BENEFIT PLAN

Prepared Exclusively For
TW Ventures Inc.

OA Managed Choice POS

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

OA Managed Choice POS

Booklet-certificate

Prepared exclusively for:

Policyholder:	TW Ventures Inc.
Group policy number:	GP-861495-C
	Booklet-certificate 2
Group policy effective date:	August 1, 2019
Plan effective date:	August 1, 2019
Plan issue date:	June 19, 2019

Underwritten by Aetna Life Insurance Company

Welcome

Thank you for choosing **Aetna**.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your **Aetna** plan for in-network and out-of-network coverage.

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

The third document is the group policy between **Aetna Life Insurance Company** ("**Aetna**") and the policyholder. Ask the policyholder if you have any questions about the group policy.

Oh, and each of these documents may have amendments attached to them. They change or add to the documents they're part of.

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

Welcome to your **Aetna** plan for in-network and out-of-network coverage.

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

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

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

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

SEE THE *IMPORTANT EXCEPTION - SURPRISE BILLS* SECTION FOR EXCEPTIONS TO THIS RULE.

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

TIMELY ACCESS TO CARE

We have standards for timely access to care and reasonable appointment wait times. These include:

- urgent care within 48 hours of the request
- non-urgent primary care within 10 business days of the request
- non-urgent specialty care within 15 business days of the request
- telephone screening within 30 minutes of the request

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

If you have a complaint because you cannot access medical care in a timely manner, you can contact us at the number shown on your ID card. You can also write to us at:

Customer Service
Aetna Life Insurance Company
151 Farmington Avenue
Hartford CT 06156
1-800-872-3862

You may also contact the California Department of Insurance with your concerns. You can contact them at:

California Department of Insurance
Consumer Services Division
300 Spring Street
South Tower
Los Angeles CA 90013
1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4833)
WWW.INSURANCE.CA.GOV

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Schedule of benefits Issued with your booklet-certificate

Let's get started!

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

Some notes on how we use words

- When we say "you" and "your", we mean both you and any covered dependents.
- When we say "us", "we", and "our", we mean **Aetna**.
- Some words appear in **bold** type. We define them in the *Glossary* section.

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

What your plan does – providing covered benefits

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

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

How your plan works – starting and stopping coverage

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

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons. To learn more see the *When coverage ends* section.

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

How your plan works while you are covered in-network

Your in-network coverage:

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

1. **Eligible health services**

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

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

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

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

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

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

3. **Paying for eligible health services– the general requirements**
   There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:
   - The **eligible health service** is **medically necessary**
   - You get the **eligible health service** from a **network** or **out-of-network provider**
   - You or your **provider precertifies** the **eligible health service** when required

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

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

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

5. **Disagreements**
   We know that people sometimes see things differently.

   The plan tells you how we will work through our differences. And if we still disagree, an independent medical review can be set up by the California Department of Insurance that can make the final decision for us.

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

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

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

Your out-of-network coverage:

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

process with **providers**.

- Means you will pay a higher cost share when you use an **out-of-network provider**. See the *Important exception – surprise bills* section for exceptions to this rule.

You will find details on:

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

How to contact us for help

We are here to answer your questions. You can contact us by logging onto your **Aetna** secure member website at www.aetna.com.

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

You can also contact us by:

- Calling **Aetna** Member Services at the toll-free number on your ID card
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

Your ID card

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

Remember, only you and your covered dependents can use your ID card.

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

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

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

When you can join the plan

As an employee you can enroll yourself and your dependents if you live or work in the **service area**:

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

If you do not enroll yourself and your dependents when you first qualify for benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent) Who can be on your plan (who can be your dependent)

If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are referred to in this booklet-certificate as your "dependents".)

- Your legal spouse
- Your civil union partner
- Your domestic partner
- Your dependent children – your own or those of your spouse, civil union partner or domestic partner
  - The children must be under 26 years of age, and they include:
    - Biological children
    - Stepchildren
    - Legally adopted children, including any children placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you and whether or not the child resides inside the service area)
    - Grandchildren in your court-ordered custody
    - Any other child with whom you have a parent-child relationship

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

Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.

- We must receive your completed enrollment information not more than 31 days after the date of your marriage.
- Ask the policyholder when benefits for your spouse will begin. It will be:
  - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
  - Within 31 days of the date of your marriage.

- A civil union partner - If you enter a civil union, you can put your civil union partner on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your civil union.
  - Ask the policyholder when benefits for your civil union partner will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 31 days of the date of your civil union.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your health plan.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership
  - Ask the policyholder when benefits for your domestic partner will begin. It will be either:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information
    - Within 31 days of the date of your Domestic Partnership
- A newborn child - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have benefits after the first 31 days.
- An adopted child - A child that you, or that you and your spouse, civil union partner or domestic partner adopts is covered on your plan for the first 31 days after the adoption is complete or the date the child is placed for adoption. “Placed for adoption” means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child.
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after the adoption or the date the child was placed for adoption.
  - If you miss this deadline, your adopted child will not have benefits after the first 31 days.
- A stepchild - You may put a child of your spouse, civil union partner or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild’s parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

Notification of change in status

It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other health plan of any covered dependent

Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another health plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
- When a court orders that you cover a current spouse, civil union partner or domestic partner or a minor child on your health plan
- You or your dependents lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You or your dependents become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.

We must receive your completed enrollment information within 31 days the of the event or the date on which you no longer have the other coverage mentioned above. However, the completed enrollment form may be submitted within 60 days of the event when:

- You lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.

Effective date of coverage

Your coverage will be in effect as of the date you become eligible for health benefits.

