

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.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Cushitic-Oromo	Tajaajiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎች ላይ ያለውን ቁጥር ይደውሉ።

Aetna Life Insurance Company



Missouri Notice of Protection Provided by Missouri Life and Health Insurance Guaranty Association

This notice provides a *brief summary* of the Missouri Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Missouri law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Missouri law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are as follows:

- Life Insurance
 - \$300,000 in death benefits
but not more than \$100,000 in net cash surrender and net cash withdrawal values
- Health Insurance
 - \$500,000 for health plans
 - \$300,000 in disability insurance benefits
 - \$300,000 in long-term care insurance benefits
 - \$100,000 in other types of health insurance benefits
- Annuities
 - \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

- \$300,000 in aggregate for all types of coverage listed above, with the exception of health benefit plans
- \$500,000 in aggregate for health benefit plans
- \$5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons "Health benefit plan" is defined in section 376.718, RSMo.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Missouri law.

Benefits provided by a long term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the basic life insurance policy or annuity contract to which it relates.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at <https://www.mo-iga.org/>, or contact:

Missouri Life and Health	Missouri Department of Insurance, Financial
Insurance Guaranty Association	301 West High Street, Room 530
2210 Missouri Boulevard	Jefferson City, Missouri 65101
Jefferson City, Missouri 65109	Fax: 573-634-8488
Ph.: 573-634-8455	Ph.: 573-522-6115
Ph.: 573-522-6115	

Insurance companies and agents are not allowed by Missouri law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Missouri law, then Missouri law will control.



Exclusive provider organization (EPO) policy

2025 MO Bronze 4 Advanced: EPO AI/AN CSR \$0

Important note:

This EPO plan only provides coverage when **covered services** are received from a **network provider**, except for **emergency services**., two (2) mental health visits or **covered services** that have been approved and authorized by us. Otherwise, this plan does not provide coverage when services are received from **out-of-network providers** . If you have questions, refer to the *How your policy works – Medical necessity and precertification* section.

This policy is by and between Aetna Life Insurance Company (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 Life Insurance Company (Aetna). Aetna is part of the CVS Health family of companies.

Read your policy carefully

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

Right to examine the policy

You have 10 days after you receive this policy to read and review it. During that 10-day period, if you decide you don't want the policy, you may return it to us or to the agent who sold it to you. As soon as it is returned, this policy will be void from the beginning. Premium paid will be paid back.

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.

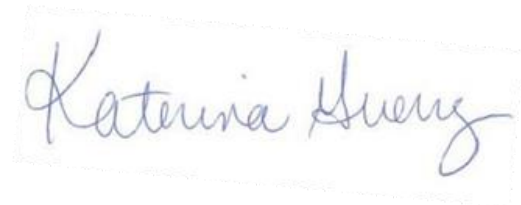
You may keep this policy in force by meeting the policy requirements and by paying the premium on time. See the *What does the policy cost you?* section for more information.

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 the Federal Marketplace, 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.

A handwritten signature in blue ink that reads "Katerina Guerraz". The signature is written in a cursive style and is enclosed within a faint, light-colored rectangular border.

Katerina Guerraz
Executive Vice President, Chief Operating Officer
Aetna Life Insurance Company
(A Stock Company)

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Welcome

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

Welcome to Aetna.

Introduction

This is your 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.

Important note:

We will not deny or refuse to issue coverage on, contract with, renew, reissue, or otherwise terminate or restrict coverage on you or you dependent(s) because you or your dependent(s) is diagnosed with autism spectrum disorder or developmental or physical disabilities.

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 voluntary programs, including but not limited to financial wellness programs; utilize tools, improve your health metrics, or continue participation as an Aetna member through incentives. These are not covered benefits under the plan, but are separate components which are not guaranteed and could be discontinued at any time. 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

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 and grievance 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. This policy will remain in force during the grace period. 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 ("reinstatement") the policy without a break in coverage. You must ask us to do so within 30 days of the policy end date. But, for us to do this, you must pay us the total premium you already owe plus the new premium. We can decide not to reinstate the policy.

Premium agreement

Your premium rate will not change during the policy term as long as there are no changes to this policy. Any premium rate change, however, will not be applied more frequently than annually or as allowed by applicable law. 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 insurance coverage for many kinds of **covered services**, such as a doctor's care and **hospital stays**, but some services aren't covered at all or are limited. For other services, the policy pays more of the expense. For example:

- **Physician** care generally is covered but **physician** care for cosmetic **surgery** is never covered. This is an exclusion.
- Home health care is generally covered but it is a **covered service** only up to a set number of visits a year. This is a limitation that appears in your schedule of benefits.
- Your **provider** may recommend services that are considered **experimental, 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 design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior.

This includes the use of:

- Direct observation
- Measurement
- Functional analysis of the relationships between environment and 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 as a neurobiological disorder, an **illness** of the nervous system that includes:

- Asperger's syndrome
- Autistic disorder
- Childhood disintegrative disorder
- Pervasive developmental disorder (not otherwise specified)
- Rett's syndrome

Covered services include services and supplies provided by a **physician**, psychologist, or **behavioral health provider** (including, but not limited to, a psychiatrist, autism service provider, or line therapist) for the diagnosis and treatment of autism spectrum disorder or developmental or physical disability, including:

- The diagnosis – assessments, evaluations, or tests to diagnose an of autism spectrum disorder or developmental or physical disability
- Psychiatric and psychological services – direct or consultative services provided by a licensed psychiatrist or psychologist
- Habilitative or rehabilitative care – professional counseling and guidance services, and treatment programs, including applied behavior analysis therapy, that are necessary to develop the functioning of an individual
- Therapeutic care – physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder or developmental or physical disability
- Medication (covered under your pharmacy benefit) used to address symptoms of autism spectrum disorder or a developmental or physical disability and any health related services to determine the need or effectiveness of the medications
- Equipment related to care

An autism service provider is a person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri, or any person who is licensed under Missouri law as a board-certified behavior analyst by the behavior analyst certification board or licensed under Missouri law as an assistant board-certified behavior analyst.

