below.

However, you and your eligible dependents may not be considered **Late Enrollees** if you qualify for one of the circumstances described in the “Special Enrollment Periods” section below.

Open enrollment period

During the annual open enrollment period, covered Employees and their covered dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of Spouse’s employment. To the extent previously satisfied coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1.

A Covered Person who fails to make an election during open enrollment will automatically retain his or her present coverages.

Covered Persons will receive detailed information regarding open enrollment from their Employer.

Special enrollment periods

You will not be considered a **Late Enrollee** if you qualify under a Special Enrollment Period as defined below. If one of these situations applies, you may enroll before the next annual enrollment period.

Loss of other health care coverage

You or your dependents may qualify for a Special Enrollment Period if:

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
 - You or your dependents were covered under other **creditable coverage**; and
 - You refused coverage and stated, in writing, at the time you refused coverage that the reason was that you or your dependents had other **creditable coverage**; and
- You or your dependents are no longer eligible for other **creditable coverage** because of one of the following:
 - The end of your employment;
 - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
 - The ending of the other plan’s coverage;
 - Death;
 - Divorce or legal separation;
 - Employer contributions toward that coverage have ended;
 - COBRA coverage ends;
 - The employer’s decision to stop offering the group health plan to the eligible class to which you belong;

- Cessation of a dependent’s status as an eligible dependent as such is defined under this Plan;
- With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage; or
- You or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.

You will need to enroll yourself or a dependent for coverage within:

- 31 days of when other **creditable coverage** ends;
- within 60 days of when coverage under Medicaid or an S-CHIP Plan ends; or
- within 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

Evidence of termination of **creditable coverage** must be provided to your employer or the party it designates. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

New dependents

You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 31 days of acquiring the dependent.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

You will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to your employer within 31 days of the change. If you do not return the form within 31 days of the change, you will need to make the changes during the next annual enrollment period.

Note: The newborn Child provision only applies to an eligible Employee and/or Dependent Spouse. For a Dependent Child, the Plan does not cover expenses related to the newborn child.

If you adopt a child

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan’s definition of an eligible dependent on the date he or she is placed for adoption; and has not reach age 18 and;
- You request coverage for the child in writing within 31 days of the placement;
- Proof of placement will need to be presented to your employer prior to the dependent enrollment;

When you receive a Qualified Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

When your coverage begins

Your effective date of coverage

If you have met all the eligibility requirements, your coverage takes effect on the first day of the calendar month following the date:

- You are eligible for coverage; and
- You return your completed enrollment information; and
- Your application is received and approved in writing by Aetna; and

If you do not return your completed enrollment information within 31 days of your eligibility date, the rules under the Special or Late Enrollment Periods section will apply.

An Employee must be an Active Employee for this coverage to take effect.

Effective date of dependent coverage

A Dependent's coverage will take effect on the day that the eligibility requirements are met: and you are covered under the Plan: and all Enrollment Requirements are met.

Important Notice:

You must pay the required contribution in full or coverage will not be effective.

Your dependent's effective date of coverage

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan. At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent as defined by the Plan.

Note: New dependents need to be reported to your employer within 31 days because they may affect your contributions. If you do not report a new dependent within 31 days of his or her eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Medical necessity and precertification requirements

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

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

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

This section addresses the **medical necessity** and **precertification** requirements.

Medically necessary; medical necessity

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

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

Precertification

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

In-network: your **physician** is responsible for obtaining any necessary **precertification** before you get the care. If your **physician** doesn't get a required **precertification**, we won't pay the **provider** who gives you the care. You won't have to pay either if your **physician** fails to ask us for **precertification**. If your **physician** requests **precertification** and we refuse it, you can still get the care but the plan won't pay for it. You will find details on requirements in the *What the plan pays and what you pay - Important exceptions – when you pay all* section.

Out-of-network: when you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from us for any services and supplies on the **precertification** list. If you do not **precertify**, your benefits may be reduced, or the plan may not pay any benefits. Refer to your schedule of benefits for this information. The list of services and supplies requiring **precertification** appears later in this section. Also, for any **precertification** benefit reduction that is applied see the schedule of benefits *Precertification benefit reduction* section.

When it is a life-threatening emergency, call 911 or go straight to the nearest emergency room. If admitted, **precertification** should be secured within the timeframes specified below. To obtain **precertification**, call us at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
For an emergency admission :	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission :	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness , the diagnosis of an illness , or an injury .
For outpatient non-emergency medical services requiring precertification :	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

We will provide a written notification to you and your **physician** of the **precertification** decision, where required by state law. If your **precertified** services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, we will notify you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be **precertified**. You, your **physician**, or the facility will need to call us at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. We will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered benefits**, the notification will explain why and how our decision can be appealed. You or your **provider** may request a review of the **precertification** decision. See the *Claim decisions and appeals procedures* section.

What if you don't obtain the required precertification?

If you don't obtain the required **precertification**:

- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits *Precertification benefit reduction* section.
- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your out-of-network **deductibles** or **maximum out-of-pocket limits**.

What types of services require precertification?

Precertification is required for the following types of services and supplies:

Inpatient services and supplies
Stays in a hospital
Stays in a skilled nursing facility
Stays in a rehabilitation facility
Stays in a hospice facility
Stays in a residential treatment facility for treatment of mental disorders and substance abuse
Bariatric surgery (obesity)
Cosmetic and reconstructive surgery

Certain **prescription drugs** are covered under the medical plan when they are given to you by your doctor or health care facility and not obtained at a **pharmacy**. The following **precertification** information applies to these **prescription drugs**:

For certain drugs, your **prescriber** or your pharmacist needs to get approval from us before we will agree to cover the drug for you. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs and makes sure there is a **medically necessary** need for the drug. For the most up-to-date information, call the toll-free Member Services number on your member ID card or log on to your Aetna Navigator® secure member website at www.aetna.com.

There is another type of **precertification** for **prescription drugs**, and that is **step therapy**. **Step therapy** is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

You can obtain the most up-to-date information about **step therapy prescription drugs** by calling the toll-free Member Services number on your member ID card or by logging on to your Aetna Navigator® secure member website at www.aetna.com. Your doctor can find additional details about the **step therapy prescription drugs** in our clinical policy bulletins.

Sometimes you or your **prescriber** may seek a medical exception to get health care services for drugs not covered or for which health care services are denied through **precertification and/or step therapy**. You or your **prescriber** can contact us and will need to provide us with the required clinical documentation. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case determination, and will not apply or extend to other covered persons.

Eligible health services under your plan

The information in this section is the first step to understanding your plan's **eligible health services**.

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

For example,

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

You can find out about these exclusions in the *exclusions* section, and about the limitations in the schedule of benefits.

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

Preventive care and wellness

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

Important notes:

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

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

2. Diagnostic testing will not be covered under the preventive care benefit. For those tests, you will pay the cost sharing specific to **eligible health services** for diagnostic testing.
3. Gender-specific preventive care benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.
4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging on to your Aetna Navigator® secure member website at www.aetna.com or at the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.

Routine physical exams

Eligible health services include office visits to your **physician, PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and 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
 - Screening for gestational diabetes for women
 - High risk Human Papillomavirus (HPV) DNA testing for women 30 and older
- Radiological services, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** checkup.

Preventive care immunizations

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

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **physician, PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes pap smears and routine chlamydia screening tests. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.

