Open Access Managed Choice (OAMC) medical plan

Certificate of coverage

Prepared for:

Policyholder:	President and Board of Trustees of Santa Clara College DBA Santa Clara University
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Underwritten by Aetna Life Insurance Company

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Welcome

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

Welcome to Aetna.

Introduction

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

It's really important that you read the entire certificate and your schedule of benefits.

If your coverage under any part of this plan replaces coverage under another plan, your coverage for benefits provided under the other coverage may reduce benefits paid by this plan. See the *Coordination of benefits - Effect of prior plan coverage* section.

If you need help or more information, see the *Contact us* section below.

WARNING: THE INSURANCE DESCRIBED IN THIS BOOKLET-CERTIFICATE IS AN OPEN ACCESS MANAGED CHOICE (OAMC) PLAN. YOU WILL BE COVERED FOR BOTH IN-NETWORK AND OUT-OF-NETWORK BENEFITS REGARDLESS OF WHERE YOU LIVE.

WE WILL PAY FOR **EMERGENCY SERVICES** AT THE IN-NETWORK LEVEL.

GENERALLY, SERVICES WILL NOT BE PAID AT THE IN-NETWORK LEVEL IF THE THEY ARE RECEIVED FROM AN OUT-OF-NETWORK PROVIDER. ANY SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER:

- **WILL BE PAID AT A LOWER PERCENTAGE**
- **MAY BE SUBJECT TO HIGHER OUT-OF-POCKET LIMIT AND DEDUCTIBLE AMOUNTS**

SEE THE *SURPRISE BILL* SECTION FOR EXCEPTIONS TO THIS RULE.

A LISTING OF ALL **NETWORK PROVIDERS** IN YOUR SERVICE AREA MAY BE ACCESSED AT ANY TIME IN OUR **DIRECTORY**. YOU CAN SEARCH THE **DIRECTORY** AT WWW.AETNA.COM.

How we use words

When we use:

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

Contact us

We are here to answer your questions, receive complaints, including those regarding *Timely access to care*, or you may keep your medical information private by requesting a confidential communication.

You can contact us by:

- **Calling the toll-free number on your ID card**
- **Writing us at 151 Farmington Ave, Hartford, CT, 06156**
- **Visiting https://www.aetna.com to register and access your member website**

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

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

You may also contact the California Department of Insurance with your concerns at:
California Department of Insurance
Consumer Services Division
300 Spring Street, South Tower, Los Angeles, CA 90013
1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4833)
www.insurance.ca.gov

Timely access to care

In-network providers agree to provide timely access to care. You will see your **provider** when you call for an appointment within these timeframes:

- Urgent care within 48 hours of the request, for services that do not require prior authorization
- Urgent care appointments within 96 hours of the request, for services that require prior authorization
- Non-urgent appointments for primary care services within 10 business days of the request
- Non-urgent appointments for specialty care within 15 business days of the request
- Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health conditions within 15 business days of the request
- Non-urgent appointments with a non-physician **mental health condition** or **substance use disorder provider** within 10 business days of the request
- Non-urgent follow-up appointments with a non-physician **mental health condition** or **substance use disorder provider** within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing **mental health condition** or **substance use disorder**
- Telephone screening within 30 minutes of the request

If a **medically necessary** health care benefit for a **mental health condition** or **substance use disorder** is unavailable in-network within applicable geographic or timely access standards, we must arrange for an available and accessible **out-of-network provider** or facility to provide care. Cost sharing for out-of-network care that is arranged by us due to network inaccessibility is limited to the amount that would have been due to a **network provider** or facility. Cost sharing paid for arranged out-of-network care will accrue to any applicable **in-network deductible** and to the in-network **out-of-pocket maximum limit**.

We may have exceptions to appointment wait times when the Department of Insurance allows such exceptions. Interpreter services will be made available to you at the time of your appointment.

Your ID card

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

Wellness and other rewards

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

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

Discount arrangements

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

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

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

Coverage and exclusions

Providing covered services

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

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

For **covered services** under the outpatient **prescription** drug plan:

- You need a **prescription** from the prescribing **provider**
- You need to show your ID card to the network pharmacy when you get a **prescription** filled

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

- **Physician** care generally is covered but **physician** care for cosmetic **surgery** is never covered. This is an exclusion.
- Home health care is generally covered but may only be covered up to a set number of visits per year. This is a limitation.
- Your **provider** may recommend services that are considered **experimental**, **investigational, or unproven** services. But an **experimental**, **investigational, or unproven** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of services below. You can request an independent medical review from the California Department of Insurance if you receive an adverse benefit determination for an **experimental, investigational, or unproven** service. Refer to the *Complaints, claim decisions and appeal procedures* section.

Note: **Medically necessary** services for gender dysphoria will be covered in accordance with the Gender affirming treatment section.

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

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

Abortion (including pre-abortion and follow-up abortion related services)

Covered services include services provided and supplies used in connection with an abortion.

Abortion means any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth, which would include, for example, medication or surgical procedures (and related services) that are necessary to stop the progression of a pregnancy or to remove the pregnancy in the case of miscarriage or ectopic pregnancy.

Acquired Immune Deficiency Syndrome (AIDS) Vaccine

Covered services include coverage for an AIDS vaccine, provided the AIDS vaccine meets the following conditions:

- Approved for marketing by the federal Food and Drug Administration
- Recommended by the United States Public Health Service

Acupuncture

Covered services include manual or electro acupuncture.

The following are not **covered services**:

- Acupressure

Ambulance services

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

Emergency

Covered services include emergency transportation when your condition is unstable and requires medical supervision and rapid transport. These emergency ambulance services are limited to transportation by a licensed ambulance:

- To the first facility to provide **emergency services**
- From one facility to another if the first can't provide the **emergency services** you need

Non-emergency

Covered services also include non-emergency transportation when an ambulance is the only safe way to transport you. These non-emergency ambulance services are limited to transportation by a licensed ambulance:

- To the nearest facility able to treat your condition
- From a facility to your home by ground ambulance

The following are not **covered services**:

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

Behavioral health

Medically necessary treatment of **mental health conditions** and **substance use disorders** are covered under the same terms and conditions applied to other medical conditions and in accordance with the federal Mental Health Parity and Addiction Equity Act.

Mental health conditions treatment

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

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes individual, group and family therapies in an office setting and **telemedicine** consultations)
  - Other outpatient mental health treatment such as:
    - Individual, group and family therapies in a non-office setting for the treatment of **mental health conditions**
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - Observation
    - Behavioral health crisis services provided by a 988 Crisis Hotline Center or mobile crisis team
    - Peer counseling support by a peer support specialist (including **telemedicine** consultation)

Substance use disorders treatment

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

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, (including management of withdrawal from alcohol or other substances).
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes individual, group and family therapies in an office setting and **telemedicine** consultations)
  - Therapy associated with medication assisted treatment and therapy provided at methadone clinics
  - Other outpatient **substance use disorders** treatment such as:
    - Individual, group and family therapies in a non-office setting for the treatment of substance use disorders
    - Partial hospitalization treatment provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
    - Ambulatory or outpatient **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Opioid treatment programs (OTPs) which combine behavioral therapy and medications to treat **substance use disorders**
    - Observation
    - Behavioral health crisis services provided by a 988 Crisis Hotline Center or mobile crisis team
    - Peer counseling support by a peer support specialist (including **telemedicine** consultation)

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

Breast cancer screening, diagnosis and treatment

Covered services for breast cancer screening, diagnosis and treatment include the services and supplies as described in the following sections:

- Coverage and exclusions – Well woman preventive visits
- Coverage and exclusions – Routine Cancer Screenings

- Coverage and exclusions – Reconstructive breast surgery and supplies
- Coverage and exclusions –Prosthetic devices

Clinical trials

Routine patient costs

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

The following are not **covered services**:

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

Experimental or investigational therapies

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

- You are eligible to participate in the approved clinical trial
- Your participation is appropriate to treat the disease or condition based on your **provider**'s conclusion or based on medical and scientific information provided by you

An approved clinical trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.

A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Dental care anesthesia

Covered services include anesthesia and facility costs for dental care. Your doctor must certify that the dental care cannot be performed in the dentist's office due to either age or medical condition.

The following are not **covered services**:

- The related dental service unless specifically listed as a **covered service** in this certificate.

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

Covered services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Injection devices including syringes, needles and pens
  - Test strips - blood glucose, ketone and urine
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs

- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
  - Continuous glucose monitors
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

Durable medical equipment (DME)

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

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

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

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

Covered services also include:

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

The following are not **covered services**:

- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

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

Covered services include only:

- Services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room or an independent freestanding emergency department, as well as further medical examination and treatment to stabilize the patient within the capabilities of the staff and facilities available at the **hospital** or independent freestanding emergency department

- Outpatient observation services, including services received after stabilization, as a result of the **emergency medical condition** visit
- Emergency room medical care including follow up health care treatment at no cost to you after any deductible is satisfied following a rape or sexual assault for the first 9 months after you initiate treatment.

