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.

Korean 무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.

French Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.

Arabic للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.

Hmong Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.

Russian Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.

Tagalog Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.

Gujarati તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.

Mon-Khmer,Cambodian ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។

German Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.

Hindi बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।

Lao ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.

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。

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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

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

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

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

The North Carolina Life and Health Insurance Guaranty Association
4441 SIX FORKS RD STE 106-153
RALEIGH, NORTH CAROLINA 27609-5729
https://www.nclifega.org/

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

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

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.
- They acquired rights to receive payments through a structured settlement factoring transaction

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
(2) Except as provided in (3), (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
(3) The guaranty association will pay a maximum of $500,000 with respect to a health benefit plan.
(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

Health maintenance organization (HMO) policy

2025 NC Gold S: HNOnly

This policy is by and between Aetna Health 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 but you are responsible for any charges. Please read your policy and the schedule of benefits because they explain your benefits in detail.

Health plans are offered or underwritten or administered by Aetna Health Inc. (Pennsylvania) (Aetna). Aetna is part of the CVS Health family of companies.

This is a legal contract

READ YOUR CERTIFICATE CAREFULLY

Important cancellation information

Please read entire *When coverage ends* section on page 60

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.

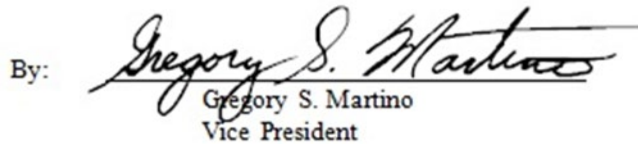
You may keep this policy in force by meeting the policy requirements and by paying the premium on time. See the *What does the policy cost you?* section for more information.

Your application

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 or if you applied through an Exchange, the exchange 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.



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Welcome

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

Welcome to Aetna.

Introduction

This is your 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. Each may have riders or amendments attached to them. These change or add to the document.

This policy is provided following your application for coverage through the Exchange. Coverage under this policy is subject to any conditions and rights as set forth in this policy and by the Exchange and/or the Federal Department of Health and Human Services. Individuals covered under this policy agree to all its requirements.

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, these are defined in the *Glossary* section

Contact us

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

- Calling the toll-free number on your ID card
- Writing us at P.O. Box 14079, Lexington, KY 40512-4079
- 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 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.

Wellness and other rewards

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

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

Discount arrangements

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

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

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

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 *Complaints, claim decisions and appeal procedures* section of this policy.

The first premium payment is due on or before your effective 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 effective date. Each premium payment is to be paid to us on or before the due date.

We provide this policy to you and you pay premium to us. We may choose not to accept premium that is paid for you by someone else unless we are required to by applicable law.

Grace period

You have a grace period of 31 days after the due date for the payment of each premium due after the first premium payment. 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.

Important note:
If you are currently getting advanced payments of the premium tax credit, as determined by the Exchange, the grace period above does not apply to you. Instead, the following applies:

If you are getting advance payment of the premium tax credit now, and you have paid at least one full month's premium as your binder payment, when applicable, you will have a grace period of three months. Your coverage will not end during the grace period.

If you receive services during the second and third months of the grace period, we will wait to pay claims until the premium is paid. We will tell you and your **providers**.

If premium is not paid by the end of the three month period, your coverage will end on the last day of the first month of the grace period. We will take back payment for any claims paid during the second and third months of the grace period.

Reinstatement

We can end this policy because you have not paid your premium. If this happens, we can reactivate ("reinstate") the policy without a break in coverage. You must ask us to do so within 60 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 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 policy 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, except for treatment related to congenital defects or anomalies of newborn, foster, and adopted children per state statute and reconstructive surgery following a mastectomy. This is an exclusion.
- Your **provider** may recommend services that are considered **experimental, investigational, or unproven** services. But an **experimental, investigational, or unproven** service is not covered and is also an exclusion unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of services below.
- 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 *Preventive care* in the list of services below. To find out how much you will pay for these services, see *Preventive care* in your schedule of benefits.

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

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

Ambulance services

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

Emergency

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

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

Non-emergency

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

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

The following are not **covered services**:

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

Applied behavior analysis

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

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

Autism spectrum disorder

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

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

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

Behavioral health

Mental health treatment

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

- Inpatient **room and board** at the **semi-private room rate** (your 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:
  - You are homebound
  - Your **physician** orders them
  - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
  - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- Observation
- Peer counseling support by a peer support specialist (includes **telemedicine** consultation)

Substance related disorders treatment

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

- Inpatient **room and board**, at the **semi-private room rate** (your 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 related disorders**
  - Other outpatient **substance related disorders** treatment such as:
    - Partial hospitalization treatment provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Ambulatory or outpatient **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Peer counseling support by a peer support specialist (includes **telemedicine** consultation)

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

Blood services

Covered services include the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Covered services also include the cost of storing a member's blood for use in a scheduled procedure.

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709 and NCGS 58-3-255.

The following are not **covered services**:

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

Experimental or investigational therapies

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

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

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

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

Dental care anesthesia

Covered services include anesthesia for dental care, that your doctor has certified, cannot be performed in the dentist's office due to age or condition of the covered person.

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

Covered services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Injection devices including syringes, needles, and pens
  - Test strips - blood glucose, ketone, and urine
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- 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 or your local emergency response service for medical and ambulance help.

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

Your coverage for **emergency services** will continue until the following conditions are met:
- You are evaluated and your condition is stabilized
- Your attending **physician** determines that you are medically able to travel or be transported, by non-medical or non-emergency 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 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 for what is not an **emergency medical condition**, the policy will not cover your expenses.