A line therapist is an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.

A developmental or physical disability is a severe chronic disability that:

- Is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness or autism spectrum disorder which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services
- Manifests before the individual reaches age 19
- Is likely to continue indefinitely
- Results in substantial functional limitations in 3 or more of the following areas of major life activities:
 - Self-care
 - Understanding and use of language
 - Learning
 - Mobility
 - Self-direction
 - Capacity for independent living

We will only cover this treatment if a **physician**, psychologist, or **behavioral health provider** orders it as part of a treatment plan that details the treatment and specifies frequency and duration. At our expense, we have the right to review that treatment plan. We will not review this more than once every 6 months unless the treating **physician** or psychologist agrees a more frequent review is necessary.

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 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)

Mental health important note:

Any **precertification**, if applicable, is waived for at least two (2) outpatient sessions a year (including out-of-network behavioral health providers) for the purpose of diagnosis or assessment of mental health. This may include diagnosis and assessment by a licensed psychiatrist, licensed psychologist, licensed professional counselor, licensed clinical social worker, or a licensed marital and family therapist (subject to contractual provisions).

Substance related disorders treatment

Covered services include the treatment of **substance related disorders** provided by a **hospital, psychiatric hospital, residential treatment facility**, non-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, residential treatment facility**, or non-residential treatment facility,
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, residential treatment facility**, or non-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**.

Chiropractic care

Covered services include initial diagnosis and treatment of the diagnosed disorder. Diagnosis and treatment must be within the scope of the chiropractor’s license.

Chiropractic care important note:

We may require prior authorization or notification before any follow-up diagnostic tests are ordered by a chiropractor or for any office visits for treatment in excess of 26 visits per calendar year.

Clinical trials

Routine patient costs

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

The following are not **covered services**:

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

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** under an “approved clinical trial” only when you have cancer 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

Cancer clinical trials (routine patient costs)

Covered services include routine patient costs for drugs or devices that have been approved for sale by the FDA, regardless of whether approved for use in treating the particular condition, incurred by you from a **provider**, in connection with participation in a phase II, III or IV clinical trial. The purpose of the clinical trial is the prevention, early detection and treatment of cancer.

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

Routine care for phase II clinical trials must satisfy all of the following:

- Sanctioned by the National Institute of Health (NIH) or NCI
- Conducted at an academic or NCI center
- You are actually enrolled in the clinical trial and not merely following the protocol of a phase II clinical trial

Routine care for phase III and IV clinical trials must satisfy the following:

- The study or investigation is approved or funded by one or more of the following:
 - The NIH
 - Cooperative group or center of any of the entities described above
 - The Agency for Health Care research and Quality
 - The Centers for Medicare & Medicaid Services
 - The Department of Veterans Affairs
 - The Department of Defense
 - An institutional review board in Missouri that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with an implementation of regulations for the protection of human subjects; or
 - A qualified research entity that meets the criteria for NIH center support grant eligibility
- The treating facility and **provider** must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.
- The clinical trial **providers** obtained your informed consent to participate in the clinical trial and they did so by following legal and ethical standards

The following are not **covered services** under this benefit:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial (i.e. protocol-induced costs) and not used in the direct clinical management of the patient
- Services and supplies provided by the trial sponsor without charge to you
- The investigational item or service itself

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

Early intervention for infants and toddlers (First steps)

Covered services include:

- Physical therapy
- Occupational therapy
- Speech/language therapy
- Assistive technology

Coverage is only for a dependent child who:

- Qualifies for early intervention services under Part C of the Individuals with Disabilities Education Act
- Demonstrates developmental delays and other qualifying medical problems
- Receives services as part of an active individualized plan to enhance functional ability

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 or facility needed to treat the **emergency medical condition**. 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 or facility needed to treat the **emergency medical condition** 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
 - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select, and adjust or fit a hearing aid, including a post-fitting evaluation and subsequent adjustments

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
- Bereavement counseling

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.

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
- Ovulation induction with menotropins, intrauterine insemination, and any related services, products, or procedures
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, and any related services, products, or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)

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) and craniomandibular joint dysfunction (CMJ) syndromes
- The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)
- Removable appliances for TMJ repositioning

Maternity and related newborn care

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

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery
- No less than 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

If the mother is discharged earlier, the plan will pay for 2 post-discharge visits (at least one of which is in the home) by an R.N. with experience in maternal and child health nursing or a **physician**. The location and schedule of the post-discharge visits will be determined by the attending **physician**.

Covered services for these visits include, but are not limited to:

- Assessing the health of the newborn and mother
- Parent education
- Assistance and training in breast or bottle feeding
- Providing childhood immunizations education and services
- Performing any necessary and appropriate clinical tests
- The performance and submission of a metabolic specimen satisfactory to the state laboratory

Post-discharge home visits will not be subject to any home health care maximums.