Medical necessity and precertification requirements

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

Your plan pays for its share of the expense for **eligible health services** only if they are **medically necessary**.

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

Medically necessary; medical necessity

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

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

Precertification

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

In-network

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

Out-of-network

When you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from us for any services and supplies on the **precertification** list. If you do not **precertify**, there may be a penalty. Refer to your schedule of benefits for this information. The list of services and supplies requiring **precertification** appears later in this section. Also, for any **precertification** penalty that is applied see the schedule of benefits *Precertification penalty* section.

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call us at the telephone number listed on your ID card. This call should be made:

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

requiring **precertification**:	outpatient care is provided, or the treatment or procedure is scheduled.

We will provide a written notification to you and your **physician** of the **precertification** decision**,** within 5 business days or within 72 hours for urgent requests. If your **precertified** services are approved**,** the approval is valid for 60 days as long as you remain enrolled in the plan**.**

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

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

You do not need **precertification** for the following inpatient **stays**:

- Following a mastectomy and/or lymph node dissection (your **physician** will determine the length of your **stay**)
- Pregnancy related **stay f**ollowing the delivery of a baby

What if you don't obtain the required precertification?
If you don't obtain the required **precertification:**

- For out-of-network services, there may be a penalty. See the schedule of benefits *Precertification penalty* section.
- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your out-of-network **deductibles** or **maximum out-of-pocket limits**.

What types of services require precertification?

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

Inpatient services and supplies	**Outpatient services and supplies**
Stays in a **hospital**	Complex imaging
Stays in a **skilled nursing facility**	Comprehensive **infertility** services
Stays in a rehabilitation facility	Reconstructive **surgery** and supplies
Stays in a **hospice facility**	Non-emergency transportation by fixed wing airplane
Stays in a **residential treatment facility** for treatment of **mental disorders** and **substance abuse**	Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, botox, hepatitis C medications
ART services	Kidney dialysis
Obesity **surgery**	Outpatient back **surgery** not performed in a **physician's** office
Transplant services	Private duty nursing services
Gender reassignment **surgery**	Sleep studies
	Knee **surgery**
	Wrist **surgery**
	Oral and maxillofacial treatment

	Durable medical equipment (motorized wheelchair/scooter and lower limb prosthetics)

Eligible health services under your plan

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

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

For example,

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

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

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

Important note:
Sex-specific **eligible health services** are covered when medically appropriate, regardless of identified gender.

1. Preventive care and wellness

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

Important notes:

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

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

2. Diagnostic testing will not be covered under the preventive care benefit. For those tests, you will pay the cost sharing specific to **eligible health services** for diagnostic testing.

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

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging on to your secure member website at www.aetna.com or at the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.

Routine physical exams

Eligible health services include office visits to your **physician, PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents
- Screening for blood levels in children under age 19 who are at risk for lead poisoning
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human immune deficiency Virus (HIV) infections
  - Screening for gestational diabetes for women
  - High risk human papillomavirus (HPV) DNA testing for women 30 and older
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial **hospital** checkup

Preventive care immunizations

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

Well woman preventive visits

Eligible health services include your routine:

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

Preventive screening and counseling services

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

- **Obesity and/or healthy diet counseling**
  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention

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

- **Misuse of alcohol and/or drugs**
  Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment

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

  Refer to the *Eligible health services under your plan – Outpatient prescription drugs* section for additional coverage information.

  Tobacco product means a substance containing tobacco or nicotine such as:
  - Cigarettes
  - Cigars
  - Smoking tobacco
  - Snuff
  - Smokeless tobacco
  - Candy-like products that contain tobacco

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

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

Routine cancer screenings

Eligible health services include routine cancer screenings such as:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes:
  - Removal of polyps performed during a screening procedure
  - Pathology exam on any removed polyps
  - Care to prepare for the procedure
  - Related anesthesia services
- Lung cancer screenings
- Cervical cancer screenings

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

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

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

Prenatal care

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

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height
- Diagnosis of fetal genetic disorders

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

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

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

Comprehensive lactation support and counseling services

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

Breast feeding durable medical equipment

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

Breast pump

Eligible health services include:

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

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

Breast pump supplies and accessories

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

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

Family planning services – female contraceptives

Eligible health services include family planning services such as:

Counseling services

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

Devices

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

Voluntary sterilization

Eligible health services include female voluntary sterilization procedures and related services and supplies, including tubal ligation and sterilization implants.

Follow up services

Eligible health services include follow up services related to the contraceptive drugs, devices, products, and procedures. This includes, but is not limited to:

- Management of side effects
- Counseling for continued adherence
- Device insertion and removal

Important note:
See the following sections for more information:

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

2. Physicians and other health professionals

Physician services

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

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

Important note:
All in-person office visits covered with a **physician** or **behavioral health provider** are also covered if you use **telemedicine** instead.

Telemedicine may have different cost sharing. See the schedule of benefits for more information.

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

Eligible health services include the services of:

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

Second opinion services

Eligible health services include a second opinion by a **physician** or other **health professional** whenever requested by you or your **provider. Reasons for a second opinion include, but are not limited to,** the following reasons:

- You are not sure if a recommended surgical procedure is reasonably necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- Your **physician** is unable to diagnose the medical condition and you request an additional diagnosis
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have tried to follow a plan of care or asked your **physician** about serious concerns about the diagnosis or plan of care

Alternatives to physician office visits

Walk-in clinic

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

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

3. Hospital and other facility care

Hospital care

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

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

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

Anesthesia and hospital charges for dental care

Eligible health services include anesthesia for dental care only if you have a condition that requires that a dental procedure be done in a **hospital** or outpatient **surgery center** and you are**:**

- Under 7 years old
- Developmentally disabled (at any age)
- In poor health and have a medical need for general anesthesia (at any age)

Alternatives to hospital stays

Outpatient surgery and physician surgical services

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

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

Home health care

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

- You are homebound.
- Your **physician** orders them.
- The services take the place of your needing to **stay** in a **hospital** or a **skilled nursing facility**, or needing to receive the same services outside your home.
- The services are a part of a **home health care plan**.
- The services are **skilled nursing services**, home health aide services or medical social services, or are

short-term speech, physical or occupational therapy.