Gender affirming treatment

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

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

Habilitation therapy services

Habilitation therapy services are services needed to keep, learn, or improve 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 aids
Hearing aid means:
- Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing
- Parts, attachments, or accessories

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

The following are not **covered services**:
- Replacement of a hearing aid that is lost, stolen, or broken
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Home health care
Covered services include home health care provided by a **home health care agency** in the home, but only when all of the following criteria are met:
- You are homebound
- Your **physician** orders them
- The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**, or you are unable to receive the same services outside your home
- The services are a part of a home health care plan
- The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy

- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker

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

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

Short-term physical, speech, and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home. See *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
- 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

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

Hospital care

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

- Semi-private **room and board**. Your 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, but not the expense of the donated blood or blood product.

The following are not **covered services**:
All services and supplies provided in:

- Rest homes
- A person's main residence
- Any place providing mainly custodial or rest care
- Health resorts
- Spas
- Schools or camps

Infertility services

Basic infertility

Covered services include seeing a **provider**:

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

Advanced reproductive technology (ART)

Covered services include the following infertility services provided by a network infertility **specialist**:

- Ovulation induction cycle(s) while on injectable medication to stimulate the ovaries

Infertility **covered services** may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your policy. For policies with cycle limits, a "cycle" is defined as:

- An attempt at ovulation induction while on injectable medication to stimulate the ovaries with or without artificial insemination

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**. You can call the NIU at 1-800-575-5999.

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

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.
  - Cryopreservation (freezing) of eggs, embryos, or sperm.
  - Storage of eggs, embryos, or sperm.
  - Thawing of cryopreserved (frozen) eggs, 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
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, and any related services, products, or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)

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, **complications of pregnancy**, 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
- Follow-up care within 72 hours of an early discharge

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

Obesity (bariatric) surgery

Obesity **surgery** is a type of procedure performed on people to help lose excess weight and reduce the risk of potentially life-threatening weight-related health problems. 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
- One obesity **surgical procedure**
- A multi-stage procedure when planned and approved by us
- Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

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.
- Except as described in the *Preventive care* services section, 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** or **PCP** services and not for a separate fee for facilities.

The following are not **covered services**:

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

Physician services

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

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

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

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

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

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

Physician surgical services

Covered services include the services of:

- The surgeon who performs your **surgery**
- The surgeon you visit before and after the **surgery**
- Another surgeon 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.

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.

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 first 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.

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

Anti-cancer drugs taken by mouth

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

Contraceptives (birth control)
For females who are able to become pregnant, **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) 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
- Continuous glucose monitors
- Diabetic syringes, needles, and pens
- 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 and injectable ovulation induction **prescription** drugs used to treat the underlying medical cause of infertility.

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

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**:
- Abortion drugs used for elective termination of pregnancy except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger
- 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 policy’s **drug guide**
- Compound **prescriptions** containing bulk chemicals that have not been approved by the FDA, including compounded bioidentical hormones
- Cosmetic drugs including medications, preparations used for cosmetic purposes
- Devices, products, and appliances, unless listed as a **covered service**
- Dietary supplements including medical foods
- 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, 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 have approved 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
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - 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 unless listed as a **covered service**
- 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
- 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
- Off-label drug use, except for indications recognized through peer-reviewed medical literature
- **Prescription** drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription** drugs for the treatment of a dental condition 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 policy's **drug guide**
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the member identified on the ID card
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the 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. 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/coverage/preventive-care-benefits/.

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 – female contraceptives

Covered services include family planning services as follows:

- Counseling services provided by a **physician** or other **provider** on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Contraceptive devices (including any related services or supplies) when they are prescribed, provided, administered, or removed by a **health professional**.

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

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

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

Immunizations

Covered services include preventive immunizations for infectious diseases.

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

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

Prenatal care

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

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

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms
- 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 infections
    - 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

Private duty nursing

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

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

The following are not **covered services**:

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

Prosthetic device

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

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

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

The following are not **covered services**:

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

Reconstructive breast surgery and supplies

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

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

Postmastectomy inpatient care and the decision whether to discharge you following the mastectomy is made by the attending **physician** in consultation with the patient. The length of the postmastectomy **hospital stay** is based on your unique characteristics taking into consideration your health and medical history.

When you have a mastectomy, we will notify you in writing that reconstruction **surgery** is available, at your option, without regard to the lapse of time between the mastectomy and the reconstruction.

Reconstructive surgery and supplies

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

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

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

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

These dental related services are limited to:

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

Sexual dysfunction services

Covered services include diagnosis, treatment and correction of any underlying causes of **sexual dysfunction**.

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**

Spinal manipulation

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

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure** 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, but only if it is expected to do one of the following:
  - Significantly improve or restore lost speech function or correct a speech impairment resulting from an acute illness, injury, or **surgical procedure**
  - Improve delays in speech function development caused by a gross anatomical defect present at birth

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

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

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

The following are not **covered services**:

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

Skilled nursing facility

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

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

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 policy. Log in to your member website at https://www.cvs.com/minuteclinic/virtual-care/telehealth-options to review our **telemedicine provider** listing. Contact us to get more information about your options, including specific cost sharing amounts.

The following are not **covered services**:

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

Tests, images, and labs – outpatient

Diagnostic complex imaging services

Covered services include:

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

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

Diagnostic 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**.

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, including related national registry donor searches, 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.

Travel and Lodging
Covered services include travel and lodging for you and a companion. Travel from your home to the IOE facility must be 50 miles or more from your home. If you are a minor, two companions may accompany you.

Eligible expenses for travel include coach class round trip air, train or bus travel.