Your coverage for **emergency services** will continue until you are evaluated, and your condition is stabilized and:

- Your attending **physician** determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another **provider** if you need more care
- An **out-of-network provider** providing **emergency services** gives written notice in accordance with federal and state requirements under the No Surprises Act and obtains your consent that you are knowingly choosing to go out-of-network. See the S*urprise bill* section for its provisions.

An independent freestanding emergency department means a health care facility that is geographically separate, distinct and licensed separately from a hospital and provides **emergency services**.

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

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

See also the *Important exception – surprise bills* section for its provisions, including the notice and consent requirements that apply.

Non-emergency services

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

Foot orthotic devices

Covered services include a mechanical device, ordered by your **physician**, to support or brace weak or ineffective joints or muscles of the foot.

Covered services also include special footwear if you suffer from a foot disfigurement including, but not limited to, disfigurement caused by:

- Cerebral palsy
- Arthritis
- Polio
- Spina bifida
- Diabetes
- Accident
- Developmental disability

Gender affirming treatment

Gender affirming treatment is subject to the provisions of the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and state mental health parity law.

Covered services include **medically necessary** services and supplies for gender affirming treatment and **surgery**.

These services include but are not limited to:

- Hormone therapy
- Hysterectomy
- Mastectomy
- Fertility preservation for iatrogenic infertility for a **mental health condition** or **substance use disorder** diagnosis
- Reconstructive **surgery** to create a normal appearance for the gender with which you identify
- Speech therapy

These services will not be denied if you enrolled as a member of the opposite sex or are in the process of a gender transition.

Important note:
We apply **medical necessity** review (precertification, concurrent and retrospective) to all inpatient services, including inpatient visits for any **mental health condition** or **substance use disorder** as specified in the certificate of coverage. In making determinations of **medical necessity** for gender affirming treatment we use the most recent version of the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People developed by the World Professional Association for Transgender Health (WPATH).

Habilitation services

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

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

Outpatient physical, occupational, and speech therapies

Covered services include:

- Physical therapy if it is expected to develop any impaired function or maintain function
- Occupational therapy if it is expected to develop any impaired function or maintain function
- Speech therapy if it is expected to develop speech function that resulted from delayed development or maintain function

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

The following are not **covered services**:

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

Hearing aids

Hearing aid means:

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

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

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

The following are not **covered services**:

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

Home health care

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

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

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

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

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

The following are not **covered services**:

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

Hospice care

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

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

Hospice care services provided by the **providers** below will 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

The following are not **covered services**:

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

Hospital care

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

- Semi-private **room and board** (your plan will cover the extra expense of a private room when appropriate because of your medical condition)
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge
- Services of **physicians** employed by the **hospital**
- Administration of blood and blood products

The following are not **covered services**:

- All services and supplies provided in:
  - Rest homes
  - Any place considered a person's main residence or providing mainly custodial or rest care. Refer to the Home health care provisions in this section for home health care services that may be covered when provided by a **home health care agency** in the home.
  - Health resorts
  - Spas
  - Schools or camps

Infertility services

Basic infertility

Covered services include seeing a **provider:**

- To diagnose and evaluate the underlying medical cause of infertility.
- To do **surgery** to treat the underlying medical cause of infertility. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.
- For artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination.

See the *Coverage and exclusions-Prescription drugs – outpatient* section for information on coverage of infertility **prescription** drugs.

Advanced reproductive technology (ART)

Fertility preservation

Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use, including all standard fertility preservation services when a medical treatment may directly or indirectly cause a need for fertility preservation services.

Covered services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned medical services that are proven to result in infertility such as:
  - Chemotherapy or radiation therapy that is established in medical literature to result in infertility
  - Other gonadotoxic therapies
  - Removing the uterus
  - Removing both ovaries or testicles
- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the FSH level and ovarian responsiveness criteria outlined in Aetna's infertility clinical policy

Infertility services exclusions:

The following are not **covered services** except as described as a **covered service** for fertility preservation:

- All infertility services associated with or in support of an ovulation induction cycle while on injectable medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Infertility medication.

Jaw joint disorder treatment

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

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

The following are not **covered services**:

- Non-surgical medical and dental services, and therapeutic services related to **jaw joint disorder**

Maternity and related newborn care

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

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery
- No less than 96 hours of inpatient care in a **hospital** after a cesarean delivery

- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

If the mother is discharged earlier, the plan will pay for 1 home visit after delivery by a health care **provider**. **Covered services** also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

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

Nutritional support

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

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids. **Covered services** also include the inpatient use of **medically necessary** pasteurized donor human milk obtained from a tissue bank licensed by the State Department of Public Health.

The following are not **covered services**:
Any food item, including:

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

Except as described in the *Coverage and exclusions-Preventive care* section

Obesity surgery and services

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

Covered services include:

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

See *Counseling services* in the *Coverage and exclusions-Preventive care* and *Weight loss drugs* in the *Prescription drugs – outpatient* section for other **covered services**.

The following non-preventive care services are not **covered services:**

- Weight management treatment
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate.
- 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)

Covered services include the following when provided by a **physician**, dentist and **hospital**:

- Cutting 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
- Cutting into gums and tissues of the mouth:
  - Only when not associated with the removal, replacement or repair of teeth

Outpatient surgery

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

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

The following are not **covered services**:

- A **stay** in a **hospital** (see *Hospital care* in this section)
- Services of another **physician** for the administration of a local anesthetic

Physician services

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

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

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

Telemedicine may have a different cost share from other **physician** services. See your schedule of benefits.

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

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

Prescription drugs - outpatient

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

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

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

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

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

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

Your cost share will not be more than the retail drug price. The amount you pay for the **prescription** drug will apply to your **maximum out-of-pocket limit** and **deductible** if you have one.

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

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

Prescription drug synchronization

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

Partial fill dispensing for Schedule II controlled substances

You or your **provider** may request your pharmacist to dispense a partial fill of a Schedule II controlled substance. Your out of pocket expenses for a partial fill will be prorated accordingly.

How to access network pharmacies

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

If you don't get your **prescriptions** at a network pharmacy, it will not be a **covered service** under the plan.

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 30 day supply of a **prescription** drug.

Mail order pharmacy

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Not all drugs are available through mail order. Controlled substances, cold-chain and specialty medications are available through retail or specialty, depending on the drug. A **mail order pharmacy** may be used for up to a 90 day supply of a **prescription** drug.

After you obtain your second fill at a network **retail pharmacy**, you must tell us whether you want to use your network **mail order pharmacy** benefit, a designated network pharmacy, or a CVS pharmacy, or continue to use your network **retail pharmacy**. See the *Contact us* section for how. If you don't tell us your choice, the next **prescription** refill and any other refills for that drug will only be covered through the network **mail order pharmacy**, a designated network pharmacy or a CVS pharmacy and will not be covered at a network **retail pharmacy**. You can tell us at any time that you intend to use a network **retail pharmacy** for future **prescription** refills. For covered **prescription** drugs that are not available through a **mail order pharmacy**, refills may continue to be covered at a network **retail pharmacy**.

Specialty pharmacy

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

All **specialty prescription drug** fills including the first fill must be filled at a network **specialty pharmacy** unless it is an urgent situation.

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

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

When the pharmacy you use leaves the network

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

How to get an emergency prescription filled

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

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

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

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

Other covered services

Abortion drugs

Covered services include **prescription** drugs used for elective termination of pregnancy.

Anti-cancer drugs taken by mouth

Covered services include any drug prescribed for cancer treatment, including chemotherapy drugs. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

Contraceptives (birth control)

Covered services include all drugs and devices that the FDA has approved to prevent pregnancy at no cost to you. You will need a **prescription** from your **provider** and must fill it at a network pharmacy.

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

A **prescription** is not required for FDA-approved over-the-counter contraceptives, drugs, devices and products at a network pharmacy and will be provided:

- At no cost to you and
- Without medical management.

You may get a 12-month supply per **prescription**. The prescribed contraceptive **prescription drug** may be filled all at once or over the course of the 12 months as prescribed by your **prescriber**. For specific cost sharing see your **schedule** of benefits *Outpatient **prescription drugs** Contraceptives (birth control)* section.

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

Diabetic supplies

Covered services include but are not limited to the following:

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

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

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

Infertility drugs
Covered services include oral and injectable ovulation induction **prescription** drugs.

Over-the-counter (OTC) drugs
Covered services include certain OTC medications when you have a **prescription** from your **provider**. You can see a list of covered OTC drugs by logging on to your member website.

Pharmacy consultation services
State licensed pharmacists are allowed to prescribe certain **prescription** drugs.

Covered services include consultation services by your state licensed pharmacist to:
- Determine the **medical necessity** of a specific **prescription** drug for your illness or condition
- Prescribe specific **medically necessary prescription** drugs

These consultation services may have a different cost share from other **provider** consultations or other **prescription** drug services. See your schedule of benefits.

Preventive care drugs and supplements
Covered services include preventive care drugs and supplements described in the *Preventive care drugs* section of the Preventive care section. Preventive care coverage includes all pharmacotherapy and behavioral interventions, and all combinations thereof for these **prescription** drugs, including OTC ones, as required by the ACA and in accordance with state law.