- If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. . The services must be provided within 14 days of discharged. See the schedule of benefits for more information on the intermittent requirement.
- Home health aide services are provided under the supervision of a R.N..
- Medical social services are provided by or supervised by a **physician** or social worker.

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

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

Hospice care

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

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

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

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

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

Outpatient private duty nursing

Eligible health services include private duty nursing care provided by an **R**.**N**. or **L**.**P**.**N**. for non-hospitalized acute **illness** or **injury** if your condition requires skilled nursing care and visiting nursing care is not adequate.

Skilled nursing facility

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

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

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

4. Emergency services and urgent care

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

urgent condition.

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

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

As it applies to in-network coverage, if you use an **out-of-network provider** to receive follow up care, you are subject to a higher out-of-pocket expense.

In case of a medical emergency

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

For emergency services, we will pay out-of-network claims (**hospital** and emergency medical transportation) at the in-network benefit level. Your cost sharing for the **emergency services** will accrue to your in-network **maximum out-of-pocket limit**.

Non-emergency condition

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

In case of an urgent condition

Urgent condition

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

Non-urgent care

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

5. Specific conditions

Birthing center and physician services

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

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery
- A shorter **stay**, if the **provider**, with the consent of the mother, discharges the mother or newborn earlier

In the case of a shorter **stay**, a follow-up visit for the mother and newborn will be provided within 48 hours after discharge. The visit includes the following **eligible health services**:

- Parent education
- Assistance and training in breast or bottle feeding
- Any necessary maternal or neonatal physical exams

Eligible health services also include charges made by:

- An operating **physician** for:
  - Delivery
  - Prenatal and postnatal care
  - Administration of an anesthetic
- A **physician** for administering an anesthetic (other than a local anesthetic)

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

Breast cancer screening, diagnosis and treatment

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

- *Eligible health services under your plan – Well woman preventive visits*
- *Eligible health services under your plan – Routine Cancer Screenings*
- *Eligible health services under your plan – Reconstructive surgery and supplies*
- *Eligible health services under your plan –Prosthetic and orthotic devices*

Diabetic equipment, supplies and education

Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Podiatric devices to prevent or treat complications
  - Insulin preparations
  - Diabetic needles and syringes
  - Injection aids for the visually impaired
  - Pen delivery systems for the administration of insulin
  - Diabetic test agents (including blood glucose and ketone urine testing strips)
  - Lancets/lancing devices

  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Injectable glucagons
  - Glucagon emergency kits
- Equipment
  - External insulin pumps
  - Blood glucose monitors without special features, unless required due to visual impairment (includes visual aids for the visually impaired for proper insulin dosing)
- Training
  - Self-management education and training, including medical nutrition therapy provided by a health care **provider** certified in diabetes self-management training for you and your family

This coverage is for the treatment of insulin (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy.

Family planning services – other

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

- Voluntary sterilization for males
- Termination of pregnancy

Gender reassignment counseling, surgery and injectable hormone replacement therapy

Eligible health services include, but are not limited to, the following services:

- Hormone therapy
- Hysterectomy
- Mastectomy
- Vocal training

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

Jaw joint disorder treatment

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

Maternity and related newborn care

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

- A minimum of 48 hours of inpatient care in a **hospital** after a vaginal delivery
- A minimum of 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

In the case of a shorter **stay**, **eligible health services** include a follow-up visit for the mother and newborn within 48 hours after discharge. The visit includes the following:

- Parent education
- Assistance and training in breast or bottle feeding
- Any necessary maternal or neonatal physical exams

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

Pregnancy complications

Eligible health services include services and supplies from your **provider** for pregnancy complications.

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

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

The plan does not cover a scheduled or non-emergency cesarean delivery.

Mental health treatment

Eligible health services include the treatment of **mental disorders,** including, but not limited to, severe mental illnesses and serious emotional disturbances of a child, provided by a **hospital**, **psychiatric hospital**, **residential treatment facility, physician** or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies (including **prescription drugs**) related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- 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 (covered under office visits)
  - All other outpatient mental health treatment, including:
    - **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 needing to receive the same services outside your home.
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications.
    - Behavioral health treatment for pervasive developmental disorder or autism
    - Electro-convulsive therapy (ECT)
    - Mental health injectables
    - Transcranial magnetic stimulation (TMS)

- Psychological testing
- Neuropsychological testing
- 23 hour observation

Severe mental illness means the following:

- Anorexia/bulimia nervosa
- Bipolar disorder
- Major depressive disorder
- Obsessive compulsive disorder
- Panic disorder
- Pervasive developmental disorder (including autism)
- Psychotic disorders/delusional disorder
- Schizoaffective disorder
- Schizophrenia

A child suffering from serious emotional disturbances means a child who:

- Has one or more **mental disorders** as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (other than a primary substance use disorder or developmental disorder)
- Has inappropriate behavior for the child's age according to expected developmental norms
- Meets the criteria in California's Welfare and Institutions Code (section 56003(a)(2))

Behavioral health treatment means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore the functioning of any individual with pervasive developmental disorder or autism. Behavioral health treatment must:

- Be prescribed by a **physician** or psychologist
- Be provided under a treatment plan prescribed by a qualified autism service provider
- Be administered by qualified autism service providers, qualified autism service professionals or qualified autism service paraprofessionals

The treatment plan must:

- Have measurable goals
- Be reviewed at least every six months
- Change whenever appropriate
- Describe the conditions that need to be treated
- Include the service type, number of hours, and parent participation needed
- End when treatment goals are met or no longer appropriate

A treatment plan is not used for **custodial care** or educational services. We can ask for a copy of the treatment plan.