For details about this program, including transportation options and **precertification** requirements, contact member services using the number on the back of your Aetna ID card.

The following are not **covered services**:

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

Urgent care services

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

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

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

- Urgent condition outside the **service area**
  - You are covered for urgent care obtained from an in-network facility outside of the **service area** if you are temporarily absent from the **service area** and getting the health care service cannot be delayed until you return to the **service area**.

The following are not **covered services**:

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

Virtual primary care (VPC)

VPC provides coverage for eligible in-network **covered services** for persons 18 years of age or older. **Covered services** include basic medical and preventive health care services when provided by a Virtual Primary Care (VPC) **telemedicine provider**.

A VPC **telemedicine provider** is a **provider** who is contracted with us to provide you with VPC **covered services** by **telemedicine**. This **provider** can also be your **PCP**.

Covered services include:

- General primary care consultations
- Preventive care screening and counseling
- Consultations for non-emergency illness or injury, including **prescriptions**, when needed
- **Prescription** drug coordination to encourage safe and appropriate use of medications
- Follow-up care and coordination with **providers**

Your VPC **telemedicine provider** can help you access **network providers** and **specialists** for **covered services** ordered during your virtual consultation, including:

- Diagnostic lab tests
- Preventive care immunizations
- In-person preventive care
- In-person biometric screenings such as cholesterol and blood sugar testing

Your regular cost share will apply for services not provided by a VPC **telemedicine provider** and for any **prescription** drugs you may need. See the schedule of benefits.

The following are not **covered services**:

- VPC **telemedicine** consultations received from a **provider** who is not a VPC **telemedicine provider**.

Vision care

Pediatric vision care

Covered services include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction, glaucoma testing
- Eyeglass frames, **prescription** lenses or contact lenses
- Low vision services
- 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:

Abortion

Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

Abortion drugs

Drugs used for elective termination of pregnancy except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

Acupuncture

- Acupuncture
- Acupressure

Behavioral health treatment

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:

- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work, or recreational activities
- Transportation

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

Examples of these are:

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

See the *Blood services* provision for medical **covered services**

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 treatment related to congenital defects or anomalies of newborn, foster, and adopted children per state statute and reconstructive surgery following a mastectomy and where described under Reconstructive surgery and supplies and Reconstructive breast surgery and supplies in the *Coverage and exclusions* section

Court-ordered testing

Court-ordered testing or care unless **medically necessary**

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

Dental care

Educational services

Examples of these are:

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

Examinations

Any health or dental examinations needed:

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

Experimental, investigational, or unproven

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

Foot care

Unless medically necessary, services and supplies for:

- The treatment of calluses, bunions, toenails, hammertoes, fallen arches
- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working, or wearing shoes
- Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments, and other equipment, devices, and supplies

Growth/height care

Except for medically necessary care and treatment of medically diagnosed congenital defects and birth abnormalities for newborn, foster and adopted children

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

Hearing exams

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

Maintenance care

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

Medical supplies – outpatient disposable

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

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

Missed appointments

Any cost resulting from a canceled or missed appointment

Nutritional support

Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- **Prescription** vitamins
- Medical foods
- Other nutritional items

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 is responsible for as the primary payer. Another party does not include Medicaid.

Personal care, comfort, or convenience items

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

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 policy.

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

Except treatment of an organic disease, any treatment, **prescription** drug, or supply to treat sexual dysfunction, enhance sexual performance, or increase sexual desire, including:

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

Strength and performance

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

Therapies and tests

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

Tobacco cessation

Any treatment, drug, service, or supply to stop or reduce smoking, the use of other tobacco products or to treat or reduce nicotine addiction, dependence, or cravings. This includes medications, nicotine patches, and gum unless recommended by the USPSTF. This also includes counseling, hypnosis, and other therapies unless stated as a **covered service**.

Treatment in a federal, state, or governmental entity

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

Vision care for adults

- Routine vision exam provided by an ophthalmologist or optometrist including refraction, glaucoma testing
- Any vision care services and supplies

Voluntary sterilization

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

Wilderness treatment programs

See *Educational services* in this section

Work related illness or injuries

Services or supplies for the treatment of an occupational **injury** or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent that such services or supplies are:

- The liability of the employee
- Employer or workers' compensation insurance carrier according to final adjudication under the North Carolina Workers' Compensation Act or
- An order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act

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. You can find **network providers** and see important information about them by logging in to your member website. There you'll find our online **provider** directory. See the *Contact us* section for more information.

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

Your policy often will pay a bigger share for **covered services** you get through your **PCP**, so choose a **PCP** as soon as you can.

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

Service area

Your 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 transplant services. 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 reasonably available – You can get services from an **out-of-network provider** if an appropriate **network provider** is not reasonably available. You or your **provider** must request approval from us before you get the care. Contact us for assistance. When this happens you will pay the in-network cost share.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

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

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

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

How you choose your PCP
You can choose a **PCP** from the list of **PCP**s in our directory.

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

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

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

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.

If this situation applies to you, contact us for details. You need to complete a Transition of Coverage Request form and send it to us. If you are undergoing treatment for an acute or chronic condition and the **provider** didn't leave the network because of fraud or lack of quality standards you'll be able to receive transitional care from your **provider** for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

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

If you are terminally ill, the transitional period is the remainder of your life for care directly related to treatment of the terminal illness.

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

Medical necessity and precertification requirements
Your 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 the service from a network provider
- You or your provider precertifies the service when required

Medically necessary, medical necessity

The **medical necessity** requirements are in the *Glossary* section, where we define "**medically necessary**, **medical necessity**." That is where we also explain what our medical directors or a **physician** they assign consider when determining if a service is **medically necessary**. A **physician** licensed in this State shall evaluate the clinical appropriateness of noncertifications.

