

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-844-365-7373 (TTY: 711).

Smartphone or Tablet

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

Non-Discrimination

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

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

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

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

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

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

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

Language Assistance

TTY:711

English	To access language services at no cost to you, call the number on your ID card.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Armenian	Ձեր նախընտրած լեզվով ավելճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հեռախոսահամարով
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫੋਨ ਕਰੋ।
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน



Health maintenance organization (HMO) policy

(combined Evidence of Coverage and Disclosure form)

Platinum 90 OFF PD

This policy is by and between Aetna Health of California Inc. (Aetna®, we, us, or our) and the policyholder (you, your).

Coverage starts on your effective date of coverage and continues until it ends as described in this policy.

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

This policy is underwritten by Aetna Health of California Inc. and is governed by federal law and the laws of California. Aetna is part of the CVS Health family of companies.

Read your policy carefully

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

Guaranteed renewable

You can renew this policy each year (“guaranteed renewable”). We decide the premium rates. But, we may decide not to renew the policy under certain conditions, which are explained in this policy, or when required by law. See the *When coverage ends* section for more information.

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


Your application

We relied on your answers to all questions in the application process when we issued the policy to you.

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

It is your responsibility to make sure the application that you submitted is accurate and complete. It is important that you notify us immediately of any mistakes that you find in your application.

If we learn that you defrauded us or you intentionally misrepresented material facts when you gave information and answers in the application, or in the application process, we may decide to cancel the policy. We may also report fraud to criminal authorities. See the *Honest mistakes and intentional deception* topic in the *General provisions – other things you should know* section for more information.

By: 

Gregory S. Martino
Vice President

Table of contents

Welcome	4
What does the policy cost you?	7
Coverage and exclusions	8
General policy exclusions	36
How your policy works	40
Grievance and appeal procedures	50
Eligibility, starting and stopping coverage	53
When coverage ends	57
General provisions – other things you should know	59
Glossary	63
Schedule of benefits	Issued with your policy

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 policy. It describes your **covered services** – what they are and how to get them. The second document is the schedule of benefits. It tells you how we share expenses for **covered services** and explains any limits – like when your policy covers only a certain number of visits.

This combined Evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

How we use words

When we use:

- “You” and “your” we mean you as the policyholder and any covered dependents, if dependent coverage is available under the policy
- “Us,” “we,” and “our” we mean Aetna
- Words that are in bold, we define them in the *Glossary* section

Contact us

For questions about your policy or request a confidential communication to keep your medical information private, you can contact us by:

- Calling the toll-free number on your ID card
- Writing us at 1385 East Shaw Ave., Fresno, CA 93710
- Visiting <https://www.aetnacvshealth.com> to register and access your member website

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

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

Your ID card

Your member ID card tells doctors, **hospitals**, and other **providers** that you are covered by this policy. Show your ID card each time you get **covered services** from a **provider**.

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

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

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan that includes:

- **Family planning**
- **Contraceptive services, including emergency contraception**
- **Sterilization, including tubal ligation at the time of labor and delivery**
- **Infertility treatments**
- **Abortion**

Call your provider or contact us for help if you have any questions.

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 complete a health risk questionnaire, select a PCP or provide demographic information on <https://www.aetna.com>, your member website. We may provide incentives based on your participation such as gift cards or debit cards.

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.

Timely access to care

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

- Urgent care within 48 hours of the request
- Non-urgent primary care or non-**physician mental health disorder** or **substance use disorder** care within 10 business days of the request and follow-up care for non-physician **mental health disorder** or **substance use disorder** care within 10 business days of the prior appointment
- Non-urgent specialty care or ancillary services within 15 business days of the request
- Telephone screening within 30 minutes of the request

You will see your **network provider** for pediatric vision and oral essential health benefits when you call for an appointment within these timeframes:

- Urgent care within 72 hours of the request
- Non-urgent care within 36 business days of the request
- Preventive care within 40 days of the request

Network providers may have exceptions to appointment wait times when the Department of Managed Health Care allows such exceptions. Interpreter services will be made available to you at the time of your appointment.

You can contact us when you have a complaint or you cannot access care in a timely manner. Contact us by calling the number on your ID card or write to us at:

Customer Service

Aetna Health of California, Inc.

PO Box 24030, Fresno, CA 93779

You can also contact the California Department of Managed Health Care with your concerns at:

California Department of Managed Health Care

980 9th Street, Suite 500, Sacramento, CA 95814-2725

1-888-466-2219, Fax: 916-255-5241, TDD: 1-877-688-9891

What does the policy cost you?

Premium payment

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

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

After your first premium payment is made, premium payments are due on the 1st of each month based on your coverage start date. Each premium payment is to be paid to us on or before the due date.

Grace period

You have a grace period of 31 days after the last day of paid coverage for each premium due after the first premium payment. We will send you a notice. The grace period begins on the date the Notice of Grace Period is dated. If premiums are not paid by the end of the grace period, your coverage will automatically end on the last date for which premium was paid, or as of the date required by applicable law.

We have the right to require the return of any payments for claims paid during the grace period for which premium was not received.

Reinstatement

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

Premium agreement

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

Your premium rate is based on factors such as:

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

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

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

Coverage and exclusions

Providing covered services

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

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

This policy provides coverage for many kinds of **covered services**, such as a doctor's care and **hospital stays**, but some services aren't covered at all or are limited. For other services, the policy 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 it is a **covered service** only up to a set number of visits a year. This is a limitation that appears in your schedule of benefits
- Your **provider** may recommend services that are considered **experimental or investigational** services. But an **experimental or investigational** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of services below.
- Preventive services. Usually the policy pays more and you pay less. Preventive services are designed to help keep you healthy, supporting you in achieving your best health. To find out what these services are, see the *Preventive care* section in the list of services below. To find out how much you will pay for these services, see *Preventive care* in your schedule of benefits.

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

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

Abortion

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

Acupuncture

Covered services include manual or electro acupuncture.

The following is not a **covered service**:

- 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 or psychiatric transport van:

- 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 routine transportation to receive outpatient or inpatient services , unless your **physician** determines it is the only safe way to transport you

Behavioral health

Mental health treatment

Covered services include the treatment of **mental health disorders** provided by but not limited to a **hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider** including:

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

- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- Observation
- Peer counseling support by a peer support specialist (includes **telemedicine** consultation)

Substance use disorders treatment

Covered services include the treatment of **substance use disorders** provided by but not limited to a **hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider** as follows:

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

Behavioral health important note:

Medically necessary treatment of a mental health or substance use disorder, including but not limited to, behavioral health crisis services, provided to an enrollee by a 988 center or mobile crisis team, and evaluation and treatment provided by a CARE agreement or plan approved by a court are covered regardless of whether the service is provided by an in-network or out-of-network provider or facility.

When contacted by a mobile crisis team, Aetna will authorize post-stabilization care or authorize transfer to another provider no more than 30 minutes after receiving the request from a mobile crisis team.

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

Behavioral health and substance use disorder important note:

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Aetna fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Behavioral health exclusions

The following are not **covered services**:

Services for the following based on categories, conditions, or 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:

- Education service
- Services provided in conjunction with school, vocation, work or recreational activities

Clinical trials

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, treatment of cancer, a life threatening disease or condition or any condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted or delayed. You are eligible to participate in a clinical trial if:

- You are eligible to participate in the approved clinical trial according to the clinical trial rules and procedures
- Your provider concluded that your participation is appropriate or you provided medical and scientific information to support your participation

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. **Covered services** include all routine patient costs provided when you are not participating in an approved clinical trial.

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

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** only when you have cancer, a life-threatening illness or injury, or a **terminal illness**.