Risk reducing breast cancer prescription drugs
Covered services include **prescription** drugs used to treat people who are at:
- Increased risk for breast cancer
- Low risk for medication side effects

Sexual enhancement or dysfunction prescription drugs
Covered services include **prescription** drugs for the treatment of sexual dysfunction or enhancement.
For the most up-to-date information on covered **prescription** drugs and doses, contact us.

Tobacco cessation prescription drugs
Covered services include FDA-approved **prescription** drugs, OTC drugs, and OTC aids to help stop the use of tobacco products, including nicotine replacement therapy. A **provider** must prescribe all OTC aids.

A tobacco product is something that contains tobacco or nicotine. Examples of this are:
- Candy-like products with tobacco as an ingredient
- Cigarettes
- Cigars
- Smoking tobacco
- Smokeless tobacco
- Snuff

Nicotine replacement therapy is a **prescription** drug or aid that:

- Delivers nicotine to a person who is trying to stop using tobacco products
- Is prescribed by a **provider**

Weight loss drugs

Covered services include **prescription** drugs used only for the purpose of weight loss.

You must be diagnosed by your **provider**, including a physical exam and outpatient diagnostic lab work, with Class III obesity.

Prescription drug exclusions:

The following are not **covered services**:

- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a **covered service**
- Dietary supplements, except as described in the *Coverage and exclusions-Preventive care* section
- Drugs or medications
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a **prescription** by law, even if a **prescription** is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered **prescription** drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat or increase sexual desire, including implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a **covered service**
  - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-**prescription** appetite suppressants or other medications except as described in the certificate unless you are diagnosed by your **provider** with an eating disorder or Class III obesity
  - 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; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as a **covered service**
- Immunizations related to travel or work unless recommended by the United States Preventive Services Task Force (USPSTF)

- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except for **medically necessary** implantable drugs and associated devices used to treat behavioral health conditions or as specifically stated in the schedule of benefits or the certificate
- Injectables including:
  - Any charges for the administration or injection of **prescription** drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription** drugs:
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen **prescriptions**

- When prescribed solely for the purpose of losing weight, except when **medically necessary** for the treatment of Class III obesity.
- Test agents except diabetic test agents
- A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
- Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

Preventive care

Preventive **covered services** are designed to help keep you healthy, supporting you in achieving your best health through early detection at no cost to you if received from a **network provider**. If you need further services or testing such as diagnostic testing, you may pay more as these services aren't preventive, except for COVID-19 screening and diagnostic testing*. If a **covered service** isn't listed here under preventive care, it still may be covered under other **covered services** in this section. For more information, see your schedule of benefits.

*In compliance with state and federal law, preventive care includes **covered services** for COVID-19 screening, testing, and immunizations:

- Screening and testing for COVID-19, including a visit to a medical office, emergency room, urgent care setting, hospital, or telemedicine visit when the purpose of the visit is screening and/or testing for COVID-19, and associated lab testing and radiology services
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), regardless of whether the immunization is recommended for routine use.
- Therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for treatment of COVID-19 at no cost share when prescribed or furnished by a licensed health care provider acting within their scope of practice and standard of care.

State law and the following agencies set forth the preventive care guidelines in this section:

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

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

Please consult with your **physician** to determine what preventive services are appropriate for you. For more information regarding preventive services, contact your **physician** or us.

Preventive care items and services are covered as prescribed unless this certificate states otherwise.

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

Decisions regarding whether you are part of a high-risk population, and should therefore receive a specific preventive item or service identified for those at high-risk, will be made by your attending **provider**.

Breast-feeding support and counseling services, equipment, education and supplies

Covered services include comprehensive lactation support services, including counseling, education by clinicians and peer support services and breast-feeding equipment and supplies that are necessary to optimize the successful initiation and maintenance of breastfeeding for the duration of breastfeeding. Your plan will cover this counseling only when you get it from a source trained to provide breast-feeding support.

Counseling services

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

- Alcohol or drug misuse
  - Preventive counseling and risk factor reduction intervention
  - Structured assessment
- Chronic conditions
  - Counseling and evaluation services to help prevent or maintain chronic conditions.
- Genetic risk for breast and ovarian cancer, including:
  - Identification of:
    - Your or your family's histories of breast, ovarian, tubal or peritoneal cancer
    - Your family members with known harmful BRCA1/2 mutations
    - Your ancestry associated with harmful BRCA1/2 mutations
  - Risk assessment to identify your additional risk factors
  - Genetic counseling for your additional risk factors, including more in-depth review of family history to determine if BRCA testing would be useful
  - BRCA-mutation testing when counseling indicates genetic testing would be useful

- Obesity and healthy diet
  - Preventive counseling and risk factor reduction intervention, including behavioral interventions that focus on healthy diet and physical activity for persons with prediabetes or at risk of cardiovascular disease (CVD)
  - Nutritional counseling
  - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- Sexually transmitted infection
- Stress management
  - Counseling and evaluation services to help you prevent and reduce stress
- Tobacco cessation
  - Preventive counseling to help stop using tobacco products
  - Treatment visits
  - Class visits
  - **Physician** or nurse advice, individual or group-based counseling and telephone and mobile phone-based interventions)

Tobacco cessation **prescription** drugs are described below in the ***Preventive care drugs*** section of the certificate. Preventive care coverage includes all pharmacotherapy and behavioral interventions, and all combinations thereof for tobacco cessation.

Family planning services – contraceptives and clinical services

Covered services include FDA approved, FDA granted or FDA cleared contraceptive drugs, devices, and other products for women including over-the-counter (OTC) prescribed by your **provider**, family planning services and any follow-up care as follows, including:

- Drugs, cervical caps, vaginal rings, continuous extended oral contraceptives, patches and condoms. In addition, fertility awareness-based methods, including the lactation amenorrhea method, although less effective, is covered for women desiring an alternative method.
- Contraceptives which require medical administration in your **provider**'s office, implanted devices and professional services to implant them, sterilization procedures and device removal, and items and services that are integral to the furnishing of a recommended preventive service such as a pregnancy test needed before provision of certain contraceptives is included in contraceptive coverage.
- Counseling and education services provided by a **physician** or other **provider** on contraceptive methods, management of side effects or adherence. These will be covered when you get them in either a group or individual setting.
- FDA-approved, FDA granted or FDA cleared over the counter contraceptive devices (including any related services or supplies) when they are prescribed, provided, administered, or removed by a **health professional**.
  - FDA approved, FDA granted or FDA cleared over-the-counter contraceptive devices do not require a prescription at a network pharmacy and will be provided without cost to you and without medical management.
- Voluntary sterilization including charges billed separately by the **provider** for voluntary sterilization procedures and related services and supplies. This also could include tubal ligation, sterilization implants and vasectomies.

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

- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved", "granted" or "cleared" by the FDA

Immunizations

Covered services include preventive immunizations for infectious diseases. These services may include but are not limited to:

- Diphtheria
- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus (HPV)
- Influenza (flu shot)
- Measles
- Meningococcal
- Mumps
- Pertussis
- Pneumococcal
- Polio
- Rotavirus
- Rubella
- Tetanus
- Varicella (Chickenpox)
- Zoster (Shingles)
- State or federal government mandated immunizations intended to prevent or mitigate a disease in the event of a declared public health emergency, including COVID-19 vaccines, as recommended by the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention.

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

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

Prenatal care

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

- Anemia screening
- Blood pressure
- Fetal genetic disorders screening
- Fetal heart rate check
- Fundal height
- Gestational diabetes screening
- Hepatitis B screening
- Maternal weight
- Preeclampsia screening
- Rh incompatibility screening

Covered services also include participation in the California Prenatal Screening Program. This program is administered by the State Department of Health Services.