Preventive screening and counseling services

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

- **Obesity and/or healthy diet counseling**

Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:

- Preventive counseling visits and/or risk factor reduction intervention
- Nutritional counseling
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**

Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:

- Preventive counseling visits
- Risk factor reduction intervention
- A structured assessment

- **Use of tobacco products**

Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:

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

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

- Cigarettes
- Cigars
- Smoking tobacco
- Snuff
- Smokeless tobacco
- Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**

Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**

Eligible health services include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

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

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

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

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a **network provider** who is an OB, GYN or OB/GYN.

Prenatal care

Eligible health services include your routine prenatal physical exams as *Preventive Care*, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

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

Important note:

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

Comprehensive lactation support and counseling services

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

Breast feeding durable medical equipment

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

Breast pump

Eligible health services include:

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

If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.

Breast pump supplies and accessories

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

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, 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.

Family planning services – female contraceptives

Eligible health services include family planning services such as:

Counseling services

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

Devices

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

Voluntary sterilization

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

Important note:

See the following sections for more information:

- *Family planning services - other*
- *Maternity and related newborn care*
- *Outpatient prescription drugs*
- *Treatment of basic infertility*

Physicians and other health professionals

Physician services

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

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

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

- Allergy testing and allergy injections
- Radiological supplies, services, and tests

Physician surgical services

Eligible health services include the services of:

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

Important note:

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

Alternatives to physician office visits

Walk-in clinic

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

- Unscheduled, non-medical emergency **illnesses** and **injuries**
- The administration of immunizations administered within the scope of the clinic's license

Hospital and other facility care

Hospital care

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

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

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians** employed by the **hospital**.
- Operating and recovery rooms.
- Intensive or special care units of a **hospital**.
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.
- Radiation therapy.
- Cognitive rehabilitation.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.
- Services and supplies provided by the outpatient department of a **hospital**.

Alternatives to hospital stays

Outpatient surgery and physician surgical services

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

Important note:

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

Home health care

Eligible health 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 your needing to **stay** in a **hospital** or a **skilled nursing facility**, or needing 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.
- 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.
- Home health aide services are provided under the supervision of a registered nurse.
- Medical social services are provided by or supervised by a **physician** or social worker.

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

Hospice care

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

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

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

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

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
 - Physical and occupational therapy
 - Medical supplies
 - Outpatient **prescription drugs**
 - Psychological counseling
 - Dietary counseling

Skilled nursing facility

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

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

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

Emergency services and urgent care

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

As always, you can get emergency care from **network providers**. However, you can also get emergency care from **out-of-network providers**.

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

As it applies to in-network coverage, you are covered for follow-up care only when your **physician or PCP** provides or coordinates it. If you use an **out-of-network provider** to receive follow up care, you are subject to a higher out-of-pocket expense.

In case of a medical emergency

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

Non-emergency condition

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits and the *exclusion- Emergency services and urgent care and Precertification benefit reduction* sections for specific plan details.

In case of an urgent condition

Urgent condition

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

Non-urgent care

If you go to an **urgent care facility** for what is not an **urgent condition**, the plan may not cover your expenses. See the *exclusion –Emergency services and urgent care and Precertification covered benefit reduction* sections and the schedule of benefits for specific plan details.

Specific conditions

Birth center

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

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery

A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care.

Family planning services – other

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

- Voluntary sterilization for males

Jaw joint disorder treatment

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

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

Maternity and related newborn care

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

- 48 hours of inpatient care in a **hospital** after a vaginal delivery
- 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

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

Mental health treatment

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

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies related to your condition 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
 - **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 the following criteria are met:
 - You are homebound
 - Your **physician** orders them
 - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
 - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
 - Electro-convulsive therapy (ECT)
 - Mental health injectables
 - Transcranial magnetic stimulation (TMS)
 - Psychological testing
 - Neuropsychological testing
 - 23 hour observation

Important note:

Your plan covers telemedicine only when you get your telephone or internet based consult through an authorized internet service vendor who conducts telemedicine consultations that has contracted with Aetna to offer these services DocFind® tells you who those are.

Substance related disorders treatment

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

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies that are provided during your **stay** in a **hospital, psychiatric hospital or residential treatment facility**. Treatment of **substance abuse** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance abuse** section or unit, unless you are admitted for the treatment of medical complications of **substance abuse**.

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

- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital or residential treatment facility**, including:
 - Office visits to a **physician or behavioral health provider** such as a **psychiatrist**, psychologist, social worker, advanced practice registered nurse, or licensed professional counselor (includes **telemedicine** consultation)
 - Individual, group and family therapies for the treatment of **substance abuse**
 - Outpatient detoxification
 - **Partial hospitalization treatment** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
 - **Intensive outpatient program** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
 - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications
 - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
 - You are homebound
 - Your **physician** orders them
 - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
 - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
 - Treatment of withdrawal symptoms
 - Substance use disorder injectables
 - 23 hour observation

Important note:

Your plan covers telemedicine only when you get your telephone or internet based consult through an authorized internet service vendor who conducts telemedicine consultations that has contracted with Aetna to offer these services DocFind® tells you who those are.

Oral and maxillofacial treatment (mouth, jaws and teeth)

Eligible health services include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a **physician**, a dentist and **hospital**:

- Non-surgical treatment of infections or diseases.
- **Surgery** needed to:
 - Treat a fracture, dislocation, or wound.
 - Cut out teeth partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
 - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
 - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- **Hospital** services and supplies received for a **stay** required because of your condition.
- Dental work, **surgery** and **orthodontic treatment** needed to remove, repair, restore or reposition:
 - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair, and are firmly attached to your jaw bone at the time of your **injury**.
 - Other body tissues of the mouth fractured or cut due to **injury**.
- Crowns, dentures, bridges, or in-mouth appliances only for:
 - The first denture or fixed bridgework to replace lost teeth.
 - The first crown needed to repair each damaged tooth.
 - An in-mouth appliance used in the first course of **orthodontic treatment** after an **injury**.

Reconstructive surgery and supplies

Eligible health 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 and prostheses.
- 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.

Transplant services

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

Organ means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow

Network of transplant specialist facilities

The amount you will pay for covered transplant services is determined by where you get transplant services. You can get transplant services from:

- An **Institutes of Excellence™ (IOE) facility** we designate to perform the transplant you need

The National Medical Excellence Program® will coordinate all solid organ and bone marrow transplants, and other specialized care you need.

Treatment of infertility

Basic infertility

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

- To diagnose and evaluate the underlying medical cause of **infertility**.
- To do **surgery** to treat the underlying medical cause of **infertility**. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.

Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

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

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work and radiological services

Eligible health services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests, but only when you get them from a licensed radiological facility or lab.

Chemotherapy

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

Outpatient infusion therapy

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

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

Infusion therapy is the parenteral (e.g. intravenous) administration of prescribed medications or solutions.

Certain infused medications may be covered under the outpatient **prescription drug** coverage. You can access the list of **specialty prescription drugs** by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card to determine if coverage is under the outpatient **prescription drug** benefit or this booklet.

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

Outpatient radiation therapy

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

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

Specialty prescription drugs

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

- Purchased by your **provider**, and
- Injected or infused by your **provider** in an outpatient setting such as:
 - A free-standing outpatient facility
 - The outpatient department of a **hospital**
 - A **physician** in the office
 - A home care **provider** in your home
- And, listed on our **specialty prescription drug** list as covered under this booklet.