Important notes:

- You may still be eligible for services under state law, including the Lanterman Developmental Disabilities Services Act, California Early Intervention Services Act, and services delivered as part of an individualized education program for individuals with exceptional needs.
- All in-person office visits covered with a **physician** or **behavioral health provider** are also covered if you use telemedicine instead.

Substance related disorders treatment

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

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

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

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

Important note:
All in-person office visits covered with a **physician** or **behavioral health provider** are also covered if you use telemedicine instead.

Oral and maxillofacial treatment (mouth, jaws and teeth)

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

- Non-surgical treatment of infections or diseases.
- **Surgery** needed to:
  - Treat a fracture, dislocation, or wound.
  - Cut out cysts, tumors, or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- **Hospital** services and supplies received for a **stay** required because of your condition.
- Dental work, **surgery** and **orthodontic treatment** needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair, and are firmly attached to your jaw bone at the time of your **injury**.
  - Other body tissues of the mouth fractured or cut due to **injury.**
- Crowns, dentures, bridges, or in-mouth appliances only for:
  - The first denture or fixed bridgework to replace lost teeth.
  - The first crown needed to repair each damaged tooth.
  - An in-mouth appliance used in the first course of **orthodontic treatment** after an **injury**.
- Accidental **injuries** and other trauma. Oral **surgery** and related dental services to return sound natural teeth to their pre-trauma functional state. These services must take place no later than 24 months after the **injury**.
    - Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.
    - If a child needs oral **surgery** as the result of accidental **injury** or trauma, **surgery** may be postponed until a certain level of growth has been achieved.

Reconstructive surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema, and prostheses.
- Your **surgery** corrects or repairs abnormal structures of your body caused by:
  - Congenital defects
  - Developmental abnormalities
  - Trauma
  - Infection
  - Tumors
  - Disease
  - Cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate (includes necessary dental or orthodontic services)
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** creates a normal appearance.

Transplant services

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

Organ means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow

Network of transplant specialist facilities

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

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

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

Treatment of infertility

Basic infertility

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

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

6. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

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

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work and radiological services

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

Chemotherapy

Eligible health services for chemotherapy depends on where treatment is received. Chemotherapy is covered as outpatient care when received in an outpatient setting. There may be separate charges for the chemotherapy drugs and a facility fee for the administration. Chemotherapy administered during a **hospital stay** is covered as an inpatient benefit.

Outpatient infusion therapy

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

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

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

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

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

Specialty prescription drugs

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

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

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

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

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

Outpatient radiation therapy

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

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

Short-term cardiac and pulmonary rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a **hospital, skilled nursing facility**, or **physician's** office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living.
Eligible health services include short-term rehabilitation services your **physician** prescribes. The services have to be performed by:

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

Short-term rehabilitation services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy to diagnose and treat physical and behavioral health conditions
- Occupational therapy (except for vocational rehabilitation or employment counseling) to diagnose and treat physical and behavioral health conditions
- Speech therapy
- Cognitive rehabilitation associated with physical rehabilitation when the therapy is part of a treatment plan intended to acquire and restore previous cognitive function

Habilitation therapy services

Habilitation therapy services are services that help you 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).

Eligible health services include habilitation therapy services your **physician** prescribes. The services have to be performed by:

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

Habilitation therapy services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function
- Occupational therapy (except for vocational rehabilitation or employment counseling or services provided in an educational or training setting), if it is expected to develop any impaired function
- Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to develop speech function as a result of delayed development

7. Other services

Acquired Immune Deficiency Syndrome (AIDS) Vaccine

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

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

Acupuncture

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

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

Ambulance service

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

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

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

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

Clinical trial therapies (experimental or investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an “approved clinical trial” <u>only</u> when you have cancer or a life-threatening disease or condition and all of the following conditions are met:

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

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

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

Clinical trials (routine patient costs)

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

clinical trial must satisfy one of the following:

- Federally funded trials:
  - The study or investigation is approved or funded by one or more of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare & Medicaid Services
    - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy
  - For those approved by the Departments of Veterans Affairs, Defense or Energy, the study or investigation must have been reviewed and approved through a system of peer review that the federal Secretary of Health and Human Services determines:
    - To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health
    - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

"Routine patient costs" include:

- Health care services provided absent a clinical trial
- Health care services required solely for the provision of the investigational drug, item, device, or service
- Health care services required for the monitoring of the investigational item or service
- Health care services provided for the prevention, diagnosis, or treatment of complications from the provision of the investigational drug, item, device, or service
- Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service (including diagnosing and treating complications)

Durable medical equipment (DME)

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

Coverage includes:

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

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

Non-routine/non-preventive care hearing exams

Eligible health services for adults and children include charges for an audiometric hearing exam for evaluation and treatment of **illness**, **injury** or hearing loss, if the exam is performed by:

- A **physician** certified as an otolaryngologist or otologist
- An audiologist who is licensed in audiology, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and who performs the exam at the written direction of a licensed otolaryngologist or otologist

Nutritional supplements

Eligible health services include formula, low protein modified food products and other special food products ordered by a **physician** or **health professional** for the treatment of phenylketonuria (PKU) or an inherited disease of amino and organic acids.