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

The following are not **covered services**:

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

Nutritional support

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

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

The following are not **covered services**:

Any food item, including:

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

Outpatient surgery

Covered services include services provided and supplies used in connection with outpatient **surgery** performed in a **surgery** center or a **hospital’s** outpatient department. It includes administration of general anesthesia and hospital charges for dental care provided to the following covered persons:

- A child under the age of five
- A person who is severely disabled; or
- A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

Covered services also include the following oral **surgery** services:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia
- Orthognathic **surgery** for a physical abnormality that prevents normal function of the upper and/or lower jaw and to attain functional capacity of the affected part
- Oral/surgical correction of accidental injuries
- Treatment of non-dental lesions, such as removal of tumors and biopsies
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses

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**

Covered services also include a second opinion by a **specialist** in the field of medicine related to your newly diagnosed cancer condition.

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.

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.

We will notify you at least 30 days prior to any deletions (other than generic substitutions) in the **drug guide** that affect you. You will be notified either electronically or in writing upon your request.

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.

You will be responsible for only one **copayment** for a **prescription** drug if the required single dosage is unavailable and/or a combination of dosage amounts is needed to fill the **prescription**. Such **copayment** shall not apply to **prescriptions** in excess of any one month supply.

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.

After you obtain your first refill at a network **retail pharmacy**, you must tell us whether you want to use your network **mail-order pharmacy** benefit, a CVS pharmacy, a designated network pharmacy or continue to use your **retail pharmacy**. See the *Contact us* section for help. If you don't tell us your choice, the next **prescription** refill and any other refills at a network **retail pharmacy** will not be covered. You can tell us at any time that you intend to use a network **retail pharmacy** for future **prescription** refills.

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 after 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**.

Eye drop refills

Covered services include early refills of **prescription** eye drops prior to the last day of the prescribed dosage, as long as your **provider** authorizes the early refills and notifies us.

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.

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 to prevent the death of the female
- 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)
 - For which the cost is covered by a federal, state, or government agency , except for Medicaid (for example: Veterans Administration)
 - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care
 - Any treatment, device, drug, service, or supply to alter the body’s genes, genetic make-up, or the expression of the body’s genes 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
- Infertility
 - **Prescription** drugs used primarily for the treatment of infertility
- Injectables including:
 - Any charges for the administration or injection of **prescription** drugs
 - Needles and syringes, except those used for insulin administration
 - Any drug, which due to its characteristics, as determined by us, must typically be administered, or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting, with the exception of Depo Provera and other injectable drugs for contraception
- 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
- Missouri Department of Health and Senior Services for immunizations
- American Cancer Society
- American College of Radiology for breast cancer screenings

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

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

Important note:

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

Breast-feeding support and counseling services

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

Breast pump, accessories, and supplies

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

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

Counseling services

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

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

Family planning services –contraceptives

Covered services include family planning services as follows:

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

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
 - All forms of low-dose mammography, including digital mammography and breast tomosynthesis
 - Additional or supplemental screening and diagnostic imaging for the detection of breast cancer as provided for in the American College of Radiology guidelines for breast cancer screening. These may include, but are not limited to:
 - Diagnostic mammograms
 - Breast ultrasounds
 - Breast MRIs
- 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.
- Immunization guidelines as recommended by the Missouri Department of Health and Senior Services

- 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
- Testing for lead poisoning, including pregnant women
- For covered newborns, an initial **hospital** checkup, which includes:
 - Hearing screenings
 - Necessary re-screenings
 - Audiology assessments
 - Follow-up

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
- Wigs needed after cancer treatment (not to exceed one per year)

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

Covered services also include hearing aids provided to a newborn for initial amplification following a newborn hearing screening (including any necessary rescreening, audiological assessment and follow-up). See the *Preventive care – Routine physical exams* section.

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
 - Protheses

The reconstructive breast surgery and receipt of related protheses may follow a mastectomy at any time.

Reconstructive surgery and supplies

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

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
 - The defect results in severe facial disfigurement or major functional impairment of a body part
 - The purpose of the **surgery** is to improve function, or improve or change the appearance
- 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, or improve or change the appearance.
- Your **surgery** corrects significant deformities caused by earlier treatment and will improve function, or improve or change the appearance.

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

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

These dental related services are limited to:

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

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation services

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

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

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure** or help you maintain or prevent loss of function
- Occupational therapy, but only if it is expected to do one of the following:
 - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or **surgical procedure**
 - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, 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.aetnacshealth.com> 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 provided by a **physician** and **hospital**.

This includes the following transplant types:

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

Network of transplant facilities

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

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

Important note:

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

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

The following are not **covered services**:

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

Transplant transportation and lodging

We will cover the cost of reasonable and necessary travel expenses when you get prior approval. You need to travel more than 75 miles from your residence to reach the facility where the covered transplant procedure will be performed. We will help you with travel expenses for:

- Transportation to and from the facility
- Lodging for the patient and one companion
- Lodging for the patient and two companions if a minor is receiving the treatment

You must submit itemized receipts for all expenses when filing claims.

For lodging and ground transportation benefits, we will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code 213(d)(2)(B). If you need help or more information, see the *Contact us* section.

Transplant transportation and lodging important note:

To endure coverage, you and your **physician** must obtain **precertification** of all transportation and lodging services. Contact us for assistance.

See the schedule of benefits for details about transplant transportation expense maximums.