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

Precertification

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

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

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

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

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.aetna.com/faqs-health-insurance/pharmacy-faqs.html Submit the request in writing to:
  CVS Health
  ATTN: Aetna PA
  1300 E Campbell Road
  Richardson, TX 75081

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

What the 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**.

NOTICE: Your actual expenses for covered services may exceed the stated **coinsurance** or **copayment** amount because actual **provider** charges may not be used to determine the plan and member payment obligations.

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
  - The estimated charges for the items and services
  - Notice that the **provider** is an **out-of-network provider**
- Out-of-network air ambulance services

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

Ancillary services mean any professional services including:

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

A facility in this instance means an institution providing health care related services, or a health care setting. This includes 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 a **network provider**
- 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 from an **out-of-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**.

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

It is important that you carefully read the previous sections within *How your 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.

Claim type and timeframes

Urgent care claim

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

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

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. Determinations will be communicated within 3 business days after we obtain all necessary information.

Post-service claim

A post-service claim is a claim that involves health care services you have already received. We will make a decision within 30 days after receiving all information for a retrospective review. We will provide written notification within five business days after making a noncertification determination. We will remain liable for **covered services** until the member has been notified of the noncertification.

Concurrent care claim extension

A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 3 days.

Concurrent care claim reduction or termination

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

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

Filing a claim

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

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

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

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

Complaints, claim decisions, and appeal procedures

The difference between a complaint and an appeal

Complaint

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

Appeal

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

Key Terms

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

Adverse benefit Determination

An adverse benefit determination means a denial, reduction, termination of, failure to provide or make payment (in whole or in part) for benefits resulting from the utilization review, as well as failure to cover an item or service for which benefits are otherwise provided because it is determined to be **experimental, investigational or unproven** or cosmetic. Noncertifications are also included in adverse benefit determination.

Certification

A determination by an insurer or its designated URO that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided satisfies the insurer's requirements for medically necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness.

Grievance

A grievance is a voluntary written complaint submitted to Aetna by you or your designee about any of the following:

- A decision, policy or action related to availability, delivery, or quality of health care services
- A written complaint submitted by you about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care services in question is not a grievance if the exclusion of the specific service requested is clearly stated in the certificate of coverage
- Claims payment or handling; or reimbursement for services
- The contractual relationship between you and the health plan
- The outcome of an appeal of a noncertification under North Carolina general statute

Noncertification
A noncertification determination by **Aetna** that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet **Aetna's** requirements for **medical necessity**, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage **of emergency services** and the requested service is denied, reduced, or terminated. A noncertification is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in this **certificate of coverage**. A noncertification includes any situation in which **Aetna** determines whether a requested treatment is **experimental, investigational or unproven**, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision.

Retrospective review
Utilization review of medically necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard in G.S. 58-3-190 has been met.

Claim decisions and appeal procedures
At any time you may contact the North Carolina Department of Insurance at:

Health Insurance Smart NC
By mail: 1201 Mail Service Center, Raleigh NC 27699
In person: 3200 Beechleaf Court, Raleigh NC 27604
Telephone: 855-408-1212
Fax: 9198076865
Email: https://www.ncdoi.gov/consumers/health-insurance

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

Any time we deny even part of the claim, it is an "adverse benefit determination" or "adverse decision." An adverse benefit determination is sometimes called a grievance. For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. In most situations, you must complete the internal appeal process before you can take any other actions, such as an external review.

Appeal of an adverse benefit determination
Urgent care or pre-service claim appeal
If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. Once the appeal is received, we will give you an answer within 72 hours for an urgent appeal and within 30 days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

Any other claim appeal

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

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

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

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

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

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

For grievances concerning the quality of clinical care delivered by the covered person’s provider, we will acknowledge the grievance within 10 business days.

Exhaustion of appeal process

In most situations, you must complete an appeal with us before you can take these other actions:

- Appeal through an external review process
- Pursue arbitration, litigation, or other type of administrative proceeding

Sometimes you do not have to complete an appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
- We did not follow all of the claim determination and appeal requirements of North Carolina or the federal Department of Health and Human Services.

But you will not be able to proceed directly to external review if:

- The rule violation was minor and not likely to influence a decision or harm you
- The violation was for a good cause or beyond our control
- The violation was part of an ongoing, good faith exchange between you and us

External review

External review is a review done by people in an organization outside of **Aetna**. This is called an external review organization (ERO). Sometimes, this is called an independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an ERO to review your case once the NCDOI establishes that your request is complete and eligible for review. You or someone you have authorized to represent you may request an external review. **Aetna** will notify you in writing of your right to request an external review each time you:

- receive a noncertification decision, or
- receive an appeal decision upholding a noncertification decision

You have a right to external review only if it is a noncertification decision, such as:

- Our claim decision involved medical judgment
- We decided the service or supply is not **medically necessary** or not appropriate
- We decided the service or supply is **experimental, investigational or unproven**
- You have received an adverse determination for noncertification
- You had coverage with **Aetna** in effect when the noncertification decision was issued;
- The service for which the noncertification was issued appears to be a covered service under your policy

If our claim decision is one for which you can seek external review, we will notify you in writing of the adverse benefit determination of the noncertification or final adverse benefit determination of the noncertification. That notification also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level. A covered person may file a request for an external review with the Commissioner within 120 days after the date of receipt of a notice of right to external review.