You can submit a grievance if we deny, limit, delay or modify your **covered service** for a clinical trial. Please refer to the *Independent medical review* section for more information.

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.

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

Covered services include:

- Services
 - Foot devices and 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 visual aids, unless required due to a visual impairment
- 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 policy only covers the same type of DME that Medicare covers. But there are some DME items Medicare covers that your policy 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, 988 or your local emergency response service for medical and ambulance help.

Covered services include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room or inpatient and outpatient services to evaluate and stabilize a behavioral health crisis by a 988 center or mobile crisis team. You can get **emergency services** or behavioral health crisis services from **network providers** or **out-of-network providers**. Behavioral health crisis services means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or substance use disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services.

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

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

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

Non-emergency services

If you go to an emergency room and you did not require emergency care because you did not have an **emergency medical condition**, the policy will not cover your expenses.

Foot orthotic devices

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

Gender affirming treatment

Covered services include services and supplies for gender affirming (sometimes called sex change) treatment.

Important note:

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

Habilitation therapy services

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

Covered services include:

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

The following are not **covered services**:

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

Hearing exams

Covered services include hearing exams for evaluation and treatment of illness, injury, or hearing loss when performed by a hearing **specialist**.

The following are not **covered services**:

- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**

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 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 *Short-term rehabilitation services* and *Habilitation therapy services* in this section and the schedule of benefits.

The following are not **covered services**:

- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities)
- Transportation, unless your **physician** determines it is the only safe way to transport you
- Services or supplies provided to a minor when a family member or caregiver is not present

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 employees 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, unless your **physician** determines it is the only safe way to transport you
 - Maintenance of the house

Hospital care

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

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

The following are not **covered services**:

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

Infertility services

Infertility is the presence of a demonstrated condition recognized by a licensed **physician** and surgeon as a cause of infertility or the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Advanced reproductive technology (ART)

Advanced reproductive technology, also called “assisted reproductive technology”, is a more advanced type of treatment. **Covered services** include the following services provided by a network ART **specialist**:

- In vitro fertilization (IVF) for fertility preservation.
- Cryopreservation (freezing) and storage for eggs, embryos, sperm or reproductive tissue for fertility preservation.

Aetna’s National Infertility Unit

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with determining eligibility for benefits and **precertification**. They can also give you information about our infertility Institutes of Excellence™ (IOE) facilities. You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your fertility preservation services.

Fertility preservation

Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use.

Covered services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned medical services that may directly or indirectly cause infertility including but not limited to:
 - Chemotherapy or radiation therapy with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine
 - 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

Aetna’s clinical policy for fertility preservation **covered services** are consistent with established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Infertility services exclusions

The following are not **covered services**:

- All charges associated with:
 - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
 - Thawing of cryopreserved (frozen) eggs, embryos or sperm, or reproductive tissue.
 - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests and any charges associated with care of the donor required for donor egg retrievals or transfers.

- The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
- Home ovulation prediction kits or home pregnancy tests
- Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists
- The purchase of donor embryos, donor eggs or donor sperm
- Reversal of voluntary sterilizations, including follow-up care
- Any charges associated with obtaining sperm from a person not covered under this policy for ART services
- Ovulation induction with menotropins, intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF) except for fertility preservation, Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)

Jaw joint disorder treatment

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

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

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. 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 visits 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.

The following are not **covered services**, except as **medically necessary** for eating disorders:

Any food item, including:

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

Obesity (bariatric) surgery

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
- 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
- Travel and lodging expenses for you and a companion (if you live 50 miles or more from the facility)

The following are not **covered services**:

- Weight management treatment.
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the policy.
- Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:
 - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
 - Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

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 policy will pay only for **physician, PCP** services and not for a separate fee for facilities.

The following are not **covered services**:

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

Pediatric dental care

Your plan may include pediatric dental care. Contact us or Liberty Dental Plan of California (Liberty) at:
P.O. Box 26110, Santa Ana, CA 92799-6110
libertydentalplan.com
888-703-6999

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 lower 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
- Second opinions (you or your **provider** can request a second opinion from any **network provider**)

Physician surgical services

Covered services include the services of:

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

The following are not **covered services**:

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

Prescription drugs - outpatient

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

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

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

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

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

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. If there is a generic equivalent to a brand name drug, you will pay the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary.

Prescription drug synchronization

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

How to access network pharmacies

A network pharmacy will submit your claim. You will pay your cost share to the pharmacy. You can find a network pharmacy either online or by phone. See the *Contact us* section for help.

You may go to any of our network pharmacies. If you don't get your **prescriptions** at a network pharmacy, they will not be a **covered service** under the policy, except for medically necessary treatment of a mental health or substance use disorder, including but not limited to, behavioral health crisis services, provided by a 988 center or mobile crisis team or treatment provided by a CARE agreement or plan approved by a court are covered by an out-of-network pharmacy .

You or your prescriber may request your pharmacist dispense a partial fill of a Schedule II controlled substance such as opioids. Your out of pocket expenses for a partial fill will be prorated accordingly.

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

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

Specialty pharmacy

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 help. **Specialty prescription drugs** typically include high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected ways of giving them.

All **specialty prescription drug** fills including the initial fill must be filled at a network **specialty pharmacy** unless it is an urgent situation. **Specialty prescription drugs** may fall under various drug tiers regardless of their names. See the schedule of benefits for details on supply limits and cost sharing.

Some **specialty prescription drugs** may qualify for third-party **copayment** assistance programs that could lower your out-of-pocket costs. Any manufacturer coupon or rebate assistance amount received through one of these programs will not apply towards your **deductible** or **maximum out-of-pocket limit**.

Prescription drugs covered by this policy 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 policy'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 policy 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 certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at a network pharmacy. Your outpatient **prescription** drug plan also covers related services and supplies needed to administer covered devices. At least one form of each FDA-approved contraception method is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for help.

We also cover over-the-counter (OTC) drugs, devices, and products without a prescription from your provider and **generic prescription drugs** and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the **brand-name prescription drug** or device at no cost share.

Preventive contraceptives important note:

You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the policy 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 and insulin

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 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 **prescription** drugs used to treat the underlying medical cause of infertility.

Obesity drugs

Covered services include **prescription** drugs used only for the purpose of weight loss. These are sometimes called anti-obesity agents. You must have a **prescription** and get it filled at a network pharmacy. You must be diagnosed by your **provider**, including a physical exam and outpatient diagnostic lab work, with morbid obesity.

Off-label use

Covered services may include off-label use of FDA-approved prescription drugs when it is not approved for your condition. Eligibility for coverage is subject to the following:

- The drug has been recognized for treatment of your condition in any of the following:
 - Thomson Micromedex DrugDex System (DrugDex)
 - Clinical Pharmacology (Gold Standard, Inc.)
 - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium
 - The American Hospital Formulary Service's Drug Information
- Use for your condition and the dosage has been proven as safe and effective by at least one published major peer reviewed medical journal known

Services related to off-label use of these drugs may:

- Require precertification
- Require **step therapy**
- Have additional requirements
- Have limits

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

Preventive care drugs and supplements

Covered services include preventive care drugs and supplements, including OTC ones, as required by the ACA.

Risk reducing breast cancer prescription drugs

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

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

Sexual dysfunction or enhancement drugs

Covered services include **prescription** drugs for the treatment of sexual dysfunction or enhancement. See the *Contact us* section for how to find the most up-to-date information on dosing.

Tobacco cessation prescription and OTC drugs

Covered services include FDA-approved **prescription** and OTC drugs to help stop the use of tobacco products. You must receive a **prescription** from your **provider** and submit the **prescription** to the pharmacy for processing.