Routine cancer screenings

A routine cancer screening is a screening to check your body for cancer before you have symptoms. **Covered services** include, but are not limited to, the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, a pathology exam on any removed polyp, and anesthesia services and bowel preparation medications when in connection with a preventive colonoscopy
- Colorectal cancer screening for adults 45 to 75, including:
  - Fecal Immunochemical Test (FIT)
  - Multitargeted stool DNA test (FIT-DNA, MT-sDNA)
  - CT colonography
  - A follow-up colonoscopy after a positive result at no cost to you if the service is received from a **network provider**.
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings, including low-dose computerized tomography (LDCT)
- Mammograms
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

Routine physical exams

A routine preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and includes, regardless of whether there is a physical exam:

- Abdominal aortic aneurysm one-time screening for men age 65 to 75 who have ever smoked
- Adverse childhood experiences (ACEs) screenings
- Anemia screening
- Anxiety screenings in children and adolescents age 8 to 18, and all adolescent and adult women, including those who are pregnant or postpartum
- Asymptomatic bacteriuria screenings using urine culture for pregnant persons
- Behavioral assessments
- Bilirubin concentration screening for newborns
- Blood pressure screening for adults
- Bone density screening for all women age 65 or older and postmenopausal women under age 65
- Chlamydia infection screening if you are a woman age 24 years or younger, or at high risk for infection, including testing for infection with nucleic acid amplification tests (NAATs)
- Cholesterol screening
- Colorectal cancer screening for adults age 45 to 75
- Depression screening for adults, children and adolescents
- Developmental/autism screening
- Diabetes (Type 2) screening for adults 35 to 70 years who are overweight or obese, and effective preventive interventions, including lifestyle interventions that focus on diet, physical activities, and metformin, for patients with prediabetes
- Discussion of use of risk-reducing medications such as tamoxifen, raloxifene, or aromatase inhibitors, with women who are age 35 years or older and who are at increased risk for breast cancer and at low risk for adverse medication effects
- Fall prevention for community-dwelling adults 65 years or older who are at increased risk for falls
- FDA approved low to moderate dose statin prescription drugs for the prevention of cardiovascular disease events and mortality when all the following criteria are met:
  - You are aged 40-75 years;
  - You have one or more cardiovascular risk factors; and

- You have a calculated 10-year risk of a cardiovascular event of 10% or greater
- Folic acid supplements for women who plan to or could become pregnant to prevent neural tube defects
- For covered newborns, an initial **hospital** checkup and screening, including ocular prophylaxis
- Gestational diabetes screening for women
- Gonorrhea preventive medication for the eyes of all newborns
- Gonorrhea screening if you are a woman age 24 years or younger, or at high risk for infection, including testing for infection with nucleic acid amplification tests (NAATs)
- Hearing screening for all newborns and children
- Hepatitis B screening for adolescents and adults at increased risk for infection and pregnant persons
- Hepatitis C screening for adults
- High-risk Human Papillomavirus (HPV) DNA testing for women age 18-30 and older and limited to once every 6 months-three years
- Interventions, including education and brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents who have not started to use tobacco
- Latent tuberculosis infection screening for asymptomatic persons at increased risk for infection
- Lead screening
- Maternal depression screening, and counseling interventions for pregnant and postpartum persons who are at increased risk of perinatal depression
- Obesity screening and counseling
- Oral fluoride supplementation at currently recommended doses to children older than 6 months of age through 16 years of age whose primary water source is deficient in fluoride
- Oral health risk assessment for young children
- Osteoporosis screening
- Radiological services, lab and other tests given in connection with the exam
- Screening and counseling services on topics such as:
  - Interpersonal and domestic violence
  - Sexually transmitted diseases, such as chlamydia, gonorrhea and syphilis, including sexually transmitted disease home test kits and laboratory costs for processing the kits when ordered by a select care provider or in-network provider
  - Human Immune Deficiency Virus (HIV) infections
- Screening for all disorders on the Recommended Uniform Screening Panel
- Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, as soon as teeth are present, for the prevention of dental caries in children through 5 years of age
- Tuberculin testing for children at higher risk
- Urinary incontinence screening for women
- Vision screenings for children 6 months to 21 years

Covered services include:

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

Well woman preventive visits

Covered services include:

- Your routine well woman preventive office visit. This includes all visits necessary for the delivery and coordination of recommended preventive services, and any necessary services integral to the furnishing of a recommended preventive service regardless if billed separately. Well woman exam visits include routine preconception care, prenatal care and postpartum and interpregnancy visits. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury. It includes necessary preventive services, including those described in other *Preventive care* sections.
- Human papillomavirus (HPV) DNA testing for women age 30 and older, including HPV/Pap co-testing for women age 30-65, if you and your **physician**, OB, GYN or OB/GYN determines this testing strategy is best for you
- Effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy
- Low-dose aspirin use when prescribed by a licensed **provider** for women who are at least 12 weeks pregnant and at high risk for preeclampsia
- Pap smears, including to screen for cervical dysplasia
- Preventive care breast cancer (BRCA) gene blood testing, and counseling provided by a genetic counselor to interpret the test results and evaluate treatment
- Rh (D) incompatibility screening for pregnant women
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for those with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing
- Urinary incontinence screening for women yearly

Private duty nursing - outpatient

Covered services include private duty nursing care provided by an R.N. or L.P.N. when:

- You are homebound
- Your **physician** orders services as part of a written treatment plan
- Services take the place of a **hospital** or **skilled nursing facility stay**
- Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care
- Periodic skilled nursing visits are not adequate

The following are not **covered services**:

- Inpatient private duty nursing care
- Care provided outside the home
- Maintenance or custodial care
- Care for your convenience or the convenience of the family caregiver

Prosthetic device

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

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

Coverage includes:

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

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

The following are not **covered services**:

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

Reconstructive breast surgery and supplies

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

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

Reconstructive surgery and supplies

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

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part, and
  - 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.

Note: Services for gender dysphoria will be covered in accordance with the Gender affirming treatment provisions

Accidental injury to natural teeth

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

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

These accident-related dental services are limited to:

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

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation services

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

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

Covered services include:

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

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

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

  (Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.)
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

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

The following are not **covered services**:

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

Skilled nursing facility

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

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

Specialty prescription drugs

Covered services include **specialty prescription drugs** when they are:

- Purchased by your **provider**
- Injected or infused by your **provider** in an outpatient setting such as:
  - A freestanding outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in the office
  - A home care **provider** in your home

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

Telemedicine

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

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

The following are not **covered services**:

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

Tests, images and labs - outpatient

Diagnostic complex imaging services

Covered services include:

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

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

Diagnostic x-ray and other radiological services

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

Other services include biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of your condition to guide treatment decisions.

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

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

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

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

Key Terms

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

Gene

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

Molecular

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

Therapeutic

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

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

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

GCIT **covered services** include:

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

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

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

Infusion therapy

Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions.

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

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

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

Covered services also include the treatment of pediatric autoimmune neuropsychiatric disorders associated with the streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including but not limited to the use of intravenous immunoglobulin therapy.

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

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

Radiation therapy

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

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

Transplant services

Covered services include transplant services provided by a **physician** and **hospital**. These services are also available if you are infected with the human immunodeficiency virus (HIV).

This includes the following transplant types:

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

Network of transplant facilities

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

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the network **copayment**, **coinsurance**, **deductible**, **maximum out-of-pocket** and limits, unless stated differently in this certificate and schedule of benefits. You may also get transplant services at a non-IOE facility, but your cost share will be higher. Transplant services received from a non-IOE facility are subject to the out-of-network **copayment**, **coinsurance**, **deductible**, **maximum out-of-pocket**, and limits, unless stated differently in this certificate and schedule of benefits.

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

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

The following are not **covered services**:

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

Urgent care services

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

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

The following are not **covered services**:

- Non-urgent care in an urgent care center

Vision care

Covered services include:

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

The following are not **covered services**:

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

Walk-in clinic

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

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

General plan exclusions

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

Behavioral health treatment

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

- School and/or education service, including special education or remedial education programs
- Transportation

Blood and blood products

Blood, blood products, and related services which are supplied to your **provider** free of charge

Cosmetic services and plastic surgery

Any treatment, **surgery** (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, except where described in the *Coverage and exclusions* section. For example, **medically necessary** services for gender dysphoria will be covered in accordance with the Gender affirming treatment provisions.

Cost share waived

Any cost for a service when any **out-of-network provider** waives all or part of your **copayment**, **coinsurance**, **deductible**, or any other amount

Court-ordered services and supplies

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

Custodial care

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

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- Respite care, adult or child day care, or convalescent care
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and **substance use disorder** treatment):
    - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
    - Services given mainly to:

- Maintain, not improve, a level of function
- Provide a place free from conditions that could make your physical or mental state worse

Dental services

The following are not **covered services**:

- Services normally covered under a dental plan
- Dental implants except when part of an approved treatment plan for a **covered service** described in the *Coverage and exclusions - Reconstructive surgery and supplies* section

Educational services

Educational services unless **medically necessary** for **a mental health condition** or **substance use disorder**

- Any service or supply for education, training or retraining services or testing except where described in the *Covered Services - Diabetic services, supplies, equipment, and self-care programs* or *Preventive care* sections. Excluded education, training or retraining services or testing are:
  - Special education
  - Remedial education
  - Job training
  - Job hardening programs
- Educational services, any services, schooling related or similar program, including therapeutic programs within a school setting.

Examinations

Any health or dental examinations needed:

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

Experimental, investigational, or unproven

Experimental, investigational, or unproven drugs, devices, treatments or procedures unless otherwise covered under clinical trials. You can request an independent medical review from the California Department of Insurance if you receive an adverse benefit determination for an **experimental, investigational or unproven** service. Refer to the *Complaints, claim decisions and appeal procedures* section.

Foot care

Routine services and supplies for the following:

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

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

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

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

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

Growth/height care

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

This exclusion does not apply to **medically necessary** treatment for gender dysphoria.