You can access the list of **specialty prescription drugs** by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the outpatient **prescription drug** benefit or this booklet.

Certain injected and infused medications may be covered under the outpatient **prescription drug** coverage. You can access the list of **specialty prescription drugs** by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card to determine if coverage is under the outpatient **prescription drug** benefit or this booklet.

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

Short-term cardiac and pulmonary rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it 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 help you restore or develop skills and functioning for daily living.

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

- A licensed or certified physical, occupational or speech therapist
- A **hospital, skilled nursing facility, or hospice facility**
- A **physician**

Short-term rehabilitation services have to follow a specific treatment plan.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute **illness, injury or surgical procedure**.
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
 - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness, injury or surgical procedure**, or
 - Relearn skills so you can significantly improve your ability to perform the activities of daily living.
- Speech therapy, but only if it is expected to:
 - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute **illness, injury or surgical procedure**, or
 - 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 and
 - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Other services

Acupuncture

Eligible health services include the treatment by the use of acupuncture (manual or electroacupuncture) provided by your **physician**, if the service is performed:

- As a form of anesthesia in connection with a covered **surgical procedure**

Ambulance service

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

- To the first **hospital** to provide **emergency services**.
- From one **hospital** to another **hospital** if the first **hospital** cannot provide the **emergency services** you need.
- From a **hospital** to your home or to another facility if an **ambulance** is the only safe way to transport you.
- From your home to a **hospital** if an **ambulance** is the only safe way to transport you. Transport is limited to 100 miles.

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

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

Clinical trial therapies (experimental or investigational)

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

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

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

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

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

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

Durable medical equipment (DME)

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

Coverage includes:

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

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

Prosthetic devices

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

Prosthetic device means:

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

Coverage includes:

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

Spinal manipulation

Eligible health services include spinal manipulation to correct a muscular or skeletal problem, but only if your **provider** establishes or approves a treatment plan that details the treatment, and specifies frequency and duration.

Outpatient prescription drugs

What you need to know about your outpatient prescription drug plan

Read this section carefully so that you know:

- How to access **network pharmacies**
- How to access **out-of-network pharmacies**
- **Eligible health services** under your plan
- What outpatient **prescription drugs** are covered
- Other services
- How you get an emergency **prescription** filled
- Where your schedule of benefits fits in
- What precertification requirements apply
- How do I request a medical exception
- What your plan doesn't cover – some **eligible health service** exclusions
- How you share the cost of your outpatient **prescription drugs**

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

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

How to access network pharmacies

How do you find a network pharmacy?

You can find a **network pharmacy** in two ways:

- **Online:** By logging onto your Aetna Navigator® secure member website at www.aetna.com.
- **By phone:** Call the toll-free Member Services number on your member ID card. During regular business hours, a Member Services representative can assist you. Our automated telephone assistant can give you this information 24 hours a day.

You may go to any **network pharmacies**. **Pharmacies** include **network retail, mail order** and **specialty pharmacies**.

How to access out-of-network pharmacies

You can directly access an **out-of-network pharmacy** to get covered outpatient **prescription drugs**.

When you use an **out-of-network pharmacy**, you pay your in-network **copayment** or **coinsurance** then you pay any remaining **deductible** and then you pay your out-of-network **coinsurance**. If you use an **out-of-network pharmacy** to obtain outpatient **prescription drugs**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your in-network outpatient **prescription drug** cost share
- Paying your out-of-network outpatient **prescription drug deductible**
- Your out-of-network **payment percentage**
- Any charges over our **recognized charge**
- Submitting your own claims

Eligible health services under your plan

What does your outpatient prescription drug plan cover?

Any **pharmacy** service that meets these three requirements:

- They are listed in the *Eligible health services under your plan* section
- They are not carved out in the *What your plan doesn't cover - some eligible health service exceptions* section
- They are not beyond any limits in the schedule of benefits

Your plan benefits are covered when you follow the plan's general rules:

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

Your outpatient **prescription drug** plan includes drugs listed in the **drug guide**. **Prescription drugs** listed on the **formulary exclusions list** are excluded unless a medical exception is approved by us prior to the drug being picked up at the **pharmacy**. If it is **medically necessary** for you to use a **prescription drug** on the **formulary exclusions list**, you or your **prescriber** must request a medical exception. See the *How to get a medical exception* section.

Generic prescription drugs may be substituted by your pharmacist for **brand-name prescription drugs**. Your out-of-pocket costs may be less if you use a **generic prescription drug** when available.

Prescription drugs covered by this plan are subject to misuse, waste, and/or abuse utilization review by us, your **provider**, and/or your **network pharmacy**. The outcome of this review may include: limiting coverage of the applicable drug(s) to one prescribing **provider** and/or one **network pharmacy**, limiting the quantity, dosage, day supply, requiring a partial fill or denial of coverage.

What outpatient prescription drugs are covered

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

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

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

Retail pharmacy

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

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

Mail order pharmacy

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

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

Specialty pharmacy

Specialty prescription drugs often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. Each **prescription** is limited to a maximum 30 day supply. You can access the list of **specialty prescription drugs** by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.

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

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

Other services

Preventive Contraceptives

For females who are able to reproduce, your outpatient **prescription drug** plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. Your outpatient **prescription drug** plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive drugs by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.

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

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

Diabetic supplies

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

- Injection devices including insulin syringes, needles and pens
- Test strips - blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs
- blood glucose meters and insulin pumps

Also see your medical plan benefits for coverage of blood glucose meters and insulin pumps.

Immunizations

Eligible health services include preventive immunizations as required by the ACA guidelines when administered at a **network pharmacy**. You should call the number on your ID card to find a participating **network pharmacy**. You should contact the **pharmacy** for availability, as not all **pharmacies** will stock all available vaccines.

Infertility drugs

Eligible health services include oral synthetic ovulation stimulant **prescription drugs** used primarily for the purpose of treating the underlying cause of **infertility**.

Off-label use

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

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

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

Orally administered anti-cancer drugs, including chemotherapy drugs

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

Over-the-counter drugs

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

Preventive care drugs and supplements

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

Risk reducing breast cancer prescription drugs

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

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

Sexual dysfunction/enhancement

Eligible health services include **prescription drugs** for the treatment of sexual dysfunction/enhancement. For the most up-to-date information on dosing, call the toll-free number on your ID card.

Tobacco cessation prescription and over-the-counter drugs

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

Obesity drugs

Eligible health services include charges made by a **network pharmacy** for **prescription drugs** prescribed by a **prescriber** for the sole purpose of weight loss (anti-obesity agents).

You must be diagnosed by a **physician** as having one of the medical conditions listed below. The diagnosis must be documented by a **physician** through the results of a physical exam and outpatient diagnostic lab work.

The medical conditions are:

- **morbid obesity**; and/or
- obesity with **body mass index** levels (for one or more of the following obesity-related risk factors) that are considered serious enough, by the most current generally accepted standards of medical practice, to justify a **prescription drug** treatment plan:
 - Hypertension
 - Dyslipidemia (LDL cholesterol, HDL cholesterol, Triglycerides)
 - Coronary heart disease
 - Type 2 diabetes mellitus
 - Obstructive sleep apnea

Limitations:

- You may not be covered for more than one anti-obesity prescription drug or agent at one time.