Outpatient prescription drugs exclusions

The following are not **covered services**:

- Allergy sera and extracts administered by injection
- Any services related to the dispensing, injection or application of a drug
- Biological liquids and fluids unless specified on the **drug guide**
- Compound **prescriptions** containing bulk chemicals that have not been approved by the U.S. FDA, including compounded bioidentical hormones
- Cosmetic drugs including medications or preparations used for cosmetic purposes
- Devices, products and appliances, unless listed as a **covered service**
- Dietary supplements
- Drugs or medications:
 - Administered or entirely consumed at the time and place they are prescribed or dispensed
 - Which do not require a **prescription** by law, except OTC contraceptive (birth control) drugs, devices, and products, even if a **prescription** is written unless we have approved a medical exception
 - That are therapeutically the same as or an alternative to a covered **prescription drug** unless we approve a medical exception
 - Not approved by the FDA or not proven safe and effective
 - Provided under your medical benefits 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
 - For which the cost is covered by a federal, state or government agency (for example: Medicaid or Veterans Administration)
 - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies
- Duplicative drug therapy, for example, two antihistamines for the same condition
- Genetic care
 - Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up or the expression of the body's genes except for the correction of congenital birth defects
- Immunizations related to travel or work
- Immunization or immunological agents, except as specifically stated above
- Implantable drugs and associated devices except as specifically stated above
- Infertility
 - Injectable **Prescription** drugs used primarily for the treatment of infertility

- Injectables including:
 - Any charges for the administration or injection of **prescription** drugs.
 - Needles and syringes, except those used for insulin administration.
 - Any drug, which due to its characteristics, as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting, with the exception of Depo Provera and other injectable drugs for contraception.
- **Prescription** drugs:
 - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription** drugs for the treatment of a dental condition unless stated as a **covered service**
 - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **drug guide**
 - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the member identified on the ID card.
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the United States Preventive Services Task Force (USPSTF)
- We reserve the right to exclude:
 - A manufacturer’s product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the policy’s **drug guide**.
 - Any dosage or form of a drug when the same drug is available in a different dosage or form on the policy’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. If you need further services or testing such as diagnostic testing, you may pay more as these services aren’t preventive, except 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.

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

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

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

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

Important note:

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

Breast-feeding support and counseling services

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

Breast pump, accessories and supplies

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

Counseling services

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

- Alcohol or drug misuse
 - Preventive counseling and risk factor reduction intervention
 - Structured assessment
- Genetic risk for breast and ovarian cancer
- Obesity and healthy diet
 - Preventive counseling and risk factor reduction intervention
 - Nutritional counseling
 - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- Sexually transmitted infection
- Tobacco cessation
 - Preventive counseling to help stop using tobacco products
 - Treatment visits
 - Class visits

Family planning services – contraceptives

Covered services include family planning services as follows:

- Counseling services provided by a **physician** or other **provider** on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Contraceptive devices and FDA-approved over the counter contraceptive devices (including any related services or supplies).
- 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” by the FDA

- Male contraceptive methods or devices, except for male condoms prescribed by a health professional

Immunizations

Covered services include preventive immunizations for infectious diseases.

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

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

Prenatal care

Covered services include your routine pregnancy physical exams at the **physician, PCP, OB, GYN** or **OB/GYN** office and includes participation in the California Prenatal Screening Program. The exams include initial and subsequent visits for:

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

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp, and a follow-up colonoscopy after a positive result on any of the recommended tests or procedures for colorectal cancer screening
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- 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 also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the USPSTF.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.

- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
 - Screening and counseling services on topics such as:
 - Interpersonal and domestic violence
 - Sexually transmitted diseases
 - Human immune deficiency virus (HIV) infections
 - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

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

Well woman preventive visits

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

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

Prosthetic device

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

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

- Bone anchored hearing aid
- Cochlear implants, including accessories and upgrades

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
- Special contact lenses to treat aniridia (missing iris) or aphakia (absence of the crystalline lens of the eye)

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 or repairs abnormal structures of the body caused by:
 - cleft palate (includes medically necessary dental or orthodontic services)
 - congenital defects
 - developmental abnormalities
 - disease
 - infection
 - trauma
 - tumors
- The purpose of the **surgery** is to improve function or create normal appearance

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

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

These dental related services are limited to:

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

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation services

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

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

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** or help you maintain or prevent loss of function
- 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

(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

The following are not **covered services**:

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

Skilled nursing facility

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

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

Telemedicine

Covered services include **telemedicine** consultations when provided by a **physician, specialist**, or **behavioral health 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 and are covered the same as in-person diagnosis, consultation, or treatment. Log in to your member website at <https://www.aetnacvhealth.com> to review our **telemedicine provider** listing.

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
- Biomarker testing
- Other tests

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

Diagnostic radiological services (X-ray)

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.

Therapies – chemotherapy, 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**.

Outpatient Infusion therapy

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

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

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

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

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

Radiation therapy

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

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

Transplant services

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

This includes the following transplant types:

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

Network of transplant facilities

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

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

Important note:

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

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

The following are not **covered services**:

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness

- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

Urgent care services

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

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

- Urgent condition within the **service area**
 - If you need care for an urgent condition, you should first seek care through your **physician** or **PCP**. If your **physician** is not reasonably available, you may access urgent care from an urgent care center within the **service area**.
- Urgent condition outside the **service area**
 - You are covered for urgent care obtained from a facility outside of the **service area** if the health care service cannot be delayed until you return to the **service area**.

If you go to an urgent care center for what you reasonably believe is not an urgent condition, the plan will not cover your expenses.

Vision care

Pediatric vision care (through the end of the month in which the person turns 19)

Covered services include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction, glaucoma testing and dilation if your **provider** indicates one is needed
- Eyeglass frames
- **Prescription** lenses (glass, plastic or polycarbonate)
 - Single
 - Conventional (lined) bifocal or trifocal
 - Lenticular
- **Medically necessary** contact lenses
 - Keratoconus
 - Pathological Myopia
 - Aphakia
 - Anisometropia
 - Aniseikonia
 - Aniridia
 - Corneal Disorders
 - Post traumatic disorders
 - Irregular astigmatism
- Contact lenses in lieu of eyeglasses (lenses and frames)
- Low vision care services and supplies
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses

The following are not **covered services**:

- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Walk-in clinic

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

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

General policy exclusions

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

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 as **medically necessary** for gender dysphoria

Court-ordered testing

Court-ordered testing or care unless **medically necessary**. This does not include medically necessary services required or recommended by the Community Assistance, Recovery, and Empowerment (CARE) court or plan. CARE Court evaluation and treatment services will be covered regardless of whether the service is provided by an in-network or out-of-network provider.

Custodial care

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

Examples of these are:

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

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
 - Special education
 - Remedial education
 - Job training
 - Job hardening programs
- Educational services, schooling or any such related or similar program

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Foot care

Services and supplies for:

- The treatment of calluses, bunions, toenails, hammertoes, fallen arches
- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes

Growth/height care

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

Hearing aids

- Any tests, appliances and devices to:
 - Improve your hearing
 - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

The Hearing Aid Coverage for Children Program (HACCP) offers state-funded hearing aid coverage to eligible children and youth, ages 0-20. To learn more and apply, visit www.dhcs.ca.gov/HACCP.

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 policy

Other primary payer

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

Personal care, comfort or convenience items

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

Private duty nursing

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, step-child, brother, sister, in-law, or any household member

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

Treatment or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, except for **medically necessary**, evidence based services to treat a **mental health disorder** or **substance use disorder** :

- **Surgery**, implants, devices or preparations to correct or enhance erectile function, enhance 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 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

Vision care for adults

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing
- Any vision care services and supplies except where described in the *Coverage and exclusions* section

Voluntary sterilization

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

Work related illness or injuries

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

Important note:

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

How your policy works

How your policy works while you are covered

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

Providers

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

Please read the following information so you will know from whom or what group of provider's health care may be obtained.

You choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care.

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

Service area

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

Who provides the care

Network providers

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

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.
- **Network provider** not available – You can get services from an **out-of-network provider** if an appropriate **network provider** is unavailable. You or your provider must request approval from us before you get the care. Contact us for assistance.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.
- Surprise bills – Refer to the *Surprise bill* section below
- Medically necessary treatment of a mental health or substance use disorder, including but not limited to, behavioral health crisis services, provided to an enrollee by a 988 center or mobile crisis team.
- The evaluation and treatment provided by a CARE agreement or plan approved by a court.

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 policy owes.

Your PCP

To receive benefits, you must get **covered services** through your **PCP**. Your **PCP** 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 required to select a **PCP**. You may each choose a different **PCP**. You must select a **PCP** for your covered dependent if they are a minor or cannot choose a **PCP** on their own.

What your PCP will do for you

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

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

Changing your PCP

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

If you do not select a PCP

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

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

How your PCP is paid

Your **PCP** and other **network providers** may be paid a fee for each service set by a fee schedule or a fixed price per service, day or monthly amount depending on their contract with us. We encourage you to ask your **PCP**, us, your **provider**, or the **provider's** medical group or independent practice association how they are paid, including if their contracts include any financial incentives.

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

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

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

But in some cases, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. 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 (appears suddenly requiring immediate care and does not last long)	As long as the condition lasts
Serious chronic condition (continues or worsens over time and requires ongoing treatment)	No more than 12 months.
Pregnancy	All three trimesters of pregnancy and the immediate post-partum period
Maternal 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 from the diagnosis or from the end of pregnancy, whichever occurs later
Terminal illness	As long as the person lives
Care of 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

If this situation applies to you, contact us for details. As long as the **provider** didn't leave the network based on fraud, lack of quality standards, or our termination of the **provider**, you'll be able to receive transitional care from your **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, referral and precertification requirements

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

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

Medically necessary, medical necessity

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

Important note:

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

Referrals

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

Precertification

You need pre-approval from us for some **covered services**. Pre-approval is also called **precertification**. You may need **precertification** during the delivery of your care. We will review your request concurrently.

Your network **physician** or **PCP** is responsible for obtaining any necessary **precertification**. **Network providers** can't bill you if they fail to ask us for **precertification**.

Timeframes for **precertification** are listed below. For **emergency services**, **precertification** is not required, but you should notify us as shown. You can submit a grievance if we deny the **emergency service** as not **medically necessary**. Please see the *Grievance and Appeal procedures* section.

Your **physician**, **PCP**, 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 or as soon as reasonably possible after you have been 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.

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**. 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.

Type of request	Timeframes we decide	Timeframes we provide notification
Urgent care	Within 72 hours as appropriate for the medical condition	Within 24 hours of the decision to your provider Within two business days of the decision in writing to you
Non-urgent care	Within five business days as appropriate for the medical condition	Within 24 hours of the decision to your provider Within two business days of the decision in writing to you
Review after you receive care	Within 30 days	Within 30 days

We will tell you and your **physician** in writing of the **precertification** decision. An approval is valid for 180 days as long as you remain enrolled in the policy. 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 *Grievance and appeal procedures* section.

Types of services that require precertification

Precertification is required for inpatient **stays** and certain outpatient services and supplies.

The following types of services and supplies require **precertification**:

Inpatient

- Gender affirming treatment
- Gene-based, cellular and other innovative therapies (GCIT)
- Obesity (bariatric) **surgery**
- **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 disorders** and **substance use disorders**
- **Stays** in a **skilled nursing facility**

Outpatient

- Applied behavior analysis
- ART services
- Complex imaging
- Cosmetic and reconstructive **surgery**
- Non-emergency transportation by airplane
- Gender affirming treatment
- Gene-based, cellular and other innovative therapies (GCIT)
- Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
- Kidney dialysis
- Knee **surgery**
- Outpatient back **surgery** not performed in a **physician's** office
- Partial hospitalization treatment – **mental health disorders** and **substance use disorders** treatment
- Sleep studies
- Transcranial magnetic stimulation (TMS)
- Wrist **surgery**

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

Precertification is not required for services provided by a 988 center or mobile crisis team or treatment provided by a CARE agreement or plan approved by a court (except prescription drugs).

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 policies. You can find the bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>.

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.

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. You, someone who represents you, or your **provider** can contact us. You will need to provide us with the required clinical documentation. Any exception granted is based upon an individual and is a case by case decision. For directions on how you can submit a request for a review:

- Call the toll-free number on your ID card
- Go online at <https://www.aetnacvshealth.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.

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your prescriber of our decision. You can refer to the *Grievance and appeal procedure* section for more information on denial of coverage.

Your **provider** can continue to prescribe the same **prescription drug** for your medical condition under this plan if you had approval for a **prescription drug** under a prior Aetna plan.

What the policy pays and what you pay

Who pays for your **covered services** – this policy, 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 policy and you share the expense. Your share is called a **copayment** or **coinsurance**.
- Then the policy pays the entire expense after you reach your **maximum out-of-pocket limit**.

When we say “expense” in this general rule, we mean the **negotiated charge** for a **network provider**.

Negotiated charge

For health coverage:

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

For surprise billing, 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 policy.

*For **prescription drug services**:*

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

Surprise bill

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

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

- **Emergency services** provided by an **out-of-network provider** and **ancillary services initiated from your emergency services**

- Non-emergency services provided by an **out-of-network provider** at an in-network facility, except when the **out-of-network provider** has given you the following:
 - The out-of-network notice for your signature for your consent to be treated and balance billed
 - The estimated charges for the items and services
 - Notice that the **provider** is an **out-of-network provider**
- Out-of-network air ambulance services

Ancillary services mean any professional services including:

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

A facility in this instance means an institution providing health care related services, or a health care setting. This includes 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 specified in federal regulations.

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

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

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 policy to pay any part of the expense for a **covered service**. They are:

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

Generally, your policy and you share the cost for **covered services** when you meet the general requirements. But sometimes your policy 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 policy requires **precertification**, your **physician** requests it, we deny it and you get the services without **precertification**.
- You get care without a **referral** and your policy requires one.
- You get care from someone who is not a **network provider**, except for emergency and transplant services. See *Who provides the care* in this section for details.

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

You are not required to pay the network provider for any amounts that we owe but fail to pay.

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 policy. 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 policy.

Coordination of benefits

This policy does not coordinate benefits with any other policies, except for any Medicare coverage or plan you may have. Please see the *If you become eligible for Medicare section of General provisions – other things you should know* for more information.

Benefit payments and claims

A claim is a request for payment that you or your health care **provider** submits to us after you 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 policy 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.

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. When you pay for services or receive a 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.

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

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely.

We 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 *Grievance and appeal procedures* section for that information.

Grievance and appeal procedures

The difference between a complaint and an appeal

Grievance

You may not be happy about a **provider**, your quality of care, or an operational issue, and you may want to complain. You can contact us at any time. Grievances are:

- Appeals
- Complaints
- Disputes
- Inquiries (considered grievances when a distinction is not determined between them)
- Requests for reconsideration

Your grievance should include a description of the issue. We will review the information and give you a written response within 30 calendar days of receiving the grievance. We will let you know if we need more information to make a decision. You can submit your grievance by:

- Calling the toll-free number on your ID card
- Logging on to the Aetna website at <https://www.aetna.com/>
- Writing us at PO Box 24030, Fresno, CA 93779

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan by calling the toll-free number on your ID card and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

Grievance procedures

You or your **provider** may contact us at various times to make a grievance. 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. You can request an IMR from the Department of Managed Health Care (DMHC). See the *Independent medical review* section below.