The following are not **covered services**:

- Childcare
- Mileage within the medical transplant facility city
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us
- Frequent Flyer miles
- Coupons, vouchers, or travel tickets
- Prepayments or deposits
- Services for a condition that is not directly related to, or a direct result of, the transplant
- Telephone calls
- Laundry
- Postage
- Entertainment
- Interim visits to a medical care facility while waiting for the actual transplant procedure
- Travel expenses for donor companion/caregiver
- Return visits for the donor for a treatment of a condition found during the evaluation
- Meals

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

The following are not **covered services**:

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

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
- Non-conventional **prescription** contact lenses for the following conditions:
 - Aniridia
 - Aniseikonia
 - Anisometropia of 3D or more
 - Aphakia
 - Corneal disorders
 - High Ametropia exceeding -12D or +9D in spherical equivalent
 - Irregular astigmatism
 - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using conventional lenses
 - Pathological myopia
 - Post-traumatic disorders
 - When your vision can be corrected 3 lines of improvement on the visual acuity chart when compared to best corrected conventional lenses

Prescription lenses include choice of:

- Glass or plastic lenses
- All lens powers (single vision, bifocal, trifocal, lenticular)
- Standard progressive lenses
- Fashion and gradient tinting
- Oversized and glass-grey #3 **prescription** sunglass lenses

Additional lens options include:

- Polycarbonate lenses (if not child, monocular or prescription > +/-6.00 diopters)
- Blended segment lenses
- Intermediate vision lenses
- Premium Progressives (Varilux®, etc.)
- Photochromic glass lenses
- Plastic photosensitive lenses (Transitions®)
- Polarized lenses
- Standard Anti-Reflective (AR) coating
- Premium AR coating
- Ultra AR coating
- Ultra AR coating
- Hi-index lenses
- Ultraviolet protective coating

The following are not **covered services**:

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

Walk-in clinic

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

- Scheduled and unscheduled visits for illnesses and injuries that are not **emergency medical conditions**
- Preventive care immunizations administered within the scope of the clinic's license
- **Telemedicine** consultation
- 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 to prevent the death of the female

Abortion drugs

Drugs used for elective termination of pregnancy except to prevent the death of the female

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, except for the treatment of autism spectrum disorder
- 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

Chiropractic care

- Services beyond the scope of the chiropractor's license
- Preventive care services
- Service for examination and/or treatment of strictly non-neuromusculoskeletal disorders

Cosmetic services and plastic surgery

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

Court-ordered 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, except for the treatment of autism spectrum disorders.

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

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

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

The following are not **covered services**:

- Therapies and treatments including:
 - Cellular immunotherapies.
 - Genetically modified viral therapy.
 - Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.
 - All human gene therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
 - Luxturna® (Voretigene neparvovec)
 - Zolgensma® (Onasemnogene abeparvovec-xioi)
 - Spinraza® (Nusinersen)
 - Products derived from gene editing technologies, including CRISPR-Cas9.
 - Oligonucleotide-based therapies. Examples include:
 - Antisense. An example is Spinraza (Nusinersen).
 - siRNA.
 - mRNA.
 - microRNA therapies.
- All associated services when GCIT services are not covered. Examples include:
 - Infusion
 - Lab
 - Radiology
 - Anesthesia
 - Nursing services

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the IOE programs.

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

Growth/height care

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

Hearing exams

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

Maintenance care

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

Medical supplies – outpatient disposable

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

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

Missed appointments

Any cost resulting from a canceled or missed appointment

Obesity (bariatric) surgery and services

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

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

Other non-covered services

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

Other primary payer

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

Personal care, comfort, or convenience items

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

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

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

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

Important note:

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

How your policy works

How your policy works while you are covered

Your coverage 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** can 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 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.
- 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 **PCPs** in our directory.

Each covered family member is encouraged to select a **PCP**. You may each choose a different **PCP**. You should select a **PCP** for your covered dependent if they are a minor or 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. 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.

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**.

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.

If your **provider** requests **precertification** and we approve coverage, we will not change our decision, except if you intentionally misrepresent your health condition, or if your plan or coverage ends before the **covered services** are provided.

If your **provider** requests **precertification** and we don't approve your coverage, we will tell you why, by telephone or electronically, within 24 hours of our decision and explain how you or your **provider** may request a review of our decision. See the *Complaints and grievance procedures* section. We will send you and your **provider** written or electronic confirmation of this notification within one working day of our decision.

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.aetnacvshealth.com>
- Submit the request in writing to:
CVS Health
ATTN: Aetna PA
1300 E Campbell Road
Richardson, TX 75081

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

What the policy pays and what you pay

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

The general rule

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

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

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

Negotiated charge

For health coverage:

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

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

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

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

Some of these arrangements are called:

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

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

*For **prescription drug services**:*

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

Surprise bill

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

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

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

- Non-emergency services provided by an **out-of-network provider** at an in-network facility, except when the **out-of-network provider** has given you the following:
 - The out-of-network notice for your signature
 - 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.

Utilization review – claims decisions

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

For the purposes of this section, any reference to “you” and “your” also refers to an authorized representative or **provider** designated by you to act on your behalf.

Emergency care claim

An emergency claim is one that involves **emergency services** necessary to screen and stabilize you and does not require prior authorization. When you receive an **emergency service** that requires immediate post-evaluation or post-stabilization services, we will make a decision within 60 minutes. If we do not make the decision within 60 minutes, the services will be deemed approved.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. We will make a decision within 36 hours (which shall include one working day) of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. “Necessary services” includes the results of any face-to-face clinical evaluation or second opinion that may be required to make our decision.

In the case of a determination to certify an admission, procedure, or service, we will notify the **provider** rendering the service, by telephone or electronically, within 24 hours of making the certification. We will also provide written or electronic confirmation to you and the **provider** within 2 working days of making the certification.