For purposes of this benefit, "low protein modified food product" or "other special food products" means foods that are either:

- 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.
- Used in place of normal food products, such as grocery store foods, in line with the advice of qualified **health professionals** with expertise and experience in the treatment of PKU.

Osteoporosis

Eligible health services include the diagnosis, treatment and management of osteoporosis by a **physician**. The services include Food and Drug Administration approved technologies, including bone mass measurement.

Prosthetic and orthotic devices

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

Prosthetic device means:

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

Orthotic device means:

- A mechanical supportive device for the treatment of weak or muscle deficient parts of the body

Coverage includes:

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

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

- Cerebral palsy
- Arthritis
- Polio
- Spinabifida

- Diabetes
- Accident
- Developmental disability

Vision care

Routine vision exams

Eligible health services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.

8. Outpatient prescription drugs

What you need to know about your outpatient prescription drug plan

Read this section carefully so that you know:

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

FDA approved, **medically necessary** drugs are covered in accordance with this outpatient prescription drug plan. Some **prescription drugs** may not be listed on the **drug guide** or coverage may be limited. You or your **prescriber** can still request a medical exception. Or you can fill your **prescription**, but you may have to pay for it yourself. For more information see the *How do I request a medical exception* and *Where your schedule of benefits fits in* section, and see the schedule of benefits.

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

How to access network pharmacies

How do you find a network pharmacy?

You can find a network pharmacy in two ways:

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

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

What if the pharmacy you have been using 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 the toll-free Member Services number on your member ID card to find another **network pharmacy** in your area.

Eligible health services under your plan

What does your outpatient prescription drug plan cover?

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

- They are **medically necessary**

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

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

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

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

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

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

Partial fill dispensing program for Schedule II controlled substances, such as opioids

Our program allows only a partial fill of your **prescription**. Your out of pocket expenses will be prorated accordingly. You can access the list of these **prescription drugs** by calling the toll-free number on your ID card or log on to your Aetna Navigator® secure member website at www.aetna.com.

What outpatient prescription drugs are covered

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

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

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

Retail pharmacy

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

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

Mail order pharmacy

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

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

Specialty pharmacy

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

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

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

Other services

Preventive Contraceptives

For females, your outpatient **prescription drug** plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

The following female contraceptives that are **generic prescription drugs**:

- Oral drugs
- Injectable drugs
- Female contraceptive devices, including the related services and supplies to administer the device. Devices include:
  - Contraceptive vaginal rings
  - Transdermal contraceptive patches
  - Cervical cap and diaphragm
  - Implantable capsules
  - Inter-uterine devices (IUD)
  - Spermicide
  - Cervical sponge/shield
- FDA approved female generic emergency contraceptives (the brand-name emergency contraceptive "Ella" will be covered until a generic equivalent is approved by the FDA)
- FDA approved female generic over-the-counter (OTC) emergency contraceptives
- Other FDA approved female generic over-the-counter (OTC) contraceptives

To the extent **generic prescription drugs** or devices are not available, **brand-name prescription drugs** or devices will be covered.

Our **preferred drug guide** covers at least one therapeutic equivalent contraceptive service or item in the categories identified by the FDA (currently 18) at no charge. Your **prescriber** may determine that you need a contraceptive that is not listed in the **preferred drug guide**. In this case, your **prescriber** can seek a medical exception for you to receive the contraceptive at no charge. We will rely on your **prescriber's** determination and approve the request within 72 hours. See the *How do I request a medical exception* section.

Eligible health services also include follow up services related to the contraceptive drugs, devices, products, and procedures. This includes, but is not limited to:

- Management of side effects
- Counseling for continued adherence
- Device insertion and removal

Contraceptive coverage for non-contraceptive purposes

Eligible health services include female contraceptives prescribed by a **prescriber f**or reasons other than contraceptive purposes.

Diabetic supplies

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

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

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

Infertility drugs

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

Off-label use

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

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

A life-threatening condition means:

- Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted
- Any disease or condition with a likely fatal outcome where the clinical intervention is needed to survive

Chronic and seriously debilitating means diseases or conditions that require ongoing treatment to maintain remission or prevent decline and cause significant long-term sickness.

Health care services related to off-label use of these drugs may be subject to **precertification**, **step therapy** or other requirements or limitations. **Eligible health services** also include services related to the administration of the drug.

Orally administered anti-cancer drugs, including chemotherapy drugs

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

Over-the-counter drugs

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

Preventive care drugs and supplements

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

Risk reducing breast cancer prescription drugs

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

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

Sexual dysfunction/enhancement

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

Tobacco cessation

*(See the Preventive care and wellness section of this booklet-certificate for information on preventive care tobacco cessation **covered benefits**.)*

Eligible health services include charges made by a **network pharmacy** for **prescription drugs** and aids, that are approved by the U. S. Food and Drug Administration, to stop the use of tobacco products. The **prescription drug** or aid must be prescribed by a **prescriber.**

Tobacco product means a substance containing tobacco or nicotine including, but not limited to:

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

Over-the-counter (OTC) tobacco cessation aids

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

Limitations:
Eligible health services are limited to two, 90 day courses of treatment each Calendar Year for nicotine replacement therapy. Nicotine replacement therapy means a **prescription drug** or aid that is:

- Used to deliver nicotine to a person attempting to stop the use of tobacco products
- Prescribed by a **prescriber**

Obesity drugs

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

How you get an emergency prescription filled

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

Type of pharmacy	Your cost share
Network pharmacy	• You pay the **copayment**.
Out-of-network pharmacy	• You pay the **pharmacy** directly for the cost of the **prescription**. Then you fill out and send a **prescription drug** refund form to us, including all itemized **pharmacy** receipts. • Coverage is limited to items obtained in connection with covered emergency and out-of-area urgent care services. • Submission of a claim doesn't guarantee payment. If your claim is approved, you will be reimbursed the cost of your **prescription** less your **copayment/coinsurance.**

Where your schedule of benefits fits in

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

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

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

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

How your copayment/coinsurance works

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

What precertification requirements apply

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

There is another type of **precertification** for **prescription drugs**, and that is **step therapy**. **Step therapy** is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. If you went through **step therapy** under your prior plan with us or another carrier, you do not have to go through **step therapy** under this plan.