Urgent grievance

You may appeal or your **provider** may appeal for you without having to fill out an appeal form when you have an **urgent condition**, an **emergency medical condition**, or you believe your health coverage has been or will be improperly cancelled, rescinded, or not renewed. We will give you an answer within 72 hours.

Grievance and appeals

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination or you have an incident that you want to submit a grievance for.

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
- 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 an acknowledgment letter within five calendar days. You will receive a decision within 30 days for a post-service claim. You will receive a decision within five business days for an appeal for a service or supply that is **experimental or investigational**.

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 our website or by contacting us. The form will tell you where to send it to us.

Independent medical review

An IMR is an impartial review of medical decision made by us and done by an Independent Medical Review Organization (IMRO) managed by the DMHC.

You have a right to an IMR when within six months of the grievance decision if:

- You have received an adverse benefit determination
- We decided the service or supply is not **medically necessary** but your provider recommends or determines your service is **medically necessary**
- We decided the service or supply is **experimental or investigational** and your **provider** certifies you have a life-threatening or seriously debilitating illness and has recommended treatment for it
- You have been seen by a network provider for the diagnosis or treatment of a medical condition
- A grievance has remained unsolved for more than 30 days or three days for an **urgent condition** or an **emergency medical condition** or a grievance was filed and the decision was upheld

You may also request an IMR if you are seeking to determine if the federal surprise bill law applies to your situation.

If our grievance decision is one for which you can seek an IMR, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the IMR process and will include a copy of the IMR application. You will not be charged for an IMR.

You should send the completed application to the DMHC. They will review your grievance and determine if it is eligible for an IMR. We will submit the required documents to the DMHC within three days, or 24 hours for urgent requests, after we receive notice the IMR is approved. The DMHC sends your grievance to the IMRO. The IMRO will determine whether or not the care is **medically necessary**. You will receive a copy of the IMR decision.

How long will it take to get an IMR decision?

The IMR will make their decision in 30 days, or three days for an urgent request.

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

For initial adverse benefit determinations

- You or 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)

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 policy 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

Recordkeeping

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

Fees and expenses

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

Eligibility, starting and stopping coverage

You will find information in this section about:

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

Who is eligible

You are eligible as the policyholder when you are:

- A legal resident of California
- Age 19 or older
- Not enrolled in Medicare at the time of application
- Listed as the applicant on the application
- Approved by us

You are enrolled as the policyholder after you complete the eligibility and enrollment process, and we have issued the policy to you. Your effective date of coverage is when this process is complete.

Who can be a dependent on your policy

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

- Your legal spouse
- Your civil union partner who meets eligibility requirements under applicable law
- Your domestic partner who meets eligibility requirements under applicable law.
- Parent or stepparent
- Your dependent children – your own or those of your spouse, civil union partner, domestic partner

The children must be under 26 years of age and they include your:

- Biological children
- Stepchildren
- Legally adopted children, including children placed with you for adoption
- Foster children
- Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
- Grandchildren in your court-ordered custody

You can enroll your dependent:

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

A dependent must live in the state where the policy was issued and be approved by us.

Adding new dependents

You can add the following new dependents to your policy:

- A spouse - If you marry, you can put your spouse on your policy:
 - We must receive your completed enrollment information not more than 60 days after the date of your marriage
 - Coverage will be effective on the first day of the month following plan selection
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your policy:
 - We must receive your completed enrollment information not more than 60 days after the date you file a Declaration of Domestic Partnership
 - Coverage will be effective on the first day of the month following plan selection
- A newborn child - Your newborn child is covered on your policy for the first 31 days after birth:
 - To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth
 - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional premium for the covered dependent
 - If you miss this deadline, your newborn will not have benefits after the first 31 days
- An adopted child – You may put an adopted child on your policy when the adoption is complete or the date the child is placed for adoption. “Placed for adoption” means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child:
 - We must receive your completed enrollment information within 60 days after the date of the adoption or the date the child was placed for adoption
 - Benefits for your adopted child will begin on the date of the adoption (or placement) or the first day of the month following adoption (or placement)
- A foster child – You may put a foster child on your policy when the child is placed in foster care. A foster child is a child whose care, comfort, education and upbringing is left to persons other than the natural parents:
 - We must receive your completed enrollment information within 60 days after the date the child is placed with you.
 - Benefits for your foster child will begin on the date you legally become a foster parent or the first day of the month following this event.
- A stepchild - You may put a child of your spouse, domestic partner on your policy:
 - You must complete your enrollment information and send it to us within 60 days after the date of your marriage, Declaration of Domestic Partnership with your stepchild’s parent
- Court order – You can put a child you are responsible for under a qualified medical support order or court-order on your policy:
 - You must complete your enrollment information and send it to us within 60 days after the date of the court order

Effective date of coverage for your dependent

Your dependent's coverage will start on your effective date of coverage, if you enrolled them at that time, otherwise:

- As shown above under the *Adding new dependents* section
- No later than the first day of the month following the date we receive your completed enrollment information
- In accordance with the effective date of a court order
- An appropriate date based on the circumstances of the special enrollment period

Important note:

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

Special or limited enrollment periods

Federal and state law allows you and your dependents to enroll in a new policy under some circumstances. These are called special or limited enrollment periods. Examples of triggering events include, but are not limited to:

- You or your dependent have lost minimum essential coverage.
- You have added a dependent because of marriage, domestic partnership, birth, adoption, placement for adoption, or placement in foster care. See the *Adding new dependents* section (above) for more information.
 - To qualify for a special enrollment period due to marriage, at least one spouse must be able to demonstrate they were enrolled in a plan with minimum essential coverage for at least one day in the 60 days before the date of marriage, or
 - lived in a foreign country or US territory at least one day in the 60 days before the date of marriage;
 - or is an American Indian or Alaskan Native.
- You or your dependent are enrolled in any non-calendar year group health plan, individual health insurance coverage, or qualified small employer health reimbursement arrangement.
- You did not enroll a dependent in this policy before because they had other coverage and now that other coverage has ended.
- A court orders you to cover a current spouse, domestic partner or a child on your health policy.
- You or your dependent are eligible for new policies because you have moved to a new permanent location.
- You or your dependent are the victim of domestic abuse or spousal abandonment.
- You or your dependent become eligible for state premium assistance under Medicaid or an S-CHIP plan for the payment of your premium contribution for coverage under this policy.
- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan.
- You no longer receive employer contributions or government subsidies for COBRA coverage.

Regulatory changes may occur that impact and expand special enrollment periods which will apply to this policy. Please visit www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ up-to-date information. The completed enrollment form may be submitted within 60 days of the event. However, if you did not receive notice of your triggering event, you will have 60 days from the time you are made aware of the event.

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 or phone number
- Change in marital status
- Covered dependent status change
- Change in health coverage through a job-based plan or a program like Medicare, Medicaid or the Children's Health Insurance Program (CHIP) for you or your dependent

When coverage ends

When will your coverage end?

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

Your coverage under this policy will end if:

- This policy is no longer available
- You ask to end coverage by notifying us in writing 31 days before the date you want your coverage to end
- You are no longer eligible for coverage
- You stop making premium payment by the end of the grace period
- This product is discontinued in the state, if approved by the insurance department of the state where this policy was issued
- We withdraw from the individual market in the state, if approved by the insurance department of the state where this policy was issued
- We rescind your coverage, as permitted under this policy. Rescission means you lose coverage going forward and going backward. Please see the *General provisions – other things you should know* section for more information.