Hearing exams

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

Maintenance care

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

Medical supplies – outpatient disposable

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

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

Missed appointments

Any cost resulting from a canceled or missed appointment

Other non-covered services

- Services you have no legal obligation to pay
- Services that would not otherwise be charged if you did not have the coverage under the plan

Other primary payer

Payment for a portion of the charges that Medicare or another party has paid for as the primary payer

Personal care, comfort or convenience items

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

Prescription or non-prescription drugs and medicines - outpatient

- Outpatient **prescription** or non-**prescription** drugs and medicines provided by the policyholder or through a third party vendor contract with the policyholder
- **Specialty prescription drugs** except as stated in the *Coverage and exclusions* section

Routine exams and preventive services and supplies

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

Services not permitted by law

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

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

Any treatment or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Implants, devices or preparations to correct or enhance erectile function or sensitivity
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

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

Therapies and tests

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

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

Treatment in a federal, state, or governmental entity

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

Voluntary sterilization

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

How your plan works

How your medical 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.

Your cost share is lower when you use a **network provider**.

Providers

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

You may choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care. You don't have to get care through your **PCP**. You may go directly to **network providers**.

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

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

With your out-of-network coverage:

- You can get care from **providers** who are not part of the Aetna network
- You may have to pay the full cost for your care, and then submit a claim to be reimbursed
- You are responsible to get any required **precertification**
- Your cost share will be higher

Who provides the care

Network providers

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

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

- **Emergency services** – see the description of **emergency services** in the *Coverage and exclusions* section.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

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

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

Your PCP

We encourage you to get **covered services** through a **PCP**. They will provide you with primary care.

How you choose your PCP

You can choose a **PCP** from the list of **PCPs** in our directory. Each covered family member is encouraged to select a **PCP**. You may each choose a different **PCP**. You should select a **PCP** for your covered dependent if they are a minor or cannot choose a **PCP** on their own.

What your PCP will do for you

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

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

Out-of-network providers

You can also get care from **out-of-network providers**. When you use an **out-of-network provider**, your cost share is higher. You are responsible for:

- Your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over the **allowable amount**
- Submitting your own claims and getting any required **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 an Aetna member and your **provider** stops being in our network
- The **provider**'s terms of participation change, resulting in a termination of in-network status with respect to a **provider**

This does not apply to terminations of the provider contracts for failure to meet applicable quality standards or for fraud.

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

Care will continue during a transitional period that will vary based on your condition.

If you have this condition	**The length of transitional period is**
Acute condition	As long as the condition lasts
Serious chronic condition	No more than 12 months. Usually until you complete a period of treatment and your **physician** can safely transfer your care to another **physician**.
Pregnancy	All three trimesters of pregnancy and the immediate post-partum period
Maternal **mental health condition** (a **mental health condition** that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery)	Up to 12 months after diagnosis or after pregnancy ends, whichever occurs later
Terminal illness	As long as the person lives
Care of a child under 3 years	Up to 12 months
An already scheduled **surgery** or other procedure	Within 180 days of you joining the **Aetna** plan or your **provider** leaving the network

We will notify you of your right to elect continued transitional care from the **provider** if their termination leads to a change in network status. If you request to keep going to your current **provider**, we will tell you how long you can continue to see the **provider**.

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

Medical necessity and precertification requirements

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

- The service is **medically necessary**
- For in-network benefits, you get the service from a **network provider**
- You or your **provider precertifies** the service when required

Medically necessary, medical necessity

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

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

Precertification

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

In-network

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

Only the in-network services listed below require **precertification** by your network **physician.**

In-network medical/surgical services that require precertification			
	Procedure name/description		
1.	Inpatient confinements (except hospice) For example, surgical and nonsurgical **stays**, **stays** in a **skilled nursing facility** or rehabilitation facility, and maternity and newborn **stays** that exceed the standard length of **stay** (LOS).	15.	**Infertility** services and pre-implantation genetic testing
2.	Ambulance **Precertification** required for non-emergency transportation by fixed-wing aircraft (plane)	16.	Lower limb prosthetics, such as microprocess or controlled lower limb prosthetics
3.	Arthroscopic hip **surgery** to repair impingement syndrome including labral repair*	17.	Out-of-network freestanding ambulatory surgical facility services, when referred by a **network provider.** This does not include **covered services** for a **mental health condition** or **substance use disorder.**
4.	Autologous chondrocyte implantation*	18.	Orthognathic **surgery** procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint
5.	Chiari malformation decompression **surgery**	19.	Osseointegrated implant*
6.	Cochlear device and/or implantation*	20.	Osteochondral allograft/knee*

7.	Coverage at an in-network benefit level for **out-of-network provider** or facility unless services are emergent. Some plans have limited or no out-of-network benefits.	21.	Private duty nursing
8.	Dental implants	22.	Proton beam radiotherapy
9.	Dialysis visits When a **network provider** starts a request and dialysis is to be performed at an out-of-network facility.	23.	Reconstructive or other procedures that maybe considered cosmetic, such as: Blepharoplasty*, Breast reconstruction/ breast enlargement*, Breast reduction/mammoplasty*, Excision of excessive skin due to weight loss*, Gastroplasty/gastric bypass, Lipectomy or excess fat removal*, **Surgery** for varicose veins, except stab phlebectomy*. This does not include **covered services** for a **mental health condition** or **substance use disorder.**
10.	Dorsal column (lumbar) neurostimulators: trial or implantation	24.	Shoulder arthroplasty including revision procedures
11.	Electric or motorized wheelchairs and scooters	25.	Site of service. This means the physical location where a member receives care. Site of service does not include outpatient **covered services** for a **mental health condition** or **substance use disorder.**
12.	Endoscopic nasal balloon dilation procedures*	26.	Spinal procedures, such as: Artificial intervertebral disc **surgery** (cervical spine), Artificial intervertebral disc **surgery** (lumbar spine), Arthrodesis for spine deformity, Cervical laminoplasty*, Cervical, lumbar and thoracic laminectomy and\or laminotomy procedures*, Kyphectomy*, Laminectomy with rhizotomy, Spinal fusion **surgery**, Vertebral corpectomy, Vertebroplasty/Kyphoplasty
13.	Functional endoscopic sinus surgery (FESS)*	27.	Uvulopalatopharyngoplasty, including laser- assisted procedures*
14.	Hyperbaric oxygen therapy	28.	Ventricular assist devices
		29.	Whole exome sequencing

This elective procedure is subject to the **medical necessity review of the procedure and the site of service.*

*In-network behavioral health services that require **precertification***	
Procedure name/description	
1.	Inpatient confinements For example, **stays** in a **hospital**, **psychiatric hospital**, substance use disorder facility or residential treatment center/facility (RTC/RTF).
2.	Residential treatment center/facility (RTC/RTF)
3.	Gender affirmation **surgery***

** We will review all reconstructive surgery requests related to inpatient gender affirming treatment for **medical necessity**. In making determinations of **medical necessity** for gender affirming treatment we use the most recent version of the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People developed by the World Professional Association for Transgender Health (WPATH).*

Out-of-network
When you go to an **out-of-network provider**, you are responsible to get any required **precertification** from us. If you don't **precertify**:

- Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details.
- You will be responsible for the unpaid bills.
- Your additional out-of-pocket expenses will not count toward your **deductible** or **maximum out-of-pocket limit**, if you have any.

Timeframes for **precertification** are listed below. For **emergency services**, **precertification** is not required, but you should notify us as soon as possible.

To obtain **precertification**, contact us. You, your **physician** or the facility must call us within these timelines:

Type of care	Timeframe
Non-emergency admission	Call at least 14 days before the date you are scheduled to be admitted
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted
Urgent admission	Call before you are scheduled to be admitted
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment or procedure is scheduled

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 injury.

We will tell you and your **physician** in writing of the **precertification** decision within 5 business days or within 72 hours for urgent requests. An approval is valid for 180 days as long as you remain enrolled in the plan.

For an inpatient **stay** in a facility, we will tell you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that you stay longer, the extra days will need to be **precertified**, with exception of a mastectomy, lymph node dissection or maternity and postpartum care. You, your **physician**, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your **physician** in writing of an approval or denial of the extra days.

If you or your **provider** request **precertification** and we don't approve coverage, we will tell you why and explain how you or your **provider** may request review of our decision. See the *Complaints, claim decisions and appeal procedures* section.

Types of out-of-network services that require precertification
Precertification is required for inpatient **stays** and certain outpatient services and supplies when you use an **out-of-network provider**.

Precertification is required only for the following types of services and supplies when you use an **out-of-network provider**:
Inpatient –

- Gene-based, cellular and other innovative therapies (GCIT)
- **Stays** in a hospice facility
- **Stays** in a **hospital**

- **Stays** in a rehabilitation facility
- **Stays** in a **residential treatment facility** for treatment of **mental health conditions** and **substance use disorders**
- **Stays** in a **skilled nursing facility**

Outpatient –

- Complex imaging
- Gene-based, cellular and other innovative therapies (GCIT)
- Home health care
- Hospice care
- Injectables, (immunoglobulins, growth hormones*, hormone blockers*, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
- Kidney dialysis
- Knee **surgery**
- Non-emergency transportation by fixed wing airplane
- Outpatient back **surgery** not performed in a **physician's** office
- Private duty nursing services
- Reconstructive **surgery***
- Wrist **surgery**

**** Precertification is not required for these services when provided for the treatment of gender dysphoria***

Contact us to get a complete list of the services that require **precertification**. The list may change from time to time.