For a standard external review, you will be considered to have exhausted the external review process if you have:

- Completed **Aetna's** appeal process and received a written determination on the appeal from **Aetna**, or
- Filed an appeal and except to the extent that you have requested or agreed to a delay, have not received **Aetna's** written decision on appeal within 60 days of the date you can demonstrate that you submitted the request, or
- Received notification that **Aetna** has agreed to waive the requirement to exhaust the internal appeal process.

If your request for a standard external review is related to a retrospective noncertification (a noncertification which occurs after you have received the services in question), you will not be eligible to request a standard review until you have completed **Aetna's** internal appeal process and received a written final determination from **Aetna.**

If you wish to request a standard external review, you (or your representative) must make this request to NCDOI within 120 days of receiving **Aetna's** written notice of final determination that the services in question are not approved. When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of your request for a standard external review, the NCDOI will notify you and your provider of whether your request is complete and whether it is accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested additional information to the NCDOI within 150 days of the date of **Aetna's** written notice of final determination. If the NCDOI accepts your request, the acceptance notice will include:

- The name and contact information for the External Review Organization (ERO) assigned to your case;
- A copy of the information about your case that **Aetna** has provided to the NCDOI;
- Notice that **Aetna** will provide you or your authorized representative with a copy of the documents and information considered in making the denial decision (which will also be sent to the ERO); and
- Notification that you may submit additional written information and supporting documentation relevant to the initial noncertification to the assigned ERO within 7 after receipt of the notice of acceptance.

If you choose to provide any additional information to the IRO, you must also provide that same information to **Aetna** at the same time using the same means of communication (e.g., you must fax the information to **Aetna** if you faxed it to the ERO). When faxing information to **Aetna**, send it to 860-975-1526. If you choose to mail your information, send it to:

Aetna Life Insurance Company/Aetna Health Inc.
National External Review
2000 River Edge Parkway, Atlanta GA 30328

Please note that you may also provide this additional information to the NCDOI within the 7-day deadline rather than sending it directly to the ERO and **Aetna**. The NCDOI will forward this information to the ERO and **Aetna** within two business days of receiving your additional information.

The ERO will send you written notice of its determination within 45 days of the date the NCDOI received your standard external review request. If the IRO's decision is to reverse the noncertification, **Aetna** will, reverse the noncertification decision within 3 business days of receiving notice of the ERO's decision, and provide coverage for the requested service or supply that was the subject of the noncertification decision. If you are no longer covered by **Aetna** at the time **Aetna** receives notice of the IRO's decision to reverse the noncertification, **Aetna** will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

An expedited external review of a noncertification decision may be available if you have a medical condition where the time required to complete either an expedited internal appeal or second level grievance review or a standard external review would reasonably be expected to seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. If you meet this requirement, you may make a written or verbal request to the NCDOI for an expedited review after you:

- Receive a noncertification decision from **Aetna** AND file a request with **Aetna** for an expedited appeal, or
- Receive an appeal decision upholding a noncertification decision.

You may also make a request for an expedited external review if you receive an adverse first level appeal decision concerning a noncertification of an admission, availability of care, continued stay or emergency care, but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review your request and determine whether it qualifies for expedited review. You and your provider will be notified within 2 days if your request is accepted for expedited external review. If your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if **Aetna's** appeals process was already completed, or (2) require the completion of **Aetna's** appeals process before you may make another request for an external review with the NCDOI. An expedited external review is not available for retrospective noncertifications.

The ERO will communicate its decision to you within 3 days of the date the NCDOI received your request for an expedited external review. If the ERO's decision is to reverse the noncertification, **Aetna** will, within one day of receiving notice of the ERO's decision, reverse the noncertification decision for the requested service or supply that is the subject of the noncertification decision. If you are no longer covered by **Aetna** at the time **Aetna** receives notice of the ERO's decision to reverse the noncertification, **Aetna** will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

The ERO's external review decision is binding on **Aetna** and you, except to the extent you may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same noncertification decision for which you have already received an external review decision.

For further information about External Review or to submit the Request for External Review Form, contact the North Carolina Department of Insurance:

- Health Insurance Smart NC
  - By mail: 1201 Mail Service Center, Raleigh, NC 27699-1201
  - In person: 3200 Beechleaf Court, Raleigh, NC 27604
  - Telephone: 855-408-1212 or Fax: 919-807-6865
  - Email: https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-external-review
- Within 120 days of the date you received the written decision from us
- With a written, signed medical authorization for the release of any of medical records when requested by the NCDOI
- And you must include a copy of the notice from us and all other important information that supports your request

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

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 complaints and appeals for at least 10 years.

Fees and expenses

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

Eligibility, starting, and stopping coverage

The eligibility process and enrollment process are subject to any rules or other standards of the Exchange and/or the Federal Department of Health and Human Services.

Eligibility

You will find information in this section about:

- 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

You are enrolled as the policyholder after you complete the eligibility and enrollment process with the Exchange. You must pay the initial premium for your coverage to be effective. The Exchange determines your effective date of coverage.

Who can be a dependent on your policy

You can enroll eligible family members (these are your "dependents"). You can enroll the following family members:

- Your legal spouse
- Your domestic partner who meets eligibility requirements under applicable law
- Your dependent children – your own or those of your spouse, domestic partner
    - Dependent children must be under 26 years of age and include your:
        - Natural children
        - Stepchildren
        - Adopted children, including those placed with you for adoption
        - Foster children
        - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
        - Grandchildren in your court-ordered custody
        - Any children approved by the Exchange

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 the Exchange.