In the case of an adverse determination, we will notify the **provider** rendering the service, by telephone or electronically, within 24 hours of making the adverse determination. We will also provide written or electronic confirmation to you and the **provider** within one working day of the adverse determination.

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 of receiving all necessary information. We will provide written notice of our decision to you within 10 working days of our determination.

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 one working day of receiving all necessary information.

In the case of a determination to certify an extended stay or additional services, we will notify the **provider** rendering the service, by telephone or electronically, within one working day of making the certification. We will also provide written or electronic confirmation to you and the **provider** within one working day of making our decision. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an adverse determination, we will notify the **provider** rendering the service, by telephone or electronically, within 24 hours of making the adverse determination. We will also provide written or electronic confirmation to you and the **provider** within one working day of making our decision.

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. If we deny your request for a concurrent care claim extension, we will notify you of such a determination. You will have enough time to file a grievance of an adverse determination. Your coverage for the service or supply will continue until you receive a final grievance decision from us or an external review by an independent 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 grievance, you will be responsible for all of the expenses for the service or supply received during the continuation period.

If we already approved **covered services** under this plan, we would not change our decision except if you intentionally misrepresented your health condition, or the plan or your coverage ends before the **covered services** are provided.

Timely access to review

Contact us if you or your provider need to contact Aetna's review staff.

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, send it to us as soon as possible. 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. Failure to send us notice of proof within such time will not invalidate nor reduce any claim. You must send it to us as soon as reasonably possible with a claim form that you can either get online or contact us to provide. If you are unable to complete a claim form, you must send us a description of the services, the bill of charges, and any medical documentation you received from your **provider**. You should always keep your own record of the date, **providers**, and cost of your services.

We will send you a claim form within 15 days after we receive your notice of a claim. If we do not send you a claim form within those 15 days, you will automatically be considered to have met the proof of loss requirements. You should always keep your own record of the date, **provider**, 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 processing days after we receive your filed claim, or as soon as we receive all the information necessary to support the claim.

Adverse benefit determination

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 would want the money back. Any time we don't pay even part of the claim, that is an "adverse benefit determination" or "adverse decision". It is also an adverse benefit determination if we deny your request for:

- An admission
- Availability of care
- Concurrent claim extension
- Other health care service or supply

because we determined, based upon the information provided, it does not meet our requirements for **medical necessity**, appropriateness, healthcare setting, level of care or effectiveness, or are **experimental** or **investigational**.

We will give you our decision in writing. This will include the main reason(s) for the determination. It will also include instructions for submitting a grievance or reconsideration of the determination, and of requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. You may not agree with our decision. There are several ways to have us review the decisions. See the *Complaints and grievance procedures* section for that information.

Complaints and grievance procedures

For the purpose of this section, any reference to “you” or “your” also refers to an authorized representative or **provider** designated by you to act on your behalf.

The difference between a complaint and a grievance

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. We will review your complaint as quickly as possible. Complaints are resolved on an informal basis

Grievance

A grievance is a written complaint when you are unhappy about:

- The availability, delivery, or quality of service you received
- An adverse benefit determination
- Claim payment, handling, or reimbursement for services
- The contractual relationship between you and us

Your grievance should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know in writing within 10 working days that we received your grievance.

Grievance procedures

You can ask in writing us to review your grievance. This is the internal grievance process.

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

You can send your written grievance 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 grievance
- Any other information you would like us to consider

We will let you know in writing within 10 working days that we received your grievance.

We will conduct a complete review of the grievance within 15 calendar days after we receive a pre-service grievance or 20 working days after we receive a post-service grievance unless the review cannot be completed within this time. If more time or information is needed to make the determination, we will notify you in writing on or before the 20th working day and the review will be completed within 30 working days thereafter. The notice will include specific reasons why additional time is needed for the review.

Within 5 working days after the review is complete, the individual not involved in the circumstances that lead to your grievance or its review will decide upon the appropriate resolution and notify you in writing of our decision and your right to file a grievance for a second review. The notice will explain this decision, in terms that are clear and specific, and your right to file a grievance. You will be notified of the decision within 15 working days after the review is completed.

If you are unhappy with our decision, you may at any time contact the Missouri Department of Commerce and Insurance (DCI), at:

Missouri DCI
Division of Consumer Affairs
P.O. Box 690
Jefferson City, Missouri 65102-0690
Consumer Hotline: 800-726-7390
TDD: 573-526-4536

Expedited grievance review

You may request the grievance process be expedited if the time frames of the standard grievance procedures would seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of your physician, would cause you severe pain which cannot be managed without the requested services. A request for an expedited grievance review may be submitted orally or in writing.

We will notify you orally within 72 hours after receiving the expedited review request. We will send written confirmation to you within 3 working days.

External review

External review is a review done by people in an organization outside of Aetna. This is called an independent review organization (IRO).

You may request an external review if:

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

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

You do not have to exhaust our internal grievance process before you can request an external review. If you wish to pursue an external review, you may write to the Missouri Department of Commerce and Insurance (DCI) at:

Missouri DCI
Division of Consumer Affairs
P.O. Box 690
Jefferson City, Missouri 65102-0690

Include any information or documentation to support your request. If you have any questions or concerns during the external review process, you can call the DCI's Consumer Affairs Hotline at 800-726-7390.