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

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

For gender affirming treatment and behavioral health services, we use the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty to determine **medical necessity** in accordance with state law.

For certain drugs covered under your medical plan or **prescription** drug plan, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**. We will tell your **provider** the decision within 72 hours or within 24 hours when you have an **emergency medical condition**. Your advance approval request is approved if we do not respond within the timeframe.

Step therapy is a type of **precertification** where you must try one or more prerequisite drugs before a step therapy drug is covered. A 'prerequisite' is something that is required before something else. Prerequisite drugs are FDA-approved, may cost less and treat the same condition. If you don't try the prerequisite drugs first, the step therapy drug may not be covered. You do not have to repeat step therapy if you went through step therapy under your prior plan.

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

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

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

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

What the plan pays and what you pay

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

The general rule

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

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

When we say "expense" in this general rule, we mean the **negotiated charge** for a **network provider**, and **allowable amount** for an **out-of-network provider**.

Negotiated charge

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

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

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

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

Some of these arrangements are called:

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

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

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

Allowable amount

This is the amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all charges above this amount. The **allowable amount** depends on the geographic area where you get the service or supply.

Allowable amount doesn't apply to involuntary services. These are services or supplies that are:

- Provided at a network facility by an **out-of-network provider**
- Not available from a **network provider**
- An **emergency service**

The table below shows the method for calculating the **allowable amount** for specific services or supplies:

Service or supply:	**Allowable amount is based on:**
Professional services and other services or supplies not mentioned below	105% of Medicare allowed rate
Services of **hospitals** and other facilities	140% of Medicare allowed rate
Prescription drugs	110% of average wholesale price (AWP)

Important note:
See *Special terms used* below, for a description of what the **allowable amount** is based on.
If the **provider** bills less than the amount calculated using a method above, the **allowable amount** is what the **provider** bills.

Special terms used:

- Average wholesale price (AWP) is the current average wholesale price of a **prescription** drug as listed in the Facts & Comparisons®, Medi-Span daily price updates or any other similar publication we choose to use.
- Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific **provider** performance. We update our system with revised rates within 180 days of receiving them from CMS. If Medicare doesn't have a rate, we use one or more of the items below to determine the rate for a service or supply:
  - The method CMS uses to set Medicare rates
  - How much 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

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) programs
- Our rate may exclude other payments that CMS may make directly to **hospitals** or other **providers** and backdated adjustments
- For anesthesia, our rate may be at least 105% of the rate CMS establishes
- For lab, our rate may be 75% of the rate CMS establishes
- For DME, our rate may be 75% of the rate CMS establishes
- For medications that are paid as a medical benefit instead of a pharmacy benefit, our rate may be 100% of the rates CMS establishes

When the **allowable amount** is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to **providers** under Medicare programs.

Our reimbursement policies

We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the **allowable amount**. When we do this, we consider:

- The length and difficulty of a service
- Whether additional expenses are needed, when multiple procedures are billed at the same time
- Whether an assistant surgeon is needed
- If follow up care is included
- Whether other conditions change or make a service unique
- Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
- The educational level, licensure or length of training of the **provider**

We base our reimbursement policies on our review of:

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

We use commercial software to administer some of these policies. Policies may differ for professional services and facility services.

Get the most from your benefits:
We have online tools to help you decide whether to get care and if so, where. Log in to your member website. The website contains additional information that can help you determine the cost of a service or supply.

Surprise bill

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

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

- **Emergency services** provided by an **out-of-network provider** and ancillary services initiated from your **emergency services**
- Non-emergency and non-ancillary **covered services** provided by an **out-of-network provider,** initiated at an in-network facility, except when the **out-of-network provider** has given you the following:
  - The out-of-network notice for your signature
  - The estimated charges for the items and services
  - Notice that the **provider** is an **out-of-network provider**
- Out-of-network air ambulance services
- Items and services provided by an **out-of-network provider** if there is no **network provider** who can furnish such item or service at such facility

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

The notice and consent requirements do not apply to covered ancillary services from an **out-of-network provider**. Covered ancillary services will be paid as an in-network benefit.

Ancillary services mean any professional services including:

- Items and services related to emergency medicine
- Anesthesiology
- Hospitalist services
- Laboratory services
- Neonatology
- Pathology
- Radiology

Whether provided by a **physician** or non-physician **provider**

- Items and services provided by assistant surgeons, hospitalists, and intensivists
- Diagnostic services, including radiology and laboratory services
- Services provided by an **out-of-network provider** because there was no **network provider** available to perform the service, whether provided by a **physician** or non-physician **provider**

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

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

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

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

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

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

It is not a surprise bill when you knowingly choose to go out-of-network and have signed a consent notice for these services:

- 72 hours prior to the day when the service will be provided if the appointment is scheduled at least 72 hours in advance
- On the day the appointment is scheduled, no later than 24 hours in advance of care, if the appointment is scheduled between 72 hours and 24 hours in advance
- Consent must be obtained no later than 24 hours in advance of care. Same-day notice and consent is prohibited

The **provider** provided a consent form that meets all notice requirements as stated by federal and California law.

In this case, you are responsible for all charges.

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

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

Paying for covered services – the general requirements

There are several general requirements for the plan to pay any part of the expense for a **covered service**. For in-network coverage, they are:

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

For out-of-network coverage:

- The service is **medically necessary**
- You get your care from an **out-of-network provider**
- You or your **provider precertifies** the service when required

For outpatient **prescription** drugs, your costs are based on:

- The type of **prescription** you're prescribed
- Where you fill the **prescription**

The plan may make some **brand-name prescription drugs** available to you at the **generic prescription drug** cost share.

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

You pay the entire expense when:

- You get services or supplies that are not **medically necessary**.
- Your plan requires **precertification**, your **physician** requests it, we deny it and you get the services without **precertification**.
- You get care and the **provider** waives all or part of your cost share.

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

Where your schedule of benefits fits in

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

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

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

Coordination of benefits

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

Key Terms

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

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

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

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

How COB works

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

Determining who pays

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

COB rule	Primary plan	Secondary plan

COB rule	Primary plan	Secondary plan
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together	• Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent's plan if there is no court order	• Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent's plan
Child – covered by individuals who are not parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

How COB works with Medicare

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

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare.

You are eligible for Medicare if you are covered under it.

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. Your current and prior plan must be offered through the same policyholder.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

Our rights

We have the right to:

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

Benefit payments and claims

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

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

Claim type and timeframes

Urgent care claim

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

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

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. We will make a decision within 5 business days.

Post-service claim

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

Concurrent care claim extension

A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 5 business days.

Concurrent care claim reduction or termination

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

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

Filing a claim
When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider** must send us the bill within 12 months of the date you received services, unless you are legally unable to notify us. You must send it to us with a claim form that you can either get online or contact us to provide. We will send you a claim form within 15 days of your request. You should always keep your own record of the date, **providers** and cost of your services.

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

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

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

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 business days of receiving the complaint. We will let you know if we need more information to make a decision.

Appeal

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

Claim decisions and appeal procedures

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

Any time we deny even part of the claim, it is an "adverse benefit determination" or "adverse decision." For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will give you an answer within 36 hours for an urgent appeal and within 5 business days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

Any other claim appeal

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

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

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

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

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

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

After 30 business days, or after three days for an urgent care claim, (and within 6 months of either date), you can request an independent medical review (IMR) from the California Department of Insurance.

Independent medical review (IMR) managed by the California Department of Insurance

An independent medical review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO).

You have a right to an IMR only if all the following conditions are met:

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

You may apply for an IMR within six months of the date you received the decision from us. This deadline may be extended by the Commissioner of Insurance.

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

You can request an IMR from the:
California Department of Insurance, Consumer Services Division
300 Spring Street, South Tower
Los Angeles, CA 90013
1-800-927-HELP (4357), TDD: 1-800-482-4TDD (4833)
www.insurance.ca.gov
https://www.insurance.ca.gov/01-consumers/110-health/60-resources/01-imr/index.cfm

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

The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 30 calendar days of the date the California Insurance Department received your IMR request form and all the necessary information

Sometimes you can get a faster external review decision. Your **provider** must call us or send us a request for external review form.

You may be able to get a faster external review when:

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

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

Utilization review

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

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

Refer to the **Mental health conditions** and **Substance use disorder** benefit provisions for information regarding review of **mental health conditions** and **substance use disorder** services.

Recordkeeping

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

Fees and expenses

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

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

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

When you can join the plan

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

You can enroll:

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

You can enroll eligible family members (these are your "dependents") at this time too.
If you don't enroll when you first qualify for benefits, you may have to wait until the next annual enrollment period to join.

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Your civil union partner who meets any requirements under state law
- Your domestic partner who meets the requirements under state law
- Dependent children – yours or your spouse's or partner's
  - Dependent children must be:
    - Under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including those placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court order
    - Grandchildren in your legal custody

Adding new dependents

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

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

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

We must receive a completed enrollment form not more than 31 days after the event date.