How you get an emergency prescription filled

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

Type of pharmacy	Your cost share
Network pharmacy	<ul style="list-style-type: none">You pay the copayment.
Out-of-network pharmacy	<ul style="list-style-type: none">You pay the pharmacy directly for the cost of the prescription. Then you fill out and send a prescription drug refund form to us, including all itemized pharmacy receipts.Coverage is limited to items obtained in connection with covered emergency and out-of-area urgent care services.Submission of a claim doesn't guarantee payment. If your claim is approved, you will be reimbursed the cost of your prescription less your copayment/payment percentage.

Where your schedule of benefits fits in

You are responsible for paying your part of the cost sharing. The schedule of benefits shows any benefit limitations and any out-of-pocket costs you are responsible for. Keep in mind that you are responsible for costs not covered under this plan.

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

- The type of **prescription drug** you're prescribed.
- Where you fill your **prescription**.

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

How your copayment/payment percentage works

Your **copayment/payment percentage** is the amount you pay for each **prescription** fill or refill. Your schedule of benefits shows you which **copayments/payment percentage** you need to pay for specific **prescription** fill or refill. You will pay any cost sharing directly to the **network pharmacy**.

What precertification requirements apply

For certain drugs, you, your **prescriber** or your pharmacist needs to get approval from us before we will cover the drug. This is called "**precertification**". The requirement for getting approval in advance guides appropriate use of precertified drugs and makes sure they are **medically necessary**. For the most up-to-date information, call the toll-free number on your member ID card or log on to your Aetna Navigator® secure member website at www.aetna.com.

How do I request a medical exception?

Sometimes you or your **prescriber** may seek a medical exception to get health care services for drugs not listed on the **drug guide** or for which health care services are denied through **precertification**. You, someone who represents you or your **prescriber** can contact us and will need to provide us with the required clinical documentation. Any exception granted is based upon an individual, case by case decision, and will not apply to other members. If approved by us, you will receive the **preferred** or **non-preferred drug** benefit level.

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

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

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your **prescriber** of our decision.

Prescribing units

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

Any outpatient **prescription drug** that has duration of action extending beyond one (1) month shall require the number of **copayments** per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) **copayments**.

Exclusions: What your plan doesn't cover

We already told you about the many health care services and supplies that are eligible for coverage under your plan in the *Eligible health services under your plan* section. And we told you there, that some of those health care services and supplies have exclusions. For example, **physician** care is an **eligible health service** but **physician** care for **cosmetic surgery** is never covered. This is an exclusion.

In this section we tell you about the exclusions. We've grouped them to make it easier for you to find what you want.

- Under "General exclusions" we've explained what general services and supplies are not covered under the entire plan.
- Below the general exclusions, in "Exclusions under specific types of care," we've explained what services and supplies are exceptions under specific types of care or conditions.

Please look under both categories to make sure you understand what exclusions may apply in your situation.

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

General exclusions

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

Examples of these are:

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

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

Cosmetic services and plastic surgery

- Any treatment, **surgery (cosmetic or plastic)**, service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons. This cosmetic services exclusion does not apply to **surgery** after an accidental **injury** when performed as soon as medically feasible. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected.

Counseling

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

Court-ordered services and supplies

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

Custodial care

Examples are:

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

Dental care except as covered in the *Eligible health services under your plan* Oral and maxillofacial treatment section.

Dental services related to:

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

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

Early intensive behavioral interventions

Examples of those services are:

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

Educational services

Examples of those services are:

- Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, wilderness treatment program, job training and job hardening programs
- Services provided by a school district.

Examinations

Any health examinations needed:

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

Experimental or investigational

- **Experimental or investigational** drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (**experimental or investigational**) or covered under clinical trials (routine patient costs). See the *Eligible health services under your plan – Other services* section.

Facility charges

For care, services or supplies provided in:

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

Foot care

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

Growth/height care

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

Hearing aids and exams

Maintenance care

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

Medical supplies – outpatient disposable

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

Other primary payer

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

Outpatient prescription or non-prescription drugs and medicines

- Outpatient **prescription** or non-**prescription drugs** and medicines provided by the employer or through a third party vendor contract with the employer.

Personal care, comfort or convenience items

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

Pregnancy charges

- Charges in connection with pregnancy care other than for complications of pregnancy and other covered expenses as specifically described in the *Eligible health services under your plan* section

Routine exams

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Eligible health services under your plan* section

Services provided by a family member

- Services provided by a spouse, 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 booklet.

Sex change

- Any treatment, drug, service or supply related to changing sex or sexual characteristics.
Examples of these are:
 - **Surgical procedures** to alter the appearance or function of the body
 - Hormones and hormone therapy
 - Prosthetic devices

Sexual dysfunction and enhancement

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

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
 - Strength
 - Physical condition
 - Endurance
 - Physical performance

Telemedicine

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

Therapies and tests

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

Tobacco cessation

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

Treatment in a federal, state, or governmental entity

- Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Vision care

- Vision care services and supplies, including:
 - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and
 - Laser in-situ keratomileusis (LASIK), including related procedures designed to surgically correct refractive errors

Wilderness treatment programs

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

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be 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.

Additional exclusions for specific types of care

Preventive care and wellness

- Services for diagnosis or treatment of a suspected or identified **illness** or **injury**
- Exams given during your **stay** for medical care
- Services not given by or under **physician's** direction
- Psychiatric, psychological, personality or emotional testing or exams

Family planning services

- Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Voluntary sterilization procedures that were not billed separately by the **provider** or were not the primary purpose of a confinement.

Physicians and other health professionals

There are no additional exclusions specific to **physicians** and other **health professionals**.

Hospital and other facility care

Alternatives to facility stays

Outpatient surgery and physician surgical services

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

Home health care

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

Hospice care

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

Outpatient private duty nursing

(See home health care in the *Eligible health services under your plan and Outpatient and inpatient skilled nursing care* sections regarding coverage of nursing services).

Emergency services and urgent care

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

Specific conditions

Family planning services - other

- Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger
- Reversal of voluntary sterilization procedures including related follow-up care
- Family planning services received while confined as an inpatient in a **hospital** or other facility

Maternity and related newborn care

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

Mental health treatment

- Mental health services for the following categories (or equivalent terms as listed in the most recent edition 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
 - Sexual deviations and disorders except for gender identity disorders
 - Tobacco use disorders, except as described in the *Eligible health services under your plan – Preventive care and wellness* section
 - Pathological gambling, kleptomania, pyromania
 - 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

Obesity (bariatric) surgery

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

Oral and maxillofacial treatment (mouth, jaws and teeth)

- Dental implants

Transplant services

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

Treatment of infertility

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

Specific therapies and tests

Acupuncture

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Specialty prescription drugs

- **Specialty prescription drugs** and medicines provided by your employer or through a third party vendor contract with your employer.
- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient **prescription drug** plan.

Short-term rehabilitation services

Outpatient cognitive rehabilitation, physical, occupational and speech therapy

- Therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:
 - Autism Spectrum Disorder
 - Down syndrome
 - Cerebral palsy
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a **home health care agency**.
- Services provided by a **physician**, or treatment covered as part of the spinal manipulation benefit. This applies whether or not benefits have been paid under the spinal manipulation section.
- Services not given by a **physician** (or under the direct supervision of a **physician**), physical, occupational or speech therapist.
- Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth.