Adding new dependents

You can add the following new dependents to your policy:

- A spouse - If you marry, you can enroll your spouse on your policy:
    - The Exchange 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 policy selection

- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your policy:
  - The Exchange 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 policy selection
- A newborn child - Your newborn child is covered on your policy for the first 31 days after birth:
  - To keep your newborn covered, the Exchange must receive your completed enrollment information and premium payment within 60 days of birth
    - If you miss this deadline, your newborn will not have benefits after the first 31 days
  - Coverage includes treatment of **injury** or **illness**, including medically diagnosed congenital defects and birth abnormalities
- 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:
  - The Exchangemust receive your completed enrollment information and premium payment within 60 days after the date of the adoption or the date the child was placed for adoption, whichever is earlier
    - Benefits for your adopted child will begin on the date of the adoption (or placement)
  - Coverage includes treatment of **injury** or **illness**, including medically diagnosed congenital defects and birth abnormalities
- 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:
  - The Exchange must receive your completed enrollment information and premium payment within 60 days after the date the child is placed with you
    - Benefits for your foster child will begin on the date the child is placed in foster care.
  - Coverage includes treatment of **injury** or **illness**, including medically diagnosed congenital defects and birth abnormalities
- A stepchild - You may put a child of your spouse, domestic partner on your policy:
  - You must complete your enrollment information, premium payment and send it to the Exchange 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 the Exchange 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, 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 the Exchange receives 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

Special or limited enrollment periods

Federal law allows you and your dependents to enroll in a new policy under some circumstances. These are called special or limited enrollment periods. You can enroll in these situations when:

- You or your dependent have lost minimum essential coverage.
- You have added a dependent because of marriage, 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 prove 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 one of the following:
    - Lived in a foreign country or US territory at least one day in the 60 days before the date of marriage
    - 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 or your dependent's enrollment or non-enrollment in a plan through the Exchange was not intended, was by accident or a mistake, and is because of an error, false information, or delay by the Exchange.
- You or your dependent have proven to the Exchange that their plan did not honor or maintain an important provision of its contract with you or that you meet other unusual circumstances.
- 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 newly eligible or not eligible for the premium tax credit or change in eligibility for cost share reduction, for Exchange coverage.
- 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 a citizen, a national, or lawfully present in the United States.
- You are an American Indian or Alaska Native as defined by the Indian Health Care Improvement Act. In this situation:
  - You, or you and your dependents, can enroll in a qualified health plan (QHP) or change from one QHP to another
  - You can do this one time per month
- You or your dependent 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 or your dependent are released from incarceration.
- 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 http://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ for up-to-date information. The completed enrollment form must 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

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

- Address
- Phone number
- Marital status
- Dependent status
- Health coverage through a job-based plan or program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) for you or your dependent

When coverage ends

When your coverage will 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 ends when:

- This policy is no longer available
- You ask to end coverage by notifying the Exchange in writing at least 14 days before the date you want your coverage to end
- You no longer meet the eligibility requirements of the Exchange including moving out of the **service area**
- You stop making premium payments 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 end your coverage, as permitted under this policy

When dependent coverage ends

Dependent coverage ends when:

- They no longer meet the eligibility requirements of the Exchange
- You stop making premium contribution toward the cost of dependent 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 the Exchange.

Notice of coverage ending

The Exchange 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. See the *General provisions – other things you should know* section for more information.

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 policy

This section explains options you may have after your 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 chiefly on you for support and maintenance

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

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

How you can extend coverage for dental work when coverage ends

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

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

Ordered means:

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

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. Also, you are bound by our interpretation of this policy when we administer your coverage.

How we administer this policy

We apply policies and procedures we've developed 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 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 and riders too. Under certain circumstances, we or an applicable law may change your policy. When an emergency or epidemic is declared, we may modify or waive **precertification**, **prescription** quantity limits, or your cost share if you are affected. Only we may waive a requirement of your 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 may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception

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

- Rescission of coverage
- Loss of coverage going forward
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage:

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

Some other money issues

Assignment of benefits

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

Legal action

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

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

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.

The recovery of overpayments or offsetting of future payments shall be made within the two (2) years after the date of the original claim payment unless we have reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents, or the claim involves a health care provider or health care facility receiving payment for the same service from a government payor.

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

Services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act

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 policies

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

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.

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

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

Brand-name prescription drug

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

Coinsurance

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

Complications of pregnancy

Complications of pregnancy means problems caused by pregnancy that pose a significant threat to the health of the mother or baby, including:

- Hyperemesis gravidarum (pernicious vomiting of pregnancy), toxemia with convulsions, severe bleeding before delivery due to premature separation of the placenta from any cause, bleeding after delivery severe enough to need a transfusion or blood
- Amniotic fluid tests, analyses, or intra-uterine fetal transfusion made for Rh incompatibility
- An emergency medical cesarean section due to pregnancy complications
- Miscarriage if not elective or therapeutic

A non-elective cesarean section is considered a complication of pregnancy.

We will cover pregnancy complications the same as we would for any other **illness** or **injury**.

Copay, copayment

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

Covered service

The benefits, subject to varying cost shares, covered by 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 and precertification requirements* section and the *Glossary* for more information

Creditable coverage

Creditable coverage includes:

- A group health plan (including a governmental or church plan)
- A health insurance coverage (either group or individual insurance)
- Medicare

- Medicaid
- A military-sponsored health care (CHAMPUS)
- A program of the Indian Health Service
- A State health benefits risk pool
- The Federal Employees Health Benefits Program (FEHBP)
- A public health plan, including coverage received under a plan established or maintained by a foreign country or political subdivision as well as one established and maintained by the government of the United States
- Any health benefit plan under section 5(e) of the Peace Corps Act
- The State Children's Health Insurance Program (S-Chip)

Creditable Coverage does not include:

- Coverage only for accident
- Workers' Compensation or similar insurance
- Automobile medical payment insurance
- Coverage for on-site medical clinics
- Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that are provided in a separate policy

Short-term limited-duration health insurance coverage shall be considered creditable coverage.
A Certificate of Creditable Coverage will be provided to you upon request.