You will find the **step therapy prescription drugs** on the **preferred drug guide.** For the most up-to-date information, call the toll-free Member Services number on your ID card or log on to your Aetna Navigator® secure member website at www.aetna.com.

How can I get a drug precertified?

When you use a **network pharmacy**, your **prescriber** is responsible for obtaining any necessary **precertification.** You, someone who represents you or your **prescriber** may submit a request for a **precertification** by:

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

The chart below shows the different types of **precertification** requests and how much time we have to tell you about our decision.

Type of request	Standard (non-urgent)	Exigent circumstances
Initial decision by us	72 hours	As soon as possible, but not longer than 24 hours
If we need more information, we will notify you within	Not applicable	24 hours
Once we have more information, our decision will be made	Not applicable	24 hours
How long the drug will be covered if request is approved	As long as it is prescribed, including refills	As long as it is prescribed, including refills

A request under exigent circumstances can be made when:

- Your condition may seriously affect your life, health, or ability to get back maximum function
- You are going through a current course of treatment using a **non-preferred drug**

What if my precertification request is denied?

If **precertification** is denied, we will notify you and your **provider** and let you know how the decision can be appealed. You can also request an external review by an independent organization. For more information see the *When you disagree - claim decisions and appeals procedures* section.

What if you do not respond to my precertification request?

If we do not respond to your completed precertification request in the time frames above, your request will be deemed approved.

How do I request a medical exception?

Sometimes you or your **prescriber** may seek a medical exception to get health care services for drugs not listed on the **drug guide** or for which health care services are denied through **precertification** or **step therapy**. You, someone who represents you or your **prescriber** can contact us and will need to provide us with the required clinical documentation. We will make a coverage determination for a standard request within 72 hours after we receive your request and any information and will tell you or your **prescriber** of our decision. Any exception is based upon an individual, case by case decision, and will not apply to other covered persons. If approved by us, you will receive the **preferred** or **non-preferred drug** benefit level.

You, someone who represents you or your **prescriber** may seek a quicker medical exception process to get coverage for drugs not listed in the drug guide based on exigent circumstances. You, someone who represents you or your **prescriber** may submit a request for a quicker review for an urgent situation by:

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

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your **prescriber** of our decision. If approved by us, the exception will apply for the entire time of either the exigent circumstances or of the **prescription**.

If you are denied a medical exception based on the above processes, you have the right to a third party review by an independent external review organization. We will say that you can ask for an external review in the notice of adverse benefit determination we send you. That notice also will describe the external review process. We will tell you, someone who represents you or your **prescriber** of the coverage determination of the external review no later than 72 hours after we receive your request. If the medical exception is approved, coverage will be provided for the entire time of the prescription. For quicker medical exceptions in exigent circumstances, we will tell you, someone who represents you or your **prescriber** of the coverage determination no later than 24 hours after we receive your request. If the quicker medical exception is approved, coverage will be provided for the entire time of either the exigent circumstances or of the **prescription**.

If you had approval for a **prescription drug** under a prior plan, your **prescriber** can continue to prescribe the same **prescription drug** for your medical condition under this plan.

Prescribing units

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

Some outpatient **prescription drugs** are limited to 100 units dispensed per **prescription** order or refill.

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

What your plan doesn't cover – some eligible health service exceptions

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

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

- Under "General exceptions" we've explained what general services and supplies are not covered under the entire plan.
- Below the general exceptions, in "Exceptions under specific types of care," we've explained what services and supplies are exceptions under specific types of care or conditions. The services noted in this section may be covered under a different benefit. For example, psychiatric testing is not covered under the preventive care and wellness benefit. Rather, it would be covered under the mental health treatment benefit.

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

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

General exceptions

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

Examples of these are:

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

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

Cosmetic services and plastic surgery

- Any treatment, **surgery** (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, except where described in the *Eligible health services under your plan – Reconstructive surgery and supplies* section. This cosmetic services exclusion does not apply to **surgery** after an accidental **injury** when performed as soon as medically feasible. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected.

Counseling

- Religious, career, or financial counseling

Court-ordered services and supplies

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

Custodial care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed

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

Dental care except as covered in the *Eligible health services under your plan o*ral and maxillofacial treatment section.
Dental services related to:

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

This exclusion does not include bone fractures, removal of tumors, and odontogenic cysts

Educational services

Examples of those services are:

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

Examinations

Any health examinations needed:

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

Experimental or investigational

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

review from the California Department of Insurance sections.

Facility charges

For care, services or supplies provided in:

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

Foot care

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Routine pedicure services, such as such as routine cutting of nails, when there is no **illness** or **injury** in the nails

Growth/height care

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

Hearing aids and exams

Jaw joint disorder

- Non-surgical treatment of Temporomandibular joint disorder (TMJ)
- Temporomandibular joint disorder treatment (TMJ) performed by prosthesis placed directly on the teeth and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ

Medical supplies – outpatient disposable

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

Outpatient prescription or non-prescription drugs and medicines

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

Personal care, comfort or convenience items

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

Routine exams

- Routine eye exams, routine dental exams, routine hearing exams, except as specifically provided in the *Eligible health services under your plan* section.