The Consumer Affairs Division ("Division") will review your grievance as any other consumer complaint. The Division will contact us and request our decision in writing and all supporting documentation. The Division will first review the matter to determine if they can resolve the issue instead of referring to the IRO. However, if the grievance remains unresolved after exhausting the Division's consumer complaint process, then the Director shall refer the unresolved grievance to an IRO to perform an independent review of your claim. Unresolved grievances include a difference in opinion between the treating health care professional and us concerning:

- Appropriateness
- Effectiveness of the health care service
- Health care settings
- Level of care
- **Medical necessity**

If the claim is eligible for external review, the Division will notify you and us. You and we will have 15 working days to provide any additional medical information that you and we wish to have reviewed and considered. All additional information must be received by the Division in writing.

The IRO will:

- Assign the grievance to one or more independent clinical reviewers that have proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your policy of benefits
- Notify the Director of its opinion within 20 calendar days of receiving your grievance

The IRO may request additional time for its investigation, but not more than 5 calendar days.

How long will it take to get an ERO decision?

After the Director receives the IRO's opinion, the Director will issue a decision which shall be binding on you and us, with limited exceptions for judicial review. The Director's decision will be in writing and provided to you and us within 25 calendar days of receiving the IRO's opinion. At no time will the IRO decision take longer than 45 calendar days from the date the IRO receives your request for an external review, and all the information to be considered, to the date you and we are notified of the Director's decision.

Sometimes you can get a faster IRO decision. You must call us or the Division as soon as possible.

You may be able to get a faster external review for an adverse decision if a delay in receiving health care services would:

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

- The adverse determination concerns an admission, availability of care, continued **stay** or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you and we will receive a decision from the Director within 72 hours of the IRO getting your request. If the decision is not in writing, the Director will send you and us the written decision within 48 hours after the notification.

Recordkeeping

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

Fees and expenses

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

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 or 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 or within the service area)
 - Grandchildren in your court-ordered custody
 - Any children approved by the Exchange

We will not refuse to enroll your child because the child:

- Was born out of wedlock
- Is not claimed as a dependent on your federal income tax return
- Does not live with you or within the **service area**

You can enroll your dependent:

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

A dependent must 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 within 60 days of birth
 - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional premium for the covered dependent
 - If you miss this deadline, your newborn will not have benefits after the first 31 days
 - You can request an enrollment form by calling us. When you tell us of your newborn's birth, we will give you an additional 10 days from the date we provide the enrollment form to enroll you newborn child.
- 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 in the physical custody of the adoptive parent:
 - The Exchange must receive your completed enrollment information 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:
 - From the date of birth if a petition for adoption is filed within 30 days of birth
 - From the date of placement for the purpose of adoption if a petition for adoption is filed within 30 days of placement
- A foster child – You may put a foster child on your policy when the child is placed in foster care. A foster child is a child whose care, comfort, education, and upbringing is left to persons other than the natural parents:
 - The Exchange must receive your completed enrollment information within 60 days after the date the child is placed with you
 - Benefits for your foster child will begin on the date you legally become a foster parent or the first day of the month following this event
- A stepchild - You may put a child of your spouse or domestic partner on your policy:
 - You must complete your enrollment information and send it to the Exchange within 60 days after the date of your marriage or 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; or
 - Is an American Indian or Alaskan Native
- You or your dependent are enrolled in any non-calendar year group health plan, individual health insurance coverage, or qualified small employer health reimbursement arrangement.
- You 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 will end if:

- 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 will end if:

- 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 for any number of reasons – for some reasons we will give you notice before cancelling your coverage, for other reasons we may end your coverage immediately. Cancellation will be without prejudice to any expense originating prior to the effective date of cancellation. An expense will be considered incurred on the date the medical care or supply is received.

We will give you 31 days advance written notice if we end your coverage because you failed to make any required payment which you are obligated to pay.

In addition, we will give you written notice (or such longer notice period as applicable law requires):

- 90 days if we cease to offer the product line provided by this policy
- 180 days written notice if we act as required by applicable law for uniform termination of coverage

We may immediately end your coverage if you commit fraud or make an intentional misrepresentation of material fact 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 mainly on you for support

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

We may ask you to send us proof of the disability and dependency at least 31 days after the date your child reaches the plan age limits. 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 at least 31 days of our request. If you don't, we can end coverage for your dependent child.

How you can continue coverage if you are in the military and called to active duty

If you are called into active duty, you may choose to continue health coverage for yourself and your dependents by notifying us in advance and paying any required contribution for health coverage.

Your coverage will end on the date that you or your dependents enter into active military services and request termination of coverage. If you choose to cancel coverage, upon notice to us of the cancellation, the pro rata unearned premiums will be refunded.

You will be given the opportunity to reinstate your coverage for you and your dependents after discharge from the military without evidence of insurability.

How you can extend coverage for hearing services and supplies when coverage ends

Your policy will cover hearing services and supplies within 30 days after your coverage ends if:

- The **prescription** for the hearing aid is written in the 30 days before coverage ended
- The hearing aid is ordered during the 30 days before the date coverage ends

How you can extend coverage for vision care services and supplies when coverage ends

Your policy will cover vision services and supplies for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete vision exam was performed in the 30 days before your coverage ended, and the exam included refraction
- The exam resulted in contact or frame lenses being prescribed for the first time, or new contact or frame lenses ordered due to a change in **prescription**

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.

Interpretation of this policy is subject to the *Complaints and grievance procedures* section when we administer your coverage.

Following the law

If, on the policy's effective date, language in the policy is different from a law that applies to it, the policy will follow applicable law.

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. Changes can only be made through a written authorization signed by an officer of Aetna. No change will be made to this policy unless made by an amendment or a rider that is issued by us. 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 an agent or 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.