When dependent coverage ends

Dependent coverage will end if:

- They are no longer eligible for coverage
- You stop making premium contribution toward the cost of dependents' coverage
- Your coverage ends for any of the reasons listed above

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

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

Notice of coverage ending

- We will send you notice if your coverage is ending. This notice will tell you the date that coverage ends. Coverage will end immediately on the next premium contribution due date following the date on which you no longer meet the eligibility requirements.

When we would end coverage

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

We will not end your coverage because of your health status, health care needs or you filed an appeal. You may request a review by the Director of the California Department of Managed Health Care if you believe we ended your coverage for these reasons. See the *Grievance and appeal procedures* section.

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

Special coverage options after your coverage ends

When coverage may continue under the plan

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

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

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

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

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

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

We will send you a notice at least 90 days before your child reaches the plan age limit. We may ask you to send us proof of the disability within 90 days of the date coverage would have ended.

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 two years. You must send it to us within 60 days of our request. If you don't, we can end coverage for your dependent child.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this policy

We prepared this policy according to federal and state laws that apply. You and we will interpret it according to these laws.

How we administer this policy

We apply policies and procedures to administer this policy.

Who's responsible to you

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

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

When you are no longer the policyholder

If you are no longer the policyholder, and the policy wasn't cancelled, your covered spouse, civil union partner or domestic partner will become the policyholder. For a covered dependent child, the parent or legal guardian who is also covered under the policy will become the policyholder. If there is no policyholder at the end of a premium period, the policy will be cancelled.

Child-only coverage

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

Coverage and services

Your coverage can change

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

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.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage within 24 months of your effective date. These serious consequences include:

- Rescission of coverage
- Loss of coverage going forward
- Ending your coverage
- Recovery of amounts we already paid

We also may report fraud to criminal authorities. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind or end your coverage:

- We will give you 30 days advance written notice of any rescission of coverage or ending your coverage
- You have the right to an Aetna appeal
- You have the right to a third party review conducted by the Department of Managed Health Care

Some other money issues

Assignment of benefits

When you see a **network provider**, they will usually bill us directly. When you see an **out-of-network provider**, we may choose to pay you or to pay the **provider** directly. When you assign your benefits to your out-of-network provider, we will pay them directly.

Public policy participation by members

Contact us if you would like to participate in the committee that establishes public policy of the plan or want more information.

Legal action

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

Financial sanctions exclusions

If coverage provided under this policy violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **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 Assets Control (OFAC). You can find out more by visiting <https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Recovery of overpayments

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

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 (not exceeding one third if you used an attorney or one half if you did not use an attorney) 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.

We may reduce the amount we're due if you are partially responsible for your injury .

Effect of benefits under other policies

When you are enrolled in Medicare

When you are enrolled in Medicare Parts A, B, or D, we coordinate the benefits we pay with the benefits that Medicare pays. Sometimes, this policy pays benefits before Medicare pays and sometimes, this policy pays benefits after Medicare. Notify us immediately if you enroll in Medicare while covered under this policy.

If you have questions about Medicare, you can contact your local Social Security Administration office.

Workers' compensation

If benefits are paid by us and we determine you received worker's compensation benefits for the same event, we have the right to get back the payment we made ("recover") as described under the *When you are injured* section. We will work to recover the money from you.

These recovery rights will be applied even though:

- The workers' compensation benefits are in dispute or are made by means of settlement or compromise
- No final determination is made that bodily injury or illness was sustained in the course of, or resulted from, your employment
- The amount of workers' compensation due to medical or health care is not agreed upon or defined by you or the workers' compensation carrier
- The medical or health care benefits are specifically excluded from the workers' compensation settlement or compromise

You agree that you will notify us of any workers' compensation claim you make, and that you will reimburse us as described above. If benefits are paid under this policy and you or any covered dependent recover payment or benefits from a responsible party, we have a right to recover from you or any covered dependent an amount equal to the amount we paid.

Non-duplication of benefits

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

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

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

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

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 policy.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

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

Glossary

Behavioral health provider

A **health professional** who is certified to provide **covered services** for **mental health** and **substance use disorders** in the state where the person practices. This includes:

- Group, individual, family or multi-family group psychotherapy
- An associate marriage and family therapist or marriage and family therapist trainee
- A qualified autism service provider or qualified autism service professional certified by a national entity
- An associate clinical social worker
- An associate professional clinical counselor or professional clinical counselor trainee
- A registered psychologist or psychological assistant
- A psychology trainee or person supervised

Behavioral health services

Treatment for any mental health condition or substance use disorder listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD). This includes behavioral health crisis services that are provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services.

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 you pay after your **deductible**.

Copay, copayment

This is the dollar amount you pay for **covered services**. In prescription drug plans, it is the amount you pay for covered drugs.

Covered service

The benefits, subject to varying cost shares, covered under this policy. 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 policy exclusions* section
- Not beyond any limits in the schedule of benefits
- **Medically necessary**. See the *How your policy works – Medical necessity, referral and precertification requirements* section and the *Glossary* for more information

Deductible

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

Designated network provider

A **network provider** listed in the directory under *maximum savings* as a **provider** for your policy.

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 over-the-counter (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 condition and active labor that:

- Leads you to reasonably believe that, without immediate 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

Emergency services

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

Experimental or investigational

A drug, device, procedure, supply, treatment, test, or technology is considered by us to be **experimental or investigational** 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.
- The needed approval by the FDA has not been given for marketing.
- A national medical society, dental society, or regulatory agency has written that it's **experimental or investigational** 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 or investigational**.

Generic prescription drug

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

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional

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

Home health care agency

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

Hospital

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

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 (services or supplies other than for mental health disorder and substance use disorder)

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

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

Generally accepted standards of medical practice means:

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

All medical necessity determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge of a **covered person** diagnosed with **mental health disorders** and **substance use disorders** will be made using the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

Important note:

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

Medically necessary/Medical necessity (mental health disorder and substance use disorder)

Health care services or supplies that address the specific needs of the 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 disorder** 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**

Mental health disorder

A **mental health disorder** is a condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* (ICD) or that is listed in the most recent version of the DSM. Changes in terminology, organization, or classification of **mental health disorders** in future versions of the DSM or ICD shall not affect the conditions covered in this section as long as a condition is commonly understood to be a **mental health disorder** by **providers** practicing in relevant clinical specialties.

Negotiated charge

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

Network provider

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

Non-designated network provider

A **provider** listed in the directory under *standard savings* as a **provider** for your policy.

Out-of-network provider

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

Physician

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

Precertification, precertify

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

Prescription

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

Primary care provider (PCP)

A **physician** 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 policy, 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
- 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.

Psychiatric hospital

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

Referral

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

Residential treatment facility

An institution specifically licensed as a **residential treatment facility** by applicable laws to provide for mental health or **substance use disorder** residential treatment programs. 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.

Service area

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

Skilled nursing facility

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

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

Skilled nursing facility does not include institutions that provide only:

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

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

Specialist

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

Specialty pharmacy

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

Specialty prescription drugs

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)

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 mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* (ICD) or that is listed in the most recent version of the DSM. Changes in terminology, organization, or classification of **substance use disorder** in future versions of the DSM or ICD shall not affect the conditions covered in this section 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

The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

Terminal illness

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

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.

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, 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, if you are a current member, your Aetna contact number on the back of your ID card.

Confidentiality Notice

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

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

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

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

Race/Ethnicity, Language, Sexual Orientation and Gender Identity and Social Needs Data

We may receive information related to your race, ethnicity, language, sexual orientation, gender identity, and social needs from many sources, including from you and health care providers.