Other services

Ambulance services

- Fixed wing air ambulance from an **out-of-network provider**

Clinical trial therapies (experimental or investigational)

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

Clinical trial therapies (routine patient costs)

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

Durable medical equipment (DME)

Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Nutritional supplements

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

Prosthetic devices

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

Outpatient prescription drugs

Abortion drugs

Allergy sera and extracts administered via injection

Any services related to the dispensing, injection or application of a drug

Biological sera

Cosmetic drugs

- Medications or preparations used for cosmetic purposes.

Compounded prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA)

- Including compounded bioidentical hormones

Devices, products and appliances, except those that are specially covered

Dietary supplements including medical foods

Drugs or medications

- Administered or entirely consumed at the time and place it is prescribed or dispensed
- Which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
- That includes the same active ingredient or a modified version of an active ingredient as a covered **prescription drug** (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to a covered **prescription drug** including **biosimilars** (unless a medical exception is approved)
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan while an inpatient of a healthcare facility
- Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by Pharmacy and Therapeutics Committee
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
- That are used for the purpose of weight gain or reduction, 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 hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies

Duplicative drug therapy (e.g. two antihistamine drugs)

Genetic care

- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

Immunizations related to travel or work

Immunization or immunological agents except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section.

Implantable drugs and associated devices except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section.

Infertility

- **Injectable prescription drugs** used primarily for the treatment of **infertility**.

Injectables:

- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by us
- Needles and syringes, except for those used for self-administration of an injectable drug
- Any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Prescription drugs:

- Dispensed by other than a **network retail, mail order** and **specialty pharmacies** except as specifically provided in the *What prescription drugs are covered* section.
- Dispensed by a **mail order pharmacy** that is an **out-of-network pharmacy**, except in a medical emergency or urgent care situation except as specifically provided in the *How to get an emergency prescription filled* section.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this plan.
- Dispensed by a **mail order pharmacy** that include **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
- That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug as determined by the plan.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **preferred drug guide**.
- That are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper; and drugs obtained for use by anyone other than the member identified on the ID card.

Refills

- Refills dispensed more than one year from the date the latest **prescription** order was written.

Replacement of lost or stolen prescriptions

Smoking cessation

- Smoking cessation products unless recommended by the United States Preventive Services Task Force (USPSTF)

Test agents except diabetic test agents

We reserve the right to exclude:

- A manufacturer's product when a same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the **preferred drug guide**.
- Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our **preferred drug guide**.

Who provides the care

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

Network providers

We have contracted with **providers** to provide **eligible health services** to you. These **providers** make up the network for your plan. For you to receive the network level of benefits you must use **network providers** for **eligible health services**. There are some exceptions:

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section
- **Urgent care** – refer to the description of emergency services and urgent care in the *Eligible health services under your plan* section

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

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

Your PCP

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

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

- General practitioner
- Family **physician**
- Internist
- Pediatrician

How do you choose your PCP?

You can choose a **PCP** from the list of **PCPs** in our **directory**. See the *Who provides the care, Network providers* section.

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

What will your PCP do for you?

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

Your **PCP** can also:

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

How do I change my PCP?

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

Out-of-network providers

You also have access to **out-of-network providers**. This means you can receive **eligible health services** from an **out-of-network provider**. If you use an **out-of-network provider** to receive **eligible health services**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network **deductible**
- Your out-of-network **payment percentage**
- Any charges over our **recognized charge**
- Submitting your own claims and getting **precertification**

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

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

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

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

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

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

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

What the plan pays and what you pay

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

- Your **deductible**
- Your **copayments/payment percentage**
- Your **maximum out-of-pocket limit**

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

The general rule

When you get **eligible health services**:

- You pay for the entire expense up to any **deductible** limit.

And then

- The plan and you share the expense up to any **maximum out-of-pocket limit**. The schedule of benefits lists how much your plan pays and how much you pay for each type of health care service. Your share is called a **copayment/ payment percentage**.

And then

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

When we say “expense” in this general rule, we mean the **negotiated charge** for a **network provider**, and the **recognized charge** for an **out-of-network provider**. See the *Glossary* section for what these terms mean.

Important exception – when your plan pays all

Under the in-network level of coverage, your plan pays the entire expense for all **eligible health services** under the preventive care and wellness benefit.

Important exceptions – when you pay all

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

- When you get a health care service or supply that is not **medically necessary**. See the *Medical necessity and precertification requirements* section.
- When your plan requires **precertification**, your **physician** requested it, we refused it, and you get an **eligible health service** without **precertification**. See the *Medical necessity and precertification requirements* section.

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 towards your **maximum out-of-pocket limit**.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the **negotiated charge**

Where your schedule of benefits fits in

How your deductible works

Your **deductible** is the amount you need to pay, after paying your **copayment** or **payment percentage**, for **eligible health services** per Calendar Year as listed in the schedule of benefits. Your **copayment** or **payment percentage** does not count toward your **deductible**.

How your copayment/ payment percentage works

Your **copayment/payment percentage** is the amount you pay for **eligible health services** after you have paid your **deductible**. Your schedule of benefits shows you which **copayments/payment percentage** you need to pay for specific **eligible health services**.

You will pay the **physician, PCP copayment/payment percentage** when you receive **eligible health services** from any **PCP**.

How your maximum out-of-pocket limit works

You will pay your **deductible** and **copayments/payment percentage** up to the **maximum out-of-pocket limit** for your plan. Your schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered benefits** for the remainder of that **Calendar Year**.

Important note:

See the schedule of benefits for any **deductibles, copayments/ payment percentage, maximum out-of-pocket limit** and maximum age, visits, days, hours, admissions that may apply.

Claim decisions and appeals procedures

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

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

Claims are processed in the order in which they are received.

Claim procedures

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

Notice	Requirement	Deadline
Submit a claim	<ul style="list-style-type: none"> You should notify and request a claim form from your employer. The claim form will provide instructions on how to complete and where to send the form(s). 	<ul style="list-style-type: none"> Within 15 working days of your request. If the claim form is not sent on time, we will accept a written description that is the basis of the claim as proof of loss. It must detail the nature and extent of loss within 90 days of your loss.
Proof of loss (claim)	<ul style="list-style-type: none"> A completed claim form and any additional information required by your employer. 	<ul style="list-style-type: none"> No later than 90 days after you have incurred expenses for covered benefits. We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible. Proof of loss may not be given later than 2 years after the time proof is otherwise required, except if you are legally unable to notify us.
Benefit payment	<ul style="list-style-type: none"> Written proof must be provided for all benefits. If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss. 	<ul style="list-style-type: none"> Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of claims and communicating our claim decisions

You or your **provider** are required to send us a claim in writing. You can request a claim form from us. And we will review that claim for payment to the **provider**.

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

Urgent care claim

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

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

Pre-service claim

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

Post-service claim

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

Concurrent care claim extension

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

Concurrent care claim reduction or termination

A concurrent care claim reduction or termination occurs 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.

During this continuation period, you are still responsible for your share of the costs, such as **copayments**/payment percentage 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.

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

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	72 hours	15 days	30 days	24 hours for urgent request* 15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable
Additional information request (us)	72 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

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

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** with a **network provider** and the **recognized amount** with an **out-of-network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an “adverse benefit determination” or “adverse decision”. It is also an “adverse benefit determination” if we rescind your coverage entirely.