Special times you can join the plan

You can enroll in these situations:

- You didn't enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan
- When your dependent moves outside the service area for your employee plan

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

You can also enroll in these situations:

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

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

Notification of change in status

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

- Change of address
- Dependent status change
- Dependent who enrolls in Medicare or any other health plan

Starting coverage

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

Stopping coverage

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

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

When will your coverage end

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The policyholder asks to end coverage
- You are no longer eligible for coverage
- Your work ends
- You stop making required contributions, if any apply
- We end your coverage
- You start coverage under another medical plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage.
- You stop making premium contributions, if any apply.

- Your coverage ends for any of the reasons listed above except:
  - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.

What happens to your dependents if you die?

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

Why would we end your coverage?

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

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

Special coverage options after your coverage ends

When coverage may continue under the plan

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

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

Consolidated Omnibus Budget Reconciliation Act (COBRA)

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

The qualifying events are:

- Your active employment ends for reasons other than gross misconduct
- Your working hours are reduced
- You divorce or legally separate and are no longer responsible for dependent coverage
- You become entitled to benefits under Medicare
- Your covered dependent children no longer qualify as dependents under the plan
- You die
- You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy

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

Continuation of coverage for other reasons

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

Your coverage may be extended if you are totally disabled when coverage ends. Only the medical condition which caused the total disability is covered during your extension. You are "totally disabled" if you cannot work at your occupation or any other occupation for pay or profit.

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

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

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

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

We will notify you 90 days before your dependent child coverage ends due to the plan age limits.
You must send us within 60 days of our notice a request for us to extend coverage. Coverage will continue for the child while we determine if the child is disabled.

We may ask you to send us proof of the disability. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

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 proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year, after 2 years from the date you first send us proof. You must send it to us within 60 days of our request. If you don't, we can terminate coverage for your dependent child.

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

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

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

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

How you can extend coverage for hearing services and supplies when coverage ends
If you are not totally disabled when your coverage ends, coverage for hearing services and supplies may be extended for 30 days after your coverage ends:

- If the **prescription** for the hearing aid is written during the 30 days before your coverage ends
- If the hearing aid is ordered during the 30 days before your coverage ends

How you can extend coverage for your 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
- 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
- Be certified by the treating **physician** as medically necessary due to serious illness or injury

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

General provisions – other things you should know

Administrative provisions

How you and we will interpret this certificate

We prepared this certificate according to ERISA and other federal and state laws that apply. The certificate will be interpreted according to these laws.

How we administer this plan

We administer this plan to comply with all applicable laws and regulations. We also apply policies and procedures we've developed to administer this plan.

Who's responsible to you

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

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

Coverage and services

Your coverage can change

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

Physical examination and evaluations

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

Records of expenses

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

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

Honest mistakes and intentional deception

Honest mistakes

You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it. All statements made by you or the policyholder will be deemed representations and not warranties.

Intentional deception of a material fact under the terms of coverage

If we learn that you defrauded us or you intentionally misrepresented material facts within the first 24 months of coverage, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

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

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

You have special rights if we rescind your coverage:

- We will give you written notice, via certified mail at least 30 days prior to the effective date of any rescission of coverage. The notice will explain the reason we are rescinding your 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 (ERO)
- You have the right to appeal to the California Department of Insurance

We will not rescind your coverage after it has been in force for 24 months.

Some other money issues

Legal action

You cannot take any action at law or equity until 60 days after we receive written proof of loss.

No legal action can be brought to recover payment under any benefit after 3 years from the date written proof of loss is required.

Assignment of benefits

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

Financial sanctions exclusions

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

Premium contribution

Your plan requires that the policyholder make premium contribution payments.

Recovery of overpayments

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

When you are injured

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

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

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

The amount of the money can be reduced if a judge, jury, or arbitrator decides you had some fault for the injury.

The amount of the money owed will not exceed one-third of the recovery, settlement, judgment or other source of compensation if you have an attorney or one-half of the recovery, settlement, judgment or other source of compensation if you did not have an attorney.

Sometimes your **provider** may also be entitled to that money. The lien will be the amount your **provider** has been paid.

Your health information

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

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

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

Effect of benefits under other plans

Health Maintenance Organization (HMO) plan

If you are eligible for and enrolled in coverage under an HMO plan offered by the policyholder, you will not have coverage under this plan on the date that your HMO plan coverage starts. If you are pregnant when you change plans, you may be eligible for an extension of benefits. Contact us for more information.

Glossary

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

Behavioral health provider
Behavioral health provider means any of the following:

- A person that is licensed under Division 2, Healing Arts, (beginning with Section 500), of the Business & Professions Code
- An associate marriage and family therapist or marriage and family therapist trainee functioning in accordance with Section 4980.43.3 of the Business and Professions Code
- A qualified autism service provider or qualified autism service professional certified by a national entity
- An associate clinical social worker functioning in accordance with Section 4996.23.2 of the Business and Professions Code
- An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
- A registered psychologist as described in Section 2909.5 of the Business and Professions Code or psychological assistant as described in Section 2913 of the Business and Professions Code
- A psychology trainee or person supervised under the direction of a licensed psychologist
- A 988 center or mobile crisis team

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

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

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

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

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

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

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

Drug guide

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

Emergency medical condition

An acute, severe medical condition, including severe pain that:

- Leads a person with average knowledge of health and medicine to believe that, without immediate medical care, it could result in:
  - Danger to life or health
  - Serious impairment of a bodily function
  - Serious dysfunction to a body part or organ
  - Danger to the health of an unborn baby

With respect to a pregnant woman who is having contractions, it will be considered an **emergency medical condition** if:

- There is not adequate time to effect a safe transfer to another hospital before delivery.
- The transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency services

Treatment only to evaluate and stabilize an **emergency medical condition** given in a **hospital's** emergency room or an independent freestanding emergency department, as well as further medical examination and treatment to stabilize the patient within the capabilities of the staff and facilities available at the **hospital or** independent freestanding emergency department. It also includes outpatient observation services, including services received after stabilization, as a result of the **emergency medical condition** visit.

An independent freestanding emergency department means a health care facility that is geographically separate, distinct, and licensed separately from a **hospital** and provides **emergency services**.

Experimental, investigational, or unproven

A drug, device, procedure, supply, treatment, test, or technology is considered by us to be **experimental, investigational, or unproven** if any of the following apply:

- It hasn't been shown through well-conducted clinical trials or cohort studies published in peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which it's meant.
  - A well-conducted clinical trial means a randomized, controlled trial where the experimental intervention is compared to a control group receiving care according to best practice and study participants are randomly assigned to the experimental or control group.
  - A well-conducted cohort study means a prospective cohort study from more than one institution where the experimental intervention is compared to a group of subjects receiving care according to best practice and where the comparison group is well matched to the experimental intervention group.
- There isn't FDA approval or clearance to market it for the proposed use.
- A national medical society, dental society, or regulatory agency has written that it's **experimental, investigational, or unproven**, or mainly for research purposes.
- It's the subject of a Phase I, Phase II, or the experimental or research arm of a Phase III clinical trial. The FDA and Department of Health and Human Services define these.
- Written procedures or consent form used by a facility **provider** says it's **experimental, investigational, or unproven**.

Generic prescription drug

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

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional

A person who is authorized by law to provide health care services to the public; for example, **physicians**, nurses and physical therapists. For **mental health conditions** and **substance use disorders**, it includes a **behavioral health provider**.

Home health care agency

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

Hospital

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

Jaw joint disorder

This is:

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

Mail order pharmacy

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

Maximum out-of-pocket limit

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

Medically necessary, medical necessity (for services or supplies other than for mental health conditions or substance use disorders)

Health care services or supplies that prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are all of the following:

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

- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease

Generally accepted standards of medical practice mean:

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

Medically necessary, medical necessity (for mental health conditions or substance use disorders services or supplies)

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 or injury, condition or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms that are:

- In accordance with generally accepted standards of **mental health conditions** and **substance use disorder** care
- Clinically appropriate, in terms of type, frequency, extent, site and duration
- Not primarily for the economic benefit for us or the convenience of the patient, **physician**, or other health care **provider**

Generally accepted standards of **mental health conditions** and **substance use disorder** care means standards of care and clinical practice that are generally recognized by health care **providers** practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of **mental health condition** and **substance use disorder** care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

All **medical necessity** determinations of a **covered person** diagnosed with a **mental health condition** or a **substance use disorder** including, but not limited to determinations concerning:

- Service intensity
- Level of care placement
- Continued stay
- Transfer or discharge

will be made in accordance with generally accepted standards of **mental health conditions** and **substance use disorder** care, including the use of the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

This includes the following Nonprofit Specialty Guidelines:

- Primary **substance use disorder** diagnosis in adolescents and adults ages 13 and older: The ASAM Criteria developed by the American Society of Addiction Medicine
- Primary **mental health condition** diagnosis in adults ages 19 and older: Level of Care Utilization System (LOCUS) developed by the American Association for Community Psychiatry (AACP)
- Primary **mental health condition** diagnosis in children ages 6-18: Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) developed by AACP and the American Academy of Child & Adolescent Psychiatry (AACAP)
- Primary **mental health condition** diagnosis in children ages 5 and younger: Early Childhood Service Intensity Instrument (ECSII) developed by AACAP

In making determinations of medical necessity for gender affirming treatment we use the most recent version of the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People developed by the World Professional Association for Transgender Health (WPATH).