Services provided by a family member

- Services provided by a spouse, 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 booklet-certificate.

Sexual dysfunction and enhancement

- Any treatment, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - **Surgery**, implants, devices or preparations to correct or enhance erectile function, or enhance sensitivity
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services]

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for the purpose of enhancing your strength, physical condition, endurance, or physical performance.

Telemedicine

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

Treatment in a federal, state, or governmental entity

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

Therapies and tests

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

Wilderness treatment programs

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

Additional exceptions for specific types of care

1. Preventive care and wellness

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

Family planning services

- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Voluntary sterilization procedures that were not billed separately by the **provider** or were not the primary purpose of a confinement.

2. Physicians and other health professionals

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

3. Hospital and other facility care

Alternatives to facility stays

Outpatient surgery and physician surgical services

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

Home health care

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

Hospice care

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

- Transportation
- Maintenance of the house

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

4. Emergency services and urgent care

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

5. Specific conditions

Family planning services - other

- Reversal of voluntary sterilization procedures including related follow-up care
- Family planning services received while confined as an inpatient in a **hospital** or other facility

Maternity and related prenatal care

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

Mental health treatment

- Mental health services for the following categories (or equivalent terms as listed in the most recent version of the International Classification of Diseases (ICD)):
  - **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders, except as described in the *Eligible health services under your plan – Preventive care and wellness* section
  - Pathological gambling, kleptomania, pyromania
  - School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation.

Obesity surgery and weight management

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

Oral and maxillofacial treatment (mouth, jaws and teeth)

- Dental implants

Transplant services

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

Treatment of infertility

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

6. Specific therapies and tests

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions and blood products

Specialty prescription drugs

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

7. Other services

Ambulance services

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

Clinical trial therapies (experimental or investigational)

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

Clinical trial therapies (routine patient costs)

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

Durable medical equipment (DME)

Examples of these items are:

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

Nutritional supplements

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

Prosthetic and orthotic devices

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless covered under the *Eligible health services under your plan – Prosthetic and orthotic devices* or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Vision care

- 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

Vision care services and supplies

Your plan does not cover vision care services and supplies, except as described in the *Eligible health services under your plan – Other services* section.

- Special supplies such as non-**prescription** sunglasses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a **hospital** or other facility for health care
- Eye exams for contact lenses or their fitting
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

8. Outpatient prescription drugs

Allergy sera and extracts administered via injection

Biological sera

Cosmetic drugs

- Medications or preparations used for **cosmetic** purposes.

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

- Including compounded bioidentical hormones

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

Dietary supplements

Drugs or medications

- Which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
- Not approved by the FDA
- Provided under your medical plan while an inpatient of a healthcare facility; (prescription drugs ordered by a physician as part of an inpatient confinement are covered as any other eligible health service under the inpatient stay)
- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)

Immunizations related to travel or work unless recommended by the United States Preventive Services Task Force (USPSTF)

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

Infertility

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

Prescription drugs:

- Dispensed by other than a **network retail**, **mail order** and **specialty pharmacies** except as specifically provided in the *What outpatient prescription drugs are covered* section.
- Dispensed by a **mail order pharmacy** that is an **out-of-network pharmacy**, except in a medical emergency or urgent care situation except as specifically provided in the *How you get an emergency prescription filled* section.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this plan.
- Dispensed by a **mail order pharmacy** that include **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be

unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.

- That 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.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **preferred drug guide**.
- That are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
- That are not **medically necessary** or obtained for use by anyone other than the person identified on the ID card.

Refills

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

Replacement of lost or stolen prescriptions

Test agents except diabetic test agents

We will exclude:

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

Who provides the care

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

Network providers

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

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section
- Urgent care – refer to the description of emergency services and urgent care in the *Eligible health services under your plan* section
- If **eligible health services** are not available from a **network provider**, we will arrange for you to get the services from an **out-of-network provider**. Your claim will be paid at the **network provider** cost sharing level. This means you will pay the in-network **copayments** and coinsurance and the cost will apply to your in-network **deductible** (if any) and in-network **maximum out-of-pocket limit**.

You may select a **network provider** from the **directory** through your Aetna Navigator® secure member website at www.aetna.com. You can search our online **directory**, DocFind®, for names and locations of **providers**. A paper directory is also available at no cost to you. You can call us at the toll-free number on your ID card to request one.

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

Your PCP

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

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

- General practitioner
- Family **physician**
- Internist
- Pediatrician
- OB, GYN, and OB/GYN

How do you choose your PCP?

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

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

What will your PCP do for you?

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

Your **PCP** can also:

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

How do I change my PCP?

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

Out-of-network providers

You also have access to **out-of-network providers.** This means you can receive **eligible health services** from an **out-of-network provider.** If you use an **out-of-network provider** to receive **eligible health services**, you are subject to a higher out-of-pocket expense (see the *Important exception – surprise bills* section for exceptions to this rule)and are responsible for:

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

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

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

- You join the plan and the **provider** you have now is not in the network.
- You are already under an **Aetna** plan and your **provider** stops being in our network (for reasons other than imminent harm to patients, a determination of fraud, or a final state disciplinary action by a licensing board).