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

The difference between a complaint and an appeal

A Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

An Appeal

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

Appeals of adverse benefit determinations

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

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

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

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

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Urgent care or pre-service claim appeals

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

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

Timeframes for deciding appeals

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

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

For final adverse determinations

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

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (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.

Coordination of benefits

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

Key terms

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

Allowable expense means:

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

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

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

Here’s how COB works

- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist.
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.
- We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable expenses.

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or Dependent	The plan covering you as an employee or retired employee.	The plan covering you as a dependent.
Exception to the rule above when you are eligible for Medicare	If you or your spouse have Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us: <ul style="list-style-type: none">• Online: Log on to your Aetna Navigator® secure member website at www.aetna.com. Select Find a Form, then select Your Other Health Plans.• By phone: Call the toll-free Member Services number on your ID card.	

COB rules for dependent children		
Child of: <ul style="list-style-type: none"> • Parents who are married or living together 	The “birthday rule” applies. The plan of the parent whose birthday* (month and day only) falls earlier in the calendar year. *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*. *Same birthdays--the plan that has covered a parent longer is primary
Child of: <ul style="list-style-type: none"> • Parents separated or divorced or not living together • With court-order 	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other spouse’s plan.	The plan of the other parent. But if that parent has no coverage, then his/her spouse’s plan is primary.
Child of: <ul style="list-style-type: none"> • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody 	Primary and secondary coverage is based on the birthday rule.	
Child of: <ul style="list-style-type: none"> • Parents separated or divorced or not living together and there is no court-order 	The order of benefit payments is: <ul style="list-style-type: none"> • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last 	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.

How COB works with Medicare

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

Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you are covered under it by reason of:

- Age, disability, or
- End stage renal disease

You are also eligible for Medicare even if you are not covered if you:

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

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

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	Primary plan	Secondary plan
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan

If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months.	Medicare
	Medicare will pay first after this 30 month period.	Your plan
A disability other than ESRD and the employer has more than 100 employees	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

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

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.

- **Online:** Log on to your Aetna Navigator® secure member website at www.aetna.com. Select Find a Form, then select Your Other Health Plans.
- **By phone:** Call the toll-free Member Services number on your ID card.

Right to receive and release needed information

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

Right to pay another carrier

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

Right of recovery

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

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

When coverage ends

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

When coverage ends for employees

Your **Aetna** health benefits coverage will end if:

- The **Aetna** health benefits plan is discontinued;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- Your employer notifies **Aetna** that your employment is ended.
- Conditions for revocation due to reduction in hours of service:
 - The Employee has been in an employment status under which the Employee was reasonably expected to average at least twenty (20) hours of service per week and there is a change in that Employee's status so that the Employee will reasonably be expected to average less than (20) hours of service per week after the change. The Employee is expected to average twenty (20) hours per week to remain eligible under the group health plan; and
 - The revocation of the election of the coverage under the group health plan corresponds to the intended enrollment of the Employee, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
- Conditions for revocation due to the enrollment in a Qualified Health Plan:
 - The Employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Employee seeks to enroll in a Qualified Health Plan through a Marketplace's annual open enrollment period; and
 - The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Employee and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

It is your employer's responsibility to let **Aetna** know when your employment ends.

Employees on military leave

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
- The 24 month period beginning on the date on which the person's absence begins; or
- The day after the date on which the person was required to apply for or return to a position of the employment and fails to do so.

- A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

When coverage ends for dependents

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees;
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.
- The day a spouse of a retiree turns age 65.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See *Continuation of Coverage* for more information.

When coverage ends for retirees

Your **Aetna** health benefits coverage will end if:

- The **Aetna** health benefits plan is discontinued;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage. Coverage ends at the end of the calendar month when you attain age sixty-five (65);
- You do not make any required contributions;
- Retiree coverage cannot be reinstated under this plan once your retiree coverage ends.

It is your employer's responsibility to let **Aetna** know when your coverage ends.

Continuation of coverage

Continuing health care benefits

How can you extend coverage for a dependent who has reached the limiting age?

You may extend coverage for your dependents once they reach age 26 under the Young Adult Option. We must have a written election for each dependent who reaches 26 within 31 days of when the dependent reaches 26. We must have certification annually that the dependent continues to meet the eligibility criteria, in order to continue coverage under the Young Adult Option for longer than 12 months. We may request that the certification occur more frequently. You may contact the group or us for the Nebraska Young Adult Option Enrollment Form.

To be eligible for the Young Adult Option, the dependent must:

- Be less than 30 years of age, and
- Be unmarried, and
- Be a resident of Nebraska, or be a full-time student at any college, university, or trade school, and
- Not be covered under any other health plan including Medicare.

The dependent may continue coverage until the end of the month in which the dependent:

- Turns 30
- Gets married
- Is no longer a resident of the state, unless he or she is a full-time student
- Gets other coverage under another group or individual health plan, including Medicare

Or:

- This plan is discontinued
- You voluntarily stop your coverage
- The group policy ends, including for non-payment of premium
- Your employment ends
- You or your dependent asks us to stop your dependent's coverage
- You do not make any required contributions

Continuation of coverage for other reasons

To request an extension of coverage, just call the toll-free Member Services number on your ID card.

As to employees enrolled in the Choice POS II Medical Plan:

How can you extend coverage if you are totally disabled when coverage ends?

Your coverage may be extended if you or your dependents 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 own occupation or any other occupation for pay or profit.

Your dependent is "totally disabled" if that person cannot engage in most normal activities of 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 dependents are no longer totally disabled
- When you become covered by another health benefits plan
- 12 months of coverage

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

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

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

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

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

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

How can you extend coverage for a child in college on medical leave?

You have the right to extend coverage for your dependent college student who takes a **medically necessary** leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins, or
- The date coverage would otherwise end.

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious **illness or injury**,
- Cause the dependent child to lose status as a full-time student under the plan, and
- Be certified by the treating doctor as **medically necessary** due to a serious **illness or injury**.

The doctor treating your child will be asked to keep us informed of any changes.

Extension of benefits

Continuation during periods of employer-certified disability

A person may remain eligible for a limited time if active, full-time work ceases due to disability. This continuation will end at the end of the ninety (90) day period following the date on which the person last worked as an Active Employee.

Note: Disability leave does not run concurrently with FMLA.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Coverage for health benefits

If your health benefits end while you are totally disabled, your health expenses will be extended as described below, but, with respect to medical benefits, only as to expenses incurred in connection with the **injury** or **illness** that caused the total disability. To find out why and when your coverage may end, please refer to *When Coverage Ends*.

“Totally disabled” means that because of an **injury** or **illness**:

- You are not able to work at your own occupation and you cannot work at any occupation for pay or profit.
- Your dependent is not able to engage in most normal activities of a healthy person of the same age and gender.

Extended health coverage

Medical Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for up to 12 months.

Prescription Drug Benefits: Coverage will be available while you are totally disabled for up to 12 months.

When extended health coverage ends

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

COBRA continuation of coverage

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of contributions. Continuation rights are available following a “qualifying event” that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing coverage through COBRA

When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer’s notice of this COBRA continuation right, if later.
- Agree to pay the required contributions.

Who qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

Disability may increase maximum continuation to 29 months

If you or your covered dependents are disabled

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the contributions after the 18th month, through the 29th month.