Except for fraud, all statements made by you are considered representations and not warranties. No statement will void this policy or reduce the benefits after the coverage has been in force for 2 years from its effective date, unless the statement was in a written application or enrollment form signed by you, and you received a copy of the application or enrollment form.

If you made a misstatement about your age, we may make a fair change in premium contribution when we learn of the mistake. If we do, we will tell you what the mistake was. We will also change the premium to be equal to the amount that the premium would have been if purchased at the actual age or under the actual condition when this policy was issued.

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 would 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 submit a grievance with Aetna
- 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 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. We will not, however, request a refund or offset against a claim more than 12 month after paying the claim, except in cases of fraud or intentional misrepresentation by the **provider**.

Effect of benefits under other policies

When you are enrolled in Medicare

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

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

Workers' compensation

If benefits are paid by us and we determine you received workers' compensation benefits for the same event, we have the right to get back the payment we made ("recover"). We will work to recover the money from you.

These recovery rights will be applied even though:

- The workers' compensation benefits are in dispute or are made by means of settlement or compromise
- No final determination is made that bodily injury or illness was sustained in the course of, or resulting from, your employment

- The amount of workers' compensation due to medical or health care is not agreed upon or defined by you or the workers' compensation carrier
- The medical or health care benefits are specifically excluded from the workers' compensation settlement or compromise

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

Non-duplication of benefits

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

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

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

Deductible

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

Designated network provider

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

Detoxification

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

Drug guide

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

Emergency medical condition

An acute, sudden and unexpected medical condition, regardless of the final diagnosis that is given, that:

- Needs immediate medical care
- Leads a person with average knowledge of health and medicine to believe that, without immediate medical care, it could result in:
 - Danger to life or health
 - Loss of a bodily function
 - Loss of function to a body part or organ
 - Pain that cannot be controlled
- Endangering the health and safety of a woman in labor or her unborn baby if transfer is attempted, or there is not enough time to transfer to another **hospital** before delivery

Emergency services

Treatment given in a **hospital's** emergency room or an independent freestanding emergency department by an appropriate **provider**. This includes, but shall not be limited to, a health care item or service for the 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**.

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. This is a place that offers medical care under the supervision of a staff of one or more licensed **physicians** and provide 24-hour nursing service by registered nurses (R.N.) on duty or call. 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 care unit

A **hospital** permanently equipped and staffed to provide care that is more extensive for critically ill or injured patients than available in other **hospital** rooms or wards. Care includes close observation by trained and qualified personnel whose duties are primarily confined to the part of the **hospital** for which an additional charge is made.

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

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

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

Generally accepted standards of medical practice means:

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

Important note:

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

Mental health disorder

A **mental health disorder** is any condition or disorder defined 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**.

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.

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.

A prior authorization review, also called a “Utilization review”, is performed before we make a determination. This review is a formal evaluation (pre-service, concurrent or post-service) of the **medical necessity**, effectiveness, efficiency, or appropriateness of the requested service, treatment or setting. See the *How your plan works – Utilization review-claim decisions* section for more information.

Prescription

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

Primary care provider (PCP)

A **provider** who:

- The directory lists as a **PCP**
- Is selected by you from the list of **PCPs** in the directory
- Supervises, coordinates, and provides initial care and basic medical services to you
- Initiates **referrals** for **specialist** care, if required by the 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.

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

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.

Schedule of benefits

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

How your cost share works

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

Important note:

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

Contact us

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

Plan features

Deductible

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

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

Individual deductible

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

Family deductible

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

Maximum out-of-pocket limit

Maximum out-of-pocket limit	Network
Individual	\$0 per year
Family	\$0 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	\$0 no deductible applies

Allergy testing and treatment

Description	Network
At a physician or specialist office	\$0 no deductible applies

Ambulance service

Description	Network
Emergency ambulance	\$0 no deductible applies
Non-emergency ambulance	\$0 no deductible applies

Applied behavior analysis

Description	Network
Applied behavior analysis	\$0 no deductible applies

Autism spectrum disorder

Coverage is not subject to any age or benefit limits.

Description	Network
Physical therapy, occupational therapy, and speech therapy for autism spectrum disorder	\$0 no deductible applies

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)	\$0 no deductible applies
Other outpatient services including behavioral health services in the home, partial hospitalization treatment, non-residential treatment, and intensive outpatient program	\$0 no deductible applies
The cost share does not apply to network peer counseling support services (Includes telemedicine consultation) after you meet your deductible , if you have one	

Chiropractic care

The cost share for a single chiropractic service will not be more than 50% of the **negotiated charge** for that service. The plan **deductible**, if any, applies.

Description	Network
Chiropractic care	\$0 no deductible applies

Durable medical equipment (DME)

Description	Network
DME	\$0 no deductible applies

Early intervention for infants and toddlers (First Steps)

Coverage is limited to covered persons through age 2.

Description	Network
Early intervention for infants and toddlers (First Steps)	\$0 no deductible applies

Emergency services

A separate **hospital** emergency room cost share will apply for each visit to an emergency room or facility needed to treat the **emergency medical condition**.

Description	Network
Hospital emergency room or facility needed to treat the emergency medical condition	\$0 no deductible applies

Emergency services important note:

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

Habilitation therapy services

Description	Network
Physical, occupational, and speech therapies	\$0 no deductible applies

Hearing aids

Description	Network
Hearing aids	\$0 no deductible applies
Limit	1 per ear every 4 years.