Your race, ethnicity, language, sexual orientation, gender identity and social needs information are considered Protected Health Information (PHI) when we have it. PHI includes personal information that may identify you that is not public information. And it includes information about your health, medical conditions, prescriptions, and payment for health care products or services.

PHI may include:

- Demographic data (like your name, address, race, ethnicity, language, sexual orientation, and gender identity)
- Health details (like a medical history)
- Test results (like a lab test)
- Insurance information (like your member ID)
- Social Needs (like financial insecurity, food insecurity, housing insecurity, access to transportation, interpersonal safety, barriers to achieving health, or any other relevant social need)
- Other information used to identify you or that is linked to your health care or health care coverage

We protect this information. We use technical and physical safeguards designed to keep your information safe from unauthorized access, and other threats to its security. We comply with state and federal laws that apply to the security and confidentiality of your PHI.

We use this information to:

- Make sure you get the care you need
- Create programs to improve health outcomes
- Create health education information
- Let the practitioners and providers know about your language and health care needs

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

Health plans are offered or underwritten or administered by Aetna Health of California Inc., Aetna Health Inc. (Florida), Aetna Health Inc. (Georgia), Aetna Life Insurance Company, Aetna Health of Utah Inc., Aetna Health Inc. (Pennsylvania), or Aetna Health Inc. (Texas) (Aetna). Aetna is part of the CVS Health family of companies.

Race/Ethnicity, Language, Sexual Orientation and Gender Identity and Social Needs Data (cont.)

We do not use this information to:

- Determine benefits
- Pay claims
- Determine your cost or eligibility for benefits
- Discriminate against members for any reason
- Determine health care or administrative service availability or access
- Deny services, coverage, benefits or for underwriting purposes

Reasons that we will need your written okay

Except for what we explained above, we will ask for your okay before using or sharing your health information. For example, we will get your okay:

- For marketing reasons that have nothing to do with your health plan.
- Before sharing any psychotherapy notes.
- For the sale of your health information.
- For other reasons as required by law.

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

Health plans are offered or underwritten or administered by Aetna Health of California Inc., Aetna Health Inc. (Florida), Aetna Health Inc. (Georgia), Aetna Life Insurance Company, Aetna Health of Utah Inc., Aetna Health Inc. (Pennsylvania), or Aetna Health Inc. (Texas) (Aetna). Aetna is part of the CVS Health family of companies.

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles, copayments, or coinsurance**, if any, that apply to the **covered services** you get under this plan. You should read this schedule to become aware of these and any limits that apply to the **covered services**. This schedule takes the place of any others sent to you before.

How your cost share works

- You are responsible to pay any **deductibles, copayments**, and remaining **coinsurance** if they apply.
- You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit or day limits.

Important note:

All **covered services** are subject to the calendar year **deductible, maximum out-of-pocket limit, limits, copayment, or coinsurance** unless otherwise noted in this schedule. The *Surprise bill* section of the policy explains your protection from a surprise bill.

Contact us

We are here to answer your questions. See the *Contact us* section of the policy.

Plan features

Deductible

You will continue to pay **copayments or coinsurance**, if any, for **covered services** after you meet your **deductible**.

Deductible	Network
Individual	\$0 per year
Family	\$0 per year

Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

Family deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

Maximum out-of-pocket limit

Maximum out-of-pocket limit	Network
Individual	\$4,500 per year
Family	\$9,000 per year

Individual maximum out-of-pocket limit

This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately. After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for any health care service you get that is not a **covered service**
- Amounts received from a third-party **copay** assistance, like a manufacturer coupon or rebate, for a **specialty prescription drug**

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of services on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the policy.

Covered services

Your cost share for a **covered service** not listed with a specific cost share is based on the type of **covered service** you receive and where your **covered service** is received.

Your **telemedicine** cost share will not be more than your in-person visit for the same **covered service**.

Abortion

Description	Network
Termination of pregnancy	\$0 no deductible applies

Acupuncture

Description	Network
Acupuncture	\$15 no deductible applies

Ambulance service

Description	Network
Emergency ambulance	\$150 no deductible applies
Non-emergency ambulance	\$150 no deductible applies

Behavioral health

Mental health disorders and **substance use disorders** are covered under the same terms and conditions as any other illness.

Description	Network
Inpatient services	Cost share same as Inpatient services under Hospital care
Outpatient office visit to a physician or behavioral health provider (Includes telemedicine consultation)	\$15 no deductible applies
Other outpatient services including behavioral health services in the home, partial hospitalization treatment, and intensive outpatient program The cost share does not apply to network peer counseling support services after you meet your deductible , if you have one	\$0 no deductible applies

*988 center or mobile crisis team services are covered with the applicable in-network cost share when provided by in-network and out of network providers. Evaluation and treatment provided by a CARE agreement or plan approved by a court are covered with no cost share regardless of whether the service is provided by an in-network or out-of-network provider. Prescription drugs are covered regardless of whether they are provided by an in-network or out-of-network pharmacy and are subject to cost share and applicable authorization requirements.

Diabetic education

Description	Network
Education services	\$0 no deductible applies

Durable medical equipment (DME)

Description	Network
DME	10% no deductible applies

Emergency services

A separate **hospital** emergency room cost share will apply for each visit to an emergency room.

Description	Network
Hospital emergency room	\$150 no deductible applies
Hospital emergency room physician	\$0 no deductible applies

Emergency services important note:

Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by you and the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Habilitation therapy services

Description	Network
Physical, occupational, and speech therapies	\$15 no deductible applies

Hearing exams

Description	Network
Hearing exam	0% no deductible applies

Home health care

Description	Network
Outpatient	\$20 no deductible applies
Visit limit per year	100

Home health care important note:

Limited to 3 intermittent visits per day provided by a **home health care agency**. 1 visit equals a period of 4 hours or less. Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits.

Hospice care

Description	Network
Inpatient services	\$0 no deductible applies
Outpatient services	\$0 no deductible applies

Hospital care

Description	Network
Inpatient services	\$225 per day for days 1-5, no deductible applies

Per admission or per day cost share important note:

A separate cost share may apply per facility. It may apply to each admission or on a per day basis up to a per admission maximum amount. If you are in the same type of facility more than once, and your stays are separated by less than 10 days (regardless of cause), only one per admission cost share will apply.

Infertility services-Advanced reproductive technology (ART)

Description	Network
Fertility preservation	10% no deductible applies

Maternity and related newborn care

Description	Network
Inpatient delivery services and postpartum care	\$225 per day for days 1-5, no deductible applies
In a facility or at a physician office	\$0 no deductible applies

Maternity and related newborn care Important note:

Any cost share that is collected applies to the delivery and postpartum care services provided by an OB, GYN, or OB/GYN only. Review the *Maternity* section of the policy. It will give you more information about coverage for maternity care under this plan.

Nutritional support

Description	Network
Nutritional support	10% no deductible applies

Obesity (bariatric) surgery

Description	Network
Obesity (bariatric) surgery	\$225 per day for days 1-5, no deductible applies

Outpatient surgery

Description	Network
At a hospital outpatient department	\$75 no deductible applies
At a facility that is not a hospital	\$75 no deductible applies

Physician services

PCP and other practitioner

Description	Network
Office hours visit (not surgical and not preventive care) (includes telemedicine consultation)	\$15 no deductible applies

Specialist

Description	Network
Office hours visit (not surgical) (includes telemedicine consultation)	\$30 no deductible applies

Physician surgical services

Description	Network
Inpatient surgical services	\$0 no deductible applies
Outpatient surgical services	\$20 no deductible applies
Office surgical services	10% no deductible applies

Prescription drugs - outpatient

Your cost share will not be more than the retail drug price or applicable cost share for the drug, whichever is lower.