If there are multiple qualifying events

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining your contributions for continuation coverage

Your contributions are regulated by law, based on the following:

- For the 18 or 36 month periods, contributions may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, contributions for coverage during an extended disability period may never exceed 150 percent of the plan costs.

When you acquire a dependent during a continuation period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional contributions for continuation are paid on a timely basis.

Important Note

For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

When your COBRA continuation coverage ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required contributions.
- You or your covered dependents become covered under another group plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

Direct bill continuation coverage

Under certain circumstances, Covered Persons and their Enrolled Dependents may apply for continued coverage under the Direct Bill Plan. This Direct Bill Plan is available after COBRA Coverage terminates. The entire cost of the coverage must be paid by the Covered Person. There are no contributions from the Plan Administrator. Coverage under the Direct Bill Plan ends at the end of the month in which the Covered Person becomes sixty-five (65) years of age.

- In order to be eligible for the Direct Bill Plan as an early Retiree (Retired Employees aged fifty-five (55) through sixty-four (64), the Employee and any Dependents must have each had 60 months of continuous coverage under the Plan at the time coverage ended. A Retiree previously enrolled for family membership may retain a family Plan if his or her eligible Dependents meet the above 60-month participation requirement. Or the Retiree may select two single Plans (one for the Retiree and one for his/her Spouse) if the Retiree and the Spouse both meet the above 60-month participation requirement.
- An Employee who qualifies for benefits under the Plan Administrator's Long-term Disability Plan may continue under the Direct Bill Plan after twenty-nine (29) months of COBRA continuation coverage. Those previously covered under a family membership may retain a family Plan or select two single Plans (one for the disabled Employee and one for the Spouse).
- A surviving Spouse and Dependents of a deceased Employee may continue under the Direct Bill Plan after COBRA continuation coverage terminates. Eligible Dependents may remain covered as long as they are on the family Plan with the surviving Spouse. If the surviving Spouse remarries, the new Spouse and any new Dependents are not eligible for coverage.
- An Employee who has ceased employment because of a reduction-in-force or board-approved extended leave of absence may continue under the Direct Bill Plan for up to six (6) months after COBRA coverage terminates.

If you wish to elect this coverage or obtain more detailed information, contact the Plan Administrator Millard Public Schools, 5606 South 147th St. Omaha, Nebraska, 68137. The employee may also have continuation rights under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health Plan continuation.

General provisions – other things you should know

Administrative information

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 health plan. This document may have amendments too. Under certain circumstances, we or the customer or the law may change your plan. Only **Aetna** may waive a requirement of your plan. No other person – including the policyholder or **provider** – can do this.

If a service cannot be provided to you

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund you or the employer any unearned premium.

Legal action

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

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

Physical examinations and evaluations

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

Records of expenses

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

Things that would be important to keep are:

- Names of **physicians**, dentists 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 customer may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in contributions 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:

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

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage.

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

Financial information

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. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** or facility under this plan. This may include:

- The benefits due
- The right to receive payments or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this plan.

Financial sanctions exclusions

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

Recovery of overpayments

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. One of the ways Aetna recovers overpayments is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by Aetna. Aetna would then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan may be subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Effect of benefits under other plans

As to employees enrolled in the Choice POS II Medical Plan:

Effect of a Health Maintenance Organization plan (an HMO Plan) on coverage

If you are eligible and have chosen medical coverage under an HMO plan offered by the employer, you will be excluded from medical coverage (except vision care, if any,) on the date of your coverage under the HMO plan.

If you and your covered dependents:	Change of coverage:	Coverage takes effect:
Live in an HMO plan enrollment area	During an open enrollment period	Group contract anniversary date after the open enrollment period
Live in an HMO plan enrollment area	Not during an open enrollment period	Only if and when we give our written consent
Move from an HMO plan enrollment area or the HMO discontinues	Within 31 days	On the date you elect such coverage
Move from an HMO plan enrollment area or the HMO discontinues	After 31 days	Only if and when we give our written consent

Extension of benefits for pregnancy

If you are:	Evidence you must provide:	Extension:	Extension will end the earlier of:
In a hospital not affiliated with the HMO plan	The HMO plan provides an extension of benefits for pregnancy	Same length of time and for the same conditions as the HMO plan provides	<ul style="list-style-type: none"> • The end of a 90 day period, or • The date the person is not confined

No benefits will be paid for any charges for services rendered or supplies received under an HMO plan.

As to employees enrolled in the Choice POS II High Deductible Health Plan:

Effect of a Health Maintenance Organization plan (an HMO Plan) on coverage

If you are eligible and have chosen medical coverage under an HMO plan offered by the employer, you will be excluded from medical coverage (except vision care, if any,) on the date of your coverage under the HMO plan.

If you and your covered dependents:	Change of coverage:	Coverage takes effect:
Live in an HMO plan enrollment area	During an open enrollment period	Group contract anniversary date after the open enrollment period
Live in an HMO plan enrollment area	Not during an open enrollment period	Only if and when we give our written consent
Move from an HMO plan enrollment area or the HMO discontinues	Within 31 days	On the date you elect such coverage
Move from an HMO plan enrollment area or the HMO discontinues	After 31 days	Only if and when we give our written consent

No benefits will be paid for any charges for services rendered or supplies received under an HMO plan.

Continuation of coverage for other reasons

Health coverage under this plan will continue uninterrupted as to your dependent college student who takes a medically necessary leave of absence from school. See the *Special coverage options after your plan coverage ends – How can you extend coverage for a child in college on medical leave?* section.

Sutter Health and Affiliates Services

Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna’s contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). Aetna will charge the Plan for these claims in order to be able to continue providing Plan Participants with access to Sutter’s services on an in-network basis.

Glossary

Aetna

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

Ambulance

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

Behavioral health provider

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

Body mass index

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

Brand-name prescription drug

A U.S. Food and Drug Administration (FDA) approved **prescription drug** marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Copay/Copayments

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

Cosmetic

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

Covered benefits

Eligible health services that meet the requirements for coverage under the terms of this plan, including:

1. They are **medically necessary**.
2. You received **precertification** if required.

Custodial care

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

Deductible

The amount you pay for **eligible health services** per Calendar Year before your plan starts to pay as listed in the schedule of benefits.

Detoxification

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

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

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

Directory

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

Durable medical equipment (DME)

Equipment and the accessories needed to operate it, that is:

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

Effective date of coverage

The date your and your dependent's coverage begins under this booklet as noted in your employer's records.

Eligible health services

The health care services and supplies and **prescription drugs** listed in the *Eligible health services under your plan* section and not carved out or limited in the *exclusions* section or in the schedule of benefits.

Emergency admission

An admission to a **hospital** or treatment facility ordered by a **physician** within 24 hours after you receive **emergency services**.

Emergency medical condition

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

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

Emergency services

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

Experimental or investigational

A drug, device, procedure, or treatment that is found to be **experimental or investigational** because:

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

Formulary exclusions list

A list of **prescription drugs** not covered under the plan. This list is subject to change.

Generic prescription drug

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

Health professional

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

Home health care agency

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

Home health care plan

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

Hospice care

Care designed to give supportive care to people in the final phase of a **terminal illness** and focus on comfort and quality of life, rather than cure.

Hospice care agency

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

Hospice care program

A program prescribed by a **physician** or other **health professional** to provide **hospice care** and supportive care to their families.