Home health care

Description	Network
Outpatient	\$0 no deductible applies
Visit limit per year	100

Home health care important note:

Limited to 3 intermittent visits per day provided by a **home health care agency**. 1 visit equals a period of 4 hours or less. Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge.

Hospice care

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

Hospital care

Description	Network
Inpatient services	\$0 no deductible applies

Jaw joint disorder

Description	Network
Jaw joint disorder treatment	\$0 no deductible applies

Maternity and related newborn care

Description	Network
Inpatient delivery services and postpartum care	\$0 no deductible applies
In a facility or at a physician office	\$0 no deductible applies

Maternity and related newborn care Important note:

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

Medical injectables

Description	Network
Medical injectables	\$0 no deductible applies

Nutritional support

Description	Network
Nutritional support	\$0 no deductible applies

Outpatient surgery

Description	Network
At a hospital outpatient department	\$0 no deductible applies
At a facility that is not a hospital	\$0 no deductible applies

Physician services

PCP

Description	Network
Office hours visit (not surgical and not preventive care) (includes telemedicine consultation)	\$0 no deductible applies

Specialist

Description	Network
Office hours visit (not surgical) (includes telemedicine consultation)	\$0 no deductible applies

Physician surgical services

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

Prescription drugs - outpatient

Your **prescription** drug fill greater than a 30 day supply but no more than a 90 day supply can be filled at a designated network pharmacy or CVS pharmacy at the **mail order pharmacy** cost share on tiers 1, 2 and 3.

Tier 1A – low-cost generic prescription drugs

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

Tier 1 -- preferred generic prescription drugs

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

Tier 2 -- preferred brand-name prescription drugs

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

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

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

Tier 4 -- specialty prescription drugs

Description	Network
For each 30 day supply filled at a specialty pharmacy	\$0 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 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	\$0
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	\$0

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

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

Tobacco cessation prescription and over-the-counter drugs

Description	Network
For each 30 day supply filled at a retail pharmacy	\$0 no deductible applies for the first two 90-day treatment programs.
Cost share only includes generic prescription drugs when there is also a brand-name drug available.	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 <i>Contact us</i> 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.

The cost difference does not apply toward your **maximum out-of-pocket limit**.

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 (contraception and counseling) limit	Contraceptive counseling limited to 2 visits every 12 months in a group or individual setting Visits that exceed the limit are covered under the physician services office visit
Immunization limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention or by the Missouri Department of Health and Senior Services For details, contact your physician
Prenatal care	See the <i>Preventive care, Prenatal care</i> section of the policy for more information
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration American Cancer Society guidelines Lung cancer screenings that exceed this limit covered as outpatient diagnostic testing

Description	Network
Routine mammogram limits	1 baseline mammogram between age 35 and 39 1 mammogram every year age 40 and older As recommended by a physician for those at above-average risk due to personal or family history
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 or in accordance with the American Cancer Society

Private duty nursing

Description	Network
Private duty nursing	\$0 no deductible applies
Limit	Coverage is limited to 82 eight hour shifts per calendar year in home setting only.

Prosthetic devices

Description	Network
Prosthetic devices	\$0 no deductible applies

Short-term cardiac and pulmonary rehabilitation services

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

Description	Network
Cardiac and pulmonary rehabilitation	\$0 no deductible applies

Short-term rehabilitation therapy services

A visit is equal to no more than 1 hour of therapy. Your cost share for physical therapy and occupational therapy will be no greater than the cost share for a **physician's** office visit.

Outpatient physical therapy

Description	Network
Physical therapy	\$0 no deductible applies
Visit limit per year	20

Outpatient occupational therapy

Description	Network
Occupational therapy	\$0 no deductible applies
Visit limit per year	20

Outpatient speech therapy

Description	Network
Speech therapy	\$0 no deductible applies

Short-term rehabilitation therapy important note:

The benefit limits listed above do not apply to the treatment of autism spectrum disorders or early intervention for infants and toddlers (First Steps).

Skilled nursing facility

Description	Network
Inpatient services	\$0 no deductible applies
Limit	Coverage is limited to 150 days per calendar year.

Tests, images and lab – outpatient

Diagnostic complex imaging services

Description	Network
At a facility	\$0 no deductible applies
At a physician office	\$0 no deductible applies
At a specialist office	\$0 no deductible applies

Diagnostic lab work

Description	Network
At a facility	\$0 no deductible applies
At a physician office	\$0 no deductible applies
At a specialist office	\$0 no deductible applies

Diagnostic radiological services (X-ray)

Description	Network
At a facility	\$0 no deductible applies
At a physician office	\$0 no deductible applies
At a specialist office	\$0 no deductible applies

Therapies

Outpatient infusion therapy

Description	Network
In a physician office or in a person's home	\$0 no deductible applies
In an outpatient facility	\$0 no deductible applies

Transplant services

Description	Network (Exchange IOE facility)	Out-of-network (Includes Aetna's network providers who are not Exchange IOE providers)
Services and supplies	\$0 no deductible applies	Not covered
Travel and lodging limit per transplant or procedure type	\$10,000	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	\$0 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)	\$0 no deductible applies
Visit limit per year	1

Vision care services and supplies

Description	Network
Eyeglass frames, prescription lenses or prescription contact lenses	\$0 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	\$0 no deductible applies

Walk-in clinic visits

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

Description	Designated network	Non-designated network
Non-emergency services	\$0 no deductible applies	\$0 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 <i>Preventive care</i> section for more information	\$0 no deductible applies	\$0 no deductible applies