Tier 1 – preferred generic prescription drugs and low-cost preferred brand-name prescription drugs

Description	Network
For each 30 day supply filled at a retail pharmacy	\$7 no deductible applies
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a mail order pharmacy	\$14 no deductible applies

Tier 2 -- non-preferred generic prescription drugs and preferred brand-name prescription drugs

Description	Network
For each 30 day supply filled at a retail pharmacy	\$16 no deductible applies
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a mail order pharmacy	\$32 no deductible applies

Tier 3 -- non-preferred brand-name prescription drugs

Description	Network
For each 30 day supply filled at a retail pharmacy	\$25 no deductible applies
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a mail order pharmacy	\$50 no deductible applies

Tier 4 -- specialty prescription drugs

Description	Network
For each 30 day supply filled at a specialty pharmacy	10% up to \$250, no deductible applies

Important note:

Some **specialty prescription drugs** may qualify for third-party **copayment** assistance that could lower your out-of-pocket costs. Any manufacturer coupon or rebate assistance amount received through third-party **copayment** assistance will not apply towards your **deductible** or **maximum out-of-pocket limit**.

Anti-cancer prescription drugs taken by mouth

Description	Network
For each 30 day supply filled at a specialty pharmacy	\$0 no deductible applies

Contraceptive (birth control)

Coverage includes up to a 12 month supply per **prescription**.

Description	Network
For each 30 day supply of generic prescription drugs and OTC drugs and devices	\$0 no deductible applies
For each 30 day supply of brand-name prescription drugs and devices	Paid according to the tier of drug above

Contraceptive (birth control) Important note:

The **prescription** drug cost share will not apply to contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available or inadvisable by your **provider**, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription** drug cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless you receive a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Preventive care drugs and supplements and risk reducing breast cancer prescription drugs

Description	Network
For each 30 day supply filled at a retail pharmacy	\$0 no deductible applies
Limit	Subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For a current list of covered preventive care drugs and supplements and risk reducing cancer prescription drugs, see the <i>Contact us</i> section of the policy.

Tobacco cessation prescription and over-the-counter drugs

Description	Network
<p>For each 30 day supply filled at a retail pharmacy</p> <p>Cost share only includes generic prescription drugs when there is also a brand-name drug available.</p>	<p>\$0 no deductible applies</p>
<p>Limit</p>	<p>Subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation prescription drugs and OTC drugs, see the <i>Contact us</i> section of the policy.</p>

Outpatient prescription drug important note:

If you or your **provider** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the generic drug and the brand-name drug, plus the cost share that applies to the brand-name drug.

If you or your **provider** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will pay the **brand-name prescription drug** cost share if the **brand-name prescription drug** is approved as medically necessary through a medical exception.

If you or your **provider** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is not available, you will be responsible for the **brand-name prescription drug** cost share.

Preventive care

Description	Network
<p>Preventive care</p>	<p>\$0 no deductible applies</p>
<p>Breast feeding counseling and support limit</p>	<p>6 visits per 12 months in a group or individual setting</p> <p>Visits that exceed the limit are covered under the physician services office visit</p>
<p>Breast pump, accessories and supplies limit</p>	<p>Electric pump: 1 every year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump</p>
<p>Breast pump waiting period</p>	<p>Electric pump: 1 year to replace an existing electric pump</p>
<p>Counseling for risk for breast and ovarian cancer</p>	<p>Not subject to any age or frequency limitations</p>
<p>Counseling for obesity, healthy diet visit limit</p>	<p>Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling</p>

Description	Network
Counseling for sexually transmitted infection visit limit	2 visits every 12 months
Counseling for tobacco cessation visit limit	8 visits every 12 months
Family planning services (contraception and counseling) limit	Contraceptive counseling limited to 2 visits every 12 months in a group or individual setting Visits that exceed the limit are covered under the physician services office visit
Immunization limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician
Prenatal care	See the <i>Preventive care, Prenatal care</i> section of the policy for more information
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> • Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF • The comprehensive guidelines supported by the Health Resources and Services Administration Lung cancer screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to: 7 exams from age 0-1 year 3 exams age 1-2 3 exams age 2-3 and 1 exam after that age every 12 months High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older limited to 1 every 36 months
Well woman routine GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Prosthetic devices

Description	Network
Prosthetic devices	10% no deductible applies

Short-term cardiac and pulmonary rehabilitation services

A visit is equal to no more than 1 hour of therapy.

Description	Network
Cardiac and pulmonary rehabilitation	\$15 no deductible applies

Short-term rehabilitation therapy services

Outpatient physical therapy

Description	Network
Physical therapy	\$15 no deductible applies

Outpatient occupational therapy

Description	Network
Occupational therapy	\$15 no deductible applies

Outpatient speech therapy

Description	Network
Speech therapy	\$15 no deductible applies

Skilled nursing facility

Description	Network
Inpatient services	\$125 per day for days 1-5, no deductible applies
Limit	Coverage is limited to 100 days per benefit period.

Tests, images and lab – outpatient

Diagnostic complex imaging services

Description	Network
At a facility	\$75 no deductible applies
At a physician office	\$75 no deductible applies
At a specialist office	\$75 no deductible applies

Diagnostic lab work

Description	Network
At a facility	\$15 no deductible applies
At a physician office	\$15 no deductible applies
At a specialist office	\$15 no deductible applies

Diagnostic radiological services (X-ray)

Description	Network
At a facility	\$30 no deductible applies
At a physician office	\$30 no deductible applies
At a specialist office	\$30 no deductible applies

Therapies-outpatient

Infusion therapy

Description	Network
In a physician office or in a person's home	\$30 no deductible applies
In an outpatient facility	10% no deductible applies

Chemotherapy, radiation, and dialysis

Description	Network
In an outpatient facility	10% no deductible applies

Transplant services

Description	Network (Exchange IOE facility)	Out-of-network (Includes Aetna's network providers who are not Exchange IOE providers)
Services and supplies	\$225 per day for days 1-5, no deductible applies	Not covered

Urgent care services

A separate urgent care cost share will apply for each visit to an urgent care **provider**.

Description	Network
Urgent medical care at a freestanding facility that is not a hospital	\$15 no deductible applies

Vision care

Pediatric vision care

Coverage is limited to covered persons through the end of the month in which the person turns 19.

Description	Network
Pediatric vision exam (including refraction) and contact lens fitting	\$0 no deductible applies

Vision care services and supplies

Description	Network
Eyeglass frames, prescription lenses or prescription contact lenses	\$0 no deductible applies
Low vision services	Cost share same as PCP or specialist office hours visit under Physician services
Supplies	Cost share same as DME

Limits

Description	Limit
Limited to one per year	One pair of eyeglasses (prescription lenses and frames) or One pair of regular contacts or Up to 3 month supply of daily wear disposable contact lenses or Up to 6 month supply of extended wear contact lenses

Vision care important note:

See the *Vision care* section of the policy for more information about vision services and supplies. This plan will cover either the purchase of **prescription** eyeglass lenses or contact lenses but not both.

Voluntary sterilization

Description	Network
Tubal ligation and other similar sterilization procedures	\$0 no deductible applies
Vasectomy	\$0 no deductible applies

Walk-in clinic visits

Not all preventive care services are available at **walk-in clinics**. All services are available from a network **physician**.

Description	Network
Non-emergency services	\$15 no deductible applies
Telemedicine consultation for non-emergency services	\$15 no deductible applies
Preventive care immunizations and preventive screening and counseling services (Includes telemedicine consultation) See the <i>Preventive care</i> section for more information	0% no deductible applies

MinuteClinic®

Description	Network
Telemedicine consultation for non-emergency services	\$0 no deductible applies