Hospice facility

An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**.

Hospital

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

Hospital does not include a:

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

Illness

Poor health resulting from disease of the body or mind.

Infertile/infertility

A disease defined by the failure to become pregnant:

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

Injury

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

Institutes of Excellence™ (IOE) facility

A facility designated by **Aetna** in the **provider directory** as Institutes of Excellence **network provider** for specific services or procedures.

Intensive Outpatient Program (IOP)

Clinical treatment provided must be no more than 5 days per week, no more than 19 hours per week and a minimum of 2 hours each treatment day of **medically necessary** services delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a **mental disorder** or **substance abuse** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder

This is:

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

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

Mail order pharmacy

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

Maximum out-of-pocket limit

The maximum out-of-pocket amount for payment of **copayments** and payment percentage including any **deductible**, to be paid by you or any covered dependents per Calendar Year for **eligible health services**.

Medically necessary/Medical necessity

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

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

Generally accepted standards of medical practice means:

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

Mental disorder

A **mental disorder** as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. **Mental disorders** are usually associated with significant distress or disability in social, occupational, or other important activities.

Morbid obesity/morbidly obese

This means the **body mass index** is well above the normal range and severe medical conditions may also be present, such as:

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

Negotiated charge

For health coverage, this is either:

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

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

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

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

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

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

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

Network pharmacy

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

Network provider

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

Non-preferred drug

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

Out-of-network pharmacy

A **pharmacy** that is not a **network pharmacy** or a National Advantage Program (NAP) **provider** and does not appear in the **directory** for your plan.

Out-of-network provider

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

Partial hospitalization treatment

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

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

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

Payment Percentage

The specific percentage the plan pays for a health care service listed in the schedule of benefits.

Pharmacy

An establishment where **prescription** drugs are legally dispensed. This includes a **retail pharmacy**, **mail order pharmacy** and **specialty pharmacy**.

Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Precertification, precertify

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

Preferred drug

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

Preferred drug guide

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

Preferred network pharmacy

A **network retail pharmacy** that **Aetna** has identified as a **preferred network pharmacy**.

Prescriber

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

Prescription

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

Prescription drug

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

Primary care physician (PCP)

A **physician** who:

- The **directory** lists as a **PCP**
- Is selected by a person from the list of **PCPs** in the **directory**
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care **physician**, an internist, a pediatrician
- Is shown on **Aetna's** records as your **PCP**

Provider(s)

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

Psychiatric hospital

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

Psychiatrist

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

Recognized charge

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The **recognized charge** depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Service or supply	Recognized charge
Professional services and other services or supplies not mentioned below	The reasonable amount rate
Services of hospitals and other facilities	The reasonable amount rate
Prescription drugs	110% of the average wholesale price (AWP)
Important note: If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.	

Recognized charge does not apply to involuntary services.

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP **provider**. NAP **providers** are **out-of-network providers** and third party vendors that have contracts with us but are not **network providers**. Except for involuntary services, when you get care from a NAP **provider** your out-of-network cost sharing applies.

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility **provider's** estimated costs for the service and leave the facility **provider** with a reasonable profit. For **hospitals** and other facilities that report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on what the facilities report to CMS. For facilities that do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. We may adjust the formula as needed to maintain the reasonableness of the recognized charge. For example, we may make an adjustment if we determine that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Involuntary services are services or supplies that are one of the following:
 - Performed at a network facility by an **out-of-network provider**, unless that **out-of-network provider** is an assistant surgeon for your **surgery**
 - Not available from a **network provider**
 - **Emergency services**

We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**.

- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
 - The method CMS uses to set Medicare rates
 - What other **providers** charge or accept as payment
 - How much work it takes to perform a service
 - Other things as needed to decide what rate is reasonable for a particular service or supply

We may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
- Our rate may also exclude other payments that CMS may make directly to **hospitals** or other **providers**. It also may exclude any backdated adjustments made by CMS.
- For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.
- For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies.
- For **DME**, our rate is 75% of the rates CMS establishes for those services or supplies.
- For medications payable/covered as medical benefits rather than **prescription drug** benefits, our rate is 100% of the rates CMS establishes for those medications.

- "Reasonable amount rate" means your plan has established a reasonable rate amount as follows:

Service or supply	Reasonable amount rate
Professional services	80th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically: <ul style="list-style-type: none"> • We update our systems with these changes within 180 days after receiving them from FAIR Health • If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable If the alternative data source does not contain a value for a particular service or supply, we will base the recognized charge on the Medicare allowed rate.
Inpatient and outpatient charges of hospitals	The Facility charge rate (FCR) rate
Inpatient and outpatient charges of facilities other than hospitals	The Facility charge rate (FCR) rate

Our reimbursement policies

We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the **recognized charge**. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the **provider**

Our reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits

We have online tools to help decide whether to get care and if so, where. Use the "Estimate the Cost of Care" tool on Aetna Navigator®. **Aetna's** secure member website at www.aetna.com may contain additional information that can help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools.

R.N.

A registered nurse.

Residential treatment facility (mental disorders)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by **Aetna** or is accredited by one of the following agencies, commissions or committees for the services being provided:
 - The Joint Commission (TJC)
 - The Committee on Accreditation of Rehabilitation Facilities (CARF)
 - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
 - The Council on Accreditation (COA)

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

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

Residential treatment facility (substance abuse)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for **substance abuse** residential treatment programs. And is credentialed by **Aetna** or accredited by one of the following agencies, commissions or committees for the services being provided:
 - The Joint Commission (TJC)
 - The Committee on Accreditation of Rehabilitation Facilities (CARF)
 - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
 - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for chemical dependence residential treatment programs:

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

In addition to the above requirements, for chemical dependence **detoxification** programs within a residential setting:

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

Retail pharmacy

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

Room and board

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

Semi-private room rate

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

Skilled nursing facility

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

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

Skilled nursing facility does not include institutions that provide only:

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

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

Skilled nursing services

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

Specialist

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

Specialty prescription drugs

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

You can access the list of these **specialty prescription drugs** by calling the toll-free number on your ID card or by logging on to your Aetna Navigator® secure member website at www.aetna.com.

Specialty pharmacy

This is a **pharmacy** designated by Aetna as a **network pharmacy** to fill **prescriptions** for **specialty prescription drugs**.

Stay

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

Substance abuse

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

Surgery center

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

Surgery or surgical procedures

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, or otherwise physically changing body tissues and organs.

Telemedicine

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

Services can be provided by:

- Two-way audiovisual teleconferencing;
- Telephone calls , except for behavioral health services
- Any other method required by state law

Terminal illness

A medical prognosis that you are not likely to live more than 12 months.

Therapeutic drug class

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**.

Urgent care facility

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

Urgent condition

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

Walk-in clinic

A freestanding health care facility. Neither of the following should be considered a **walk-in clinic**:

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

Discount programs

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 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.

As to employees electing the Enhanced Wellness program:

Wellness and Other Incentives

We may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services and continue participation as an **Aetna** member through incentives. You and your doctor can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, we may provide incentives based on your participation and your results. Incentives may include but are not limited to:

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

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

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

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

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

Notice Regarding Women's Health and Cancer Rights Act

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

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

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

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

For more information, you can visit this U.S. Department of Health and Human Services website, <http://www.cms.gov/home/regsguidance.asp>, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

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

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

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

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.