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

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

If you have this condition	**The length of transitional period is**
Acute condition	As long as the condition lasts
Serious chronic condition	No more than 12 months. Usually until you complete a period of treatment and your **physician** can safely transfer your care to another **physician**.
Pregnancy	All three trimesters of pregnancy and the immediate post-partum period
Terminal illness	As long as the person lives
Care of a child under 3 years	Up to 12 months
An already scheduled **surgery** or other procedure	Within 180 days of you joining the **Aetna** plan or your **provider** leaving the network

Acute condition means:

- A medical condition that appears suddenly
- A medical problem that requires immediate medical care and does not last long

Serious chronic condition means:

- A medical condition due to a disease or other medical problem

- A medical disorder that is serious and:
  - Continues without full cure
  - Worsens over time
  - Requires ongoing treatment to maintain remission or prevent deterioration

You or your **provider** should call us for approval to continue any care. You can also call Member Services at the number on the back of your ID card to get a copy of our policy on continuity of care.

Your claim will be paid at the **network provider** cost sharing level.

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

Triage and screening services advice

Our **health professionals** are available to assist you when you have questions on non-emergency care that is needed after office hours. You have access to triage or screening services 24 hours per day, 7 days per week. To contact a **health professional** just log into your **Aetna** Navigator® secure member website at www.aetna.com and select Informed Health® Line.

What the plan pays and what you pay

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

- Your **deductible**
- Your **copayments** and **coinsurance**
- Your **maximum out-of-pocket limit**

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

The general rule

When you get **eligible health services**:

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

  And then

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

  And then

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

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

Important exception – when your plan pays all

Under the in-network level of coverage, your plan pays the entire expense for all **eligible health services** under

the preventive care and wellness benefit.

Important exceptions – when you pay all

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

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

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

Important exception – protection from surprise bills

A surprise bill is a bill you receive for **eligible health services** performed by an out-of-network **physician** or **heath professional** at a network facility, or as a result of treatment at a network facility. For example, this may happen when:

- A network **physician** or **health professional** is unavailable at the time the **eligible health services** are performed
- An out-of-network **physician** or **health professional** performs services without your knowledge that the **eligible health services** would be performed or that the **provider** is out-of-network
- Unforeseen medical issues or services arise at the time the **eligible health services** are performed

A surprise bill does not include a bill for **emergency services**.

In the case of a surprise bill, you will pay the same cost share you would if the **eligible health services** were received from a network **provider** (the in-network cost share). The cost share will be based on the greater of:

- The average contracted rate
- 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the geographic area where the services were rendered

Any cost share you pay related to the surprise bill will count toward:

- Your in-network **deductible**, if any
- Your **copayments/coinsurance**
- Your in-network **maximum out-of-pocket limit**

An out-of-network **physician** or **health professional** can bill you the out-of-network cost sharing only when they get your consent. The consent must:

- Be in writing, at least 24 hours before the care is given, but not at the time of admission or when you are being prepped for any **surgery** or procedure
- Be in a separate document from your consent to treatment and in the language you speak
- Include a written estimate of total out-of-pocket cost of care
- Tell you that you can either seek care from an in-network **provider** or that you can contact us to arrange services from an in-network **provider** for lower out-of-pocket costs
- Tell you that the costs for treatment may not count toward the in-network **deductible** or in-network **maximum out-of-pocket limit**

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage

Where your schedule of benefits fits in

How your deductible works

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

How your copayment/ coinsurance works

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

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

How your maximum out-of-pocket limit works

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

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

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

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

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from your employer. • The claim form will provide instructions on how to complete and where to send the form(s).	• You must send us (or our agent) notice within 20 days of the loss or as soon thereafter as soon as reasonably possible. We will send you a claim form within 15 days of your request. • If you are unable to complete a claim form, you may send us: – A description of services – Bill of charges – Any medical documentation you received from your **provider**
Proof of loss (claim)	• A completed claim form and any additional information required by us.	• You must send us the proof of loss within 90 days of the loss or as soon as reasonably possible (but in no event later than 1 year except in the absence of legal capacity).
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received, but will not be longer than 30 days after the support is received.

Types of claims and communicating our claim decisions

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

There are different types of claims. The amount of time that we have to tell you about our decision on a claim

depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim

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

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

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received.

Post-service claim

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

Concurrent care claim extension

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

Concurrent care claim reduction or termination

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

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

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

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	72 hours	5 business days	30 calendar days	24 hours for urgent request* *5 business days for non-urgent request.
Extensions	None	15 calendar days**	15 calendar days***	Not applicable
Additional information request (us)	72 hours	5 days	30 days	Not applicable
Response to additional	48 hours	45 days	45 days	Not applicable

information request (you)				

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

**We must notify you of the extension request within the first 5 business day period.
*** We must notify you of the extension request within the first 30 calendar day period.

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** with a **network provider** and the **recognized amount** with an **out-of-network provider**, except for your share of the costs. See the Important exception –*surprise bills* section for exceptions to this rule. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an "adverse benefit determination" or "adverse decision". It is also an "adverse benefit determination" if we rescind your coverage entirely.

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

The difference between a complaint and an appeal

A Complaint

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

You may also complain directly to the California Department of Insurance. You can contact them by:

- Calling them at 1-800-927-HELP (4357); TDD: 1-800-482-4TDD (4833)
- Writing them at California Department of Insurance, Consumer Services Division, 300 Spring Street, South Tower, Los Angeles, CA 90013
- Accessing their website at www.insurance.ca.gov

An Appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us by calling the toll-free number on your ID card.

Appeals of adverse benefit determinations

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

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by calling the toll-free number on your ID card. You need to include:

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

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

appeal for you. You can get this form on our website or by calling the toll-free number on your ID card. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

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

Urgent care or pre-service claim appeals

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

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

Timeframes for deciding appeals

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	36 hours	5 business days	30 calendar days	As appropriate to type of claim
Extensions	None	None	None	

If we do not respond to your appeal within 30 days, of 3 days for an urgent care claim, you can request an independent medical review (IMR) from the California Department of Insurance within 6 months of either date.

Independent medical review from