Important note:
We use the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty except when the relevant criteria and guidelines are not applicable. In that case we rely on clinical policy bulletins we have developed and maintained that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **medically necessary**, **experimental, investigational, or unproven**. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact us. See the *Contact us* section for how.

For gender affirming treatment and behavioral health services, we use the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty to determine **medical necessity** in accordance with state law.

Mental health condition

A **mental health condition** is a condition that falls under any of the diagnostic categories listed in the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or that is listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* (ICD).

Changes in terminology, organization, or classification of **mental health conditions** in future versions of the DSM or ICD will not affect the conditions covered as long as a condition is commonly understood to be a **mental health condition** by health care **providers** practicing in relevant clinical specialties.

Negotiated charge

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

Network provider

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

Out-of-network provider

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

Physician

A **health professional** trained and licensed to practice and prescribe medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy. Under some plans, a **physician** can also be a **primary care provider (PCP)**. For **mental health conditions** and **substance use disorders**, it includes a **behavioral health provider**.

Precertification, precertify

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

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

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

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

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

- General practitioner
- Family **physician**
- Internist
- Nurse practitioner
- Physician assistant
- Pediatrician
- OB, GYN, and OB/GYN
- Medical group, primary care office, or another **provider** allowed by the plan

Provider
A **physician**, pharmacist, **health professional**, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare. For **mental health conditions** and **substance use disorders**, it includes a **behavioral health provider**.

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

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

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

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

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

Semi-private room rate

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

Skilled nursing facility

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

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

Skilled nursing facility does not include institutions that provide only:

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

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

Specialist

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

Specialty prescription drug

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

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

Specialty pharmacy

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

Stay

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

Substance use disorder

A **substance use disorder** is a condition that falls under any of the diagnostic categories listed in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) or that is listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems (ICD).

Changes in terminology, organization, or classification of **substance use disorders** in future versions of the DSM or ICD will not affect the conditions covered as long as a condition is commonly understood to be a **substance use disorder** by **providers** practicing in relevant clinical specialties.

Surgery, surgical procedure

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

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

Telemedicine

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

Terminal illness

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

Walk-in clinic

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

- Drug store
- Pharmacy
- Retail store
- Supermarket

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

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

Additional Information Provided by

President and Board of Trustees of Santa Clara College DBA Santa Clara University

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Santa Clara University Group Benefit Plan

Employer Identification Number:
94-1156617

Plan Number:
501

Type of Plan:
Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
President and Board of Trustees of Santa Clara College dba Santa Clara University
500 El Camino Real
Santa Clara, CA 95053
Telephone Number: (408) 554-4097

Agent For Service of Legal Process:
President and Board of Trustees of Santa Clara College dba Santa Clara University
500 El Camino Real
Santa Clara, CA 95053

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the Senior Director of Human Resources Operation.

ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage
Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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

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

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

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

Notice Regarding Women's Health and Cancer Rights Act

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

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

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

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

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

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

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

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

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

Nondiscrimination Notice — California

Aetna does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Aetna provides free aids, in a timely manner, and services to people with disabilities and free language services to people whose primary language is not English. These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, have questions about our non-discrimination policy, or have a discrimination-related concern that you would like to discuss, contact the number on your ID card. Not an Aetna® member? Call us at **1-800-872-3862 (TTY: 711)**.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: P.O. Box 14462, Lexington, KY 40512
- HMO & DMO customers: P.O. Box 24030, Fresno, CA 93779
- Email: **CRCoordinator@aetna.com**

Please visit **https://www.aetna.com/individuals-families/member-rights-resources/complaints-grievances-appeals.html** and select California for information about how to file a complaint or grievance with the California Department of Insurance or California Department of Managed Health Care (for HMO enrollees).

You can also file a discrimination complaint with the United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex by following the instructions on the Department's website: **https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html**.

Language accessibility statement

Interpreter services are available for free.

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

Aetna.com

2268201-03-02 (3/24)

TTY: 711

To access language services at no cost to you, call 800-385-4104 .

Para acceder a los servicios de idiomas sin costo, llame al 800-385-4104 . (Spanish)

如欲使用免費語言服務，請致電 800-385-4104 。(Chinese)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 800-385-4104 . (Vietnamese)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 800-385-4104 . (Tagalog)

무료 언어 서비스를 이용하려면 800-385-4104 번으로 전화해 주십시오. (Korean)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 800-385-4104 հեռախոսահամարով: (Armenian)

برای دسترسی به خدمات زبانی به طور رایگان، با شماره 800-385-4104 تماس بگیرید . (Persian-Farsi)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 800-385-4104 . (Russian)

言語サービスを無料でご利用いただくには、800-385-4104 までお電話ください。(Japanese)

للحصول على الخدمات اللغوية دون تكلفة، الرجاء التصل على الرقم 800-385-4104 . (Arabic)

ਤੁਹਾਡੇ ਲਈ ਬਨਿ ਬਸਿੇ ਿਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵ ਦੀ ਵਰਤ ਰਿਨ ਲਈ, 800-385-4104 'ਤੇ ਫ਼ੋਨ ਰਿ। (Punjabi)

ដដ ើបីទទួលហានដេ ក ម ដ លឥតគិត លៃ រាប់ដោក នក្ន
ដទាទូរ៍ ទដទាកាន់ដលខ 800-385-4104 ។ (Mon-Khmer, Cambodian)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 800-385-4104. (Hmong)

आपके लिए बिना ककसीकीमत के भाषा सेवाओं का उपयोग करने के लिए, 800-385-4104 पर कॉ कर ।(Hindi)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 800-385-4104 . (Thai)

2268201-03-02 (3/24)

Notice of Language Assistance

HMO and DMO-based plans:

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at
1-877-287-0117 (TTY: 711).

Planes basados en DMO y HMO –

IMPORTANTE: ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al **1-877-287-0117 (TTY: 711)**.

Traditional plans:

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or
1-877-287-0117 (TTY: 711). For more help call the CA Dept. of Insurance at **1-800-927-4357**. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al **1-877-287-0117 (TTY: 711)**. Para obtener más ayuda, llame al Departamento de Seguros de CA al **1-800-927-4357**. Spanish

Your Health Insurance Choices Are Different. You May Qualify for Free or Low-Cost Health Insurance.

Because of changes in federal law, you have different health insurance choices that may save you money.

Covered California

You can buy health insurance through Covered California. The State of California set up Covered California to help people and families, like you, find affordable health insurance. You can use Covered California if you do not have insurance through your employer, or Medicare. You can also apply for Medi-Cal through Covered California.

If you are eligible for the Medicare Program you should examine your options carefully, as delaying Medicare enrollment may result in substantial financial implications

You must apply during an open or special enrollment period, except a Medi-Cal application can be made at any time. Open enrollment begins on October 15 of every year and ends on January 31 of the following year. If you have a life change such as marriage, divorce, a new child or loss of a job, you can apply at the time the life change occurs ("special enrollment period").

Through Covered California, you may also get help paying for your health insurance. You can:

- Reduce your out of pocket costs: Out-of-pocket costs are how much you pay for things like going to the doctor or hospital or getting prescription drugs.

To qualify for help paying for insurance, you must:

- Meet certain household income limits; and
- Be a U.S. citizen, U.S. national or be lawfully present in the U.S.
- In addition, other rules and requirements apply.

You can also buy coverage directly from health insurers, health plans or insurance agents during Open Enrollment and Special Enrollment periods, but the financial help is available only if you select a Covered California product.

Medi-Cal

Free or low-cost health insurance is available through Medi-Cal. Medi-Cal is California's health care program for people with low incomes. You can get Medi-Cal if:

- Your income is low; and
- You are a U. S. citizen, U.S. national or lawfully present in the U.S age 26 and older;
- Your income is low; and
- You are an adult age 19 through 25 who does not have satisfactory immigration status or is unable to establish satisfactory immigration status or to verify United States citizenship.

Your eligibility is based on your income. It is not based on how much money you have saved or if you own your own home. You do not have to be on public assistance to qualify for Medi-Cal. You can apply for Medi-Cal anytime.

You can also get Medi-Cal if you are:

- Age 21 or younger
- Age 65 or older
- Blind
- Disabled
- Pregnant
- In a skilled nursing or intermediate care home
- On refugee status for a limited time, depending how long you have been in the United States
- A parent or caretaker relative of an age eligible child
- Have been screened for breast and/or cervical cancer

Other rules or requirements may apply.

For More Information

To learn more about Covered California or Medi-Cal, visit https://www.coveredca.com/ or call 1-800-300-1506. When you apply for coverage through Covered California, you will find out if you are eligible for Medi-Cal. You can also get more information or apply for Medi-Cal by calling 1-800-430-4263, visiting www.benefitscal.org or www.beneficioscal.org (Spanish) online, or visiting your county human services office in person.

Confidentiality Notice

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

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

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

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

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.