Deductible

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

Dental provider

Any individual legally qualified to provide dental services or supplies.

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 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

A medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably believe that is you don't get immediate medical care it could result in any of the following

- Placing your health or with respect to a pregnant woman, the health of the woman or her unborn child in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ

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, investigational, or unproven

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

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

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 **medically necessary**, **experimental, investigational, or unproven**. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact us. See the *Contact us* section for how.

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.

Intensive outpatient program (IOP)

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

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

Medically necessary services or supplies are those covered services or supplies that are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease or its symptom.
- Within generally accepted standards of medical care it the community.
- Not solely for the convenience of the incurred, the insured's family, or the provider.

Nothing precludes an insurer from paring the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

Mental health disorder

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

Negotiated charge

See *How your 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**.

Partial hospitalization treatment

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

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

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

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 provider** (**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 **provider** who:

- The directory lists as a **PCP**
- Is selected by you from the list of **PCP**s 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 related disorders**).

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

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

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

- For residential treatment programs treating **mental health disorders**:
  - A **behavioral health provider** must be actively on duty 24 hours/day for 7 days/week
  - The patient must be treated by a psychiatrist at least once per week
  - The medical director must be a psychiatrist
  - It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)
- For residential treatment programs treating **substance related disorders**:
  - A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
  - The medical director must be a **physician**
  - It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)
- For **detoxification** programs within a residential setting:
  - An R.N. must be onsite 24 hours/day for 7 days/week within a residential setting
  - Residential care must be provided under the direct supervision of a **physician**

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

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

Semi-private room rate

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

Service area

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

Sexual dysfunction

Any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

Skilled nursing facility

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

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

Skilled nursing facility does not include institutions that provide only:

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

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

Specialist

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

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

Surgery, surgical procedure
The diagnosis and treatment of injury, deformity, and disease by manual and instrumental means, such as:
- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution
- Otherwise physically changing body tissues and organs

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

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

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

North Carolina state mandated benefit

Covered services include the following North Carolina mandated benefits:

- Access to nonformulary drugs
- Alcoholism and drug abuse treatment
- Anesthesia and Hospital charges for dental procedures for certain individuals
- Autism Spectrum Disorders
- Bone Mass Measurement
- Certain clinical trials
- Cervical cancer screening
- Colorectal cancer screening
- Complications of pregnancy
- Congenital defects and anomalies
- Diabetes
- Emergency Services
- Hearing Aids
- Inpatient stays following a delivery of a baby
- Lymphedema
- Mammogram screening
- Mental Illness
- Newborn hearing screening
- Off label Prescription Drugs
- Ovarian cancer surveillance tests
- Prescription Drug Contraceptives or Devices
- Procedures involving any bone or joint of the jaw, face or head
- Prostate cancer screening
- Reconstructive breast surgery following a mastectomy

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.

Aetna Health Inc.

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	$1,500 per year
Family	$3,000 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	$7,800 per year
Family	$15,600 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**

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.

Allergy injections

Description	Network
Without a **physician** or **specialist** office visit	Cost share same as **PCP** or **specialist** office hours visit under **Physician** services

Allergy testing and treatment

Description	Network
At a **physician** or **specialist** office	Cost share same as **PCP** or **specialist** office hours visit under **Physician** services

Ambulance service

Description	Network
Emergency ambulance	25% after **deductible**
Non-emergency ambulance	25% after **deductible**

Applied behavior analysis

Description	Network
Applied behavior analysis	25% after **deductible**

Autism spectrum disorder

Description	Network
Physical therapy, occupational therapy, and speech therapy for autism spectrum disorder	25% after **deductible**

Behavioral health

Mental health disorders and **substance related 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)	$30 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 (Includes **telemedicine** consultation) after you meet your **deductible**, if you have one	25% after **deductible**

Durable medical equipment (DME)

Description	Network
DME	50% after **deductible**
Limit	Includes 1 orthotic device for positional plagiocephaly per lifetime.

Emergency services

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

Description	Network
Hospital emergency room	25% after **deductible**

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	25% after **deductible**

Hearing aids

Description	Network
Hearing aids	50% after **deductible**
Limit	Coverage is limited to 1 per ear every 36 months.

Home health care

Description	Network
Outpatient	$30 no **deductible** applies

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. Services must be provided within 10 days of discharge.

Hospice care

Description	Network
Inpatient services	25% after **deductible**
Outpatient services	25% after **deductible**

Hospital care

Description	Network
Inpatient services	25% after **deductible**

Infertility services-Advanced reproductive technology (ART)

Description	Network
ART	Cost share based on type of service and where it is received
Maximum per lifetime Lifetime means any **covered services** paid under this plan, another plan with Aetna or plan associated with us, with the same policyholder	3

Jaw joint disorder

Description	Network
Jaw joint disorder treatment	Cost share based on type of service and where it is received

Maternity and related newborn care

Description	Network
Inpatient delivery services and postpartum care	25% after **deductible**
In a facility or at a **physician** office	25% after **deductible**

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.

Medical injectables

Description	Network
Medical injectables	25% after **deductible**

Obesity (bariatric) surgery

Description	Network
Obesity (bariatric) **surgery**	50% after **deductible**

Outpatient surgery

Description	Network
At a **hospital** outpatient department	25% after **deductible**
At a facility that is not a **hospital**	25% after **deductible**

Physician services

PCP

Description	Network
Office hours visit (not surgical and not preventive care) (includes **telemedicine** consultation)	$30 no **deductible** applies

Specialist

Description	Network
Office hours visit (not surgical) (includes **telemedicine** consultation)	$60 no **deductible** applies

Physician surgical services

Description	Network
Inpatient surgical services	25% after **deductible**
Outpatient surgical services	25% after **deductible**
Office surgical services	25% after **deductible**

Prescription drugs – outpatient

Tier 1 – preferred and non-preferred generic prescription drugs

Description	Network
For each 30 day supply filled at a **retail pharmacy**	$15 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**	$37.50 no **deductible** applies

Tier 2 – preferred brand-name prescription drugs

Description	Network
For each 30 day supply filled at a **retail pharmacy**	$30 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**	$75 no **deductible** applies

Tier 3 – non-preferred brand-name prescription drugs

Description	Network
For each 30 day supply filled at a **retail pharmacy**	$60 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**	$150 no **deductible** applies

Tier 4 – specialty prescription drugs

Description	Network
For each 30 day supply filled at a **specialty pharmacy**	$250 no **deductible** applies

Anti-cancer prescription drugs taken by mouth

Description	Network
For each 30 day supply	$0 after any applicable **deductible**

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 female 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, 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.

Diabetic supplies and insulin

Description	Network
For each 30 day supply filled at a **retail pharmacy**	Paid according to the tier of drug above
For each 30 day supply of preferred generic or preferred brand-name diabetic supplies and insulin filled at a **retail pharmacy**	$25
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	Paid according to the tier of drug above
For all fills of preferred generic or preferred brand-name diabetic supplies and insulin greater than a 30 day supply but no more than a 90 days supply filled at a **mail order pharmacy**	$75

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 *Contact us* section of the policy.

Tobacco cessation prescription and over-the-counter drugs

Description	Network
For each 30 day supply filled at a **retail pharmacy** Cost share only includes **generic prescription drugs** when there is also a brand-name drug available.	$0 no **deductible** applies for the first two 90-day treatment programs. Additional treatment programs will be paid according to the tier of drug above.
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 tobacco cessation **prescription** drugs and OTC drugs, see the *Contact us* section of the policy.

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.

Preventive care

Description	Network
Preventive care	0% no deductible applies
Breast feeding counseling and support limit	6 visits per 12 months in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	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
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump
Counseling for alcohol or drug misuse visit limit	5 visits every 12 months
Counseling for risk for breast and ovarian cancer	Not subject to any age or frequency limitations
Counseling for obesity, healthy diet visit limit	Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling
Counseling for sexually transmitted infection visit limit	2 visits every 12 months
Counseling for tobacco cessation visit limit	8 visits every 12 months
Family planning services (female 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

Description	Network
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 *Preventive care, Prenatal care* 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: • 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

Private duty nursing

Description	Network
Private duty nursing	50% after **deductible**

Prosthetic devices

Description	Network
Prosthetic devices	50% after **deductible**

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	$30 no **deductible** applies

Short-term rehabilitation therapy services

A visit is equal to no more than 1 hour of therapy. Therapy visit limits (physical, occupational, and spinal manipulation) are combined.

Outpatient physical therapy

Description	Network
Physical therapy	$30 no **deductible** applies
Visit limit per year	30

Outpatient occupational therapy

Description	Network
Occupational therapy	$30 no **deductible** applies
Visit limit per year	30

Outpatient speech therapy

Description	Network
Speech therapy	$30 no **deductible** applies
Visit limit per year	30

Spinal manipulation

Description	Network
Spinal manipulation	$30 no **deductible** applies
Visit limit per year	30

Skilled nursing facility

Description	Network
Inpatient services	25% after **deductible**
Limit	Coverage is limited to 90 days per calendar year.

Tests, images and lab – outpatient

Diagnostic complex imaging services

Description	Network
At a facility	25% after **deductible**
At a **physician** office	25% after **deductible**
At a **specialist** office	25% after **deductible**

Diagnostic lab work

Description	Network
At a facility	25% after **deductible**
At a **physician** office	25% after **deductible**
At a **specialist** office	25% after **deductible**

Diagnostic radiological services (X-ray)

Description	Network
At a facility	25% after **deductible**
At a **physician** office	25% after **deductible**
At a **specialist** office	25% after **deductible**

Therapies

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

Description	Network (GCIT-designated facility/provider)
Services and supplies	Not Covered

Outpatient infusion therapy

Description	Network
In a **physician** office or in a person's home	$60 no **deductible** applies
In an outpatient facility	25% after **deductible**

Transplant services

Description	Network (Exchange IOE facility)	Out-of-network (Includes Aetna's **network providers** who are not Exchange IOE **providers**)
Services and supplies	25% after **deductible**	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**	$45 no **deductible** applies

Virtual primary care

Description	Network
Preventive care consultations	0% no **deductible** applies
Other medical services consultations	0% no **deductible** applies
Routine physical exam limit	1 exam every 12 months

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)	$10 no **deductible** applies
Visit limit per year	1

Vision care services and supplies

Description	Network
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	$10 no **deductible** applies

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. Coverage does not include the office visit for contact lenses fitting.

Voluntary sterilization

Description	Network
Vasectomy	25% after **deductible**

Walk-in clinic visits

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

Description	Designated network	Non-designated network
Non-emergency services	$0 no **deductible** applies	$30 no **deductible** applies
Telemedicine consultation for non-emergency services	0% no **deductible** applies	Cost share based on type of service and where it is received
Preventive care immunizations and preventive screening and counseling services (Includes **telemedicine** consultation) See the *Preventive care* section for more information	0% no deductible applies	0% no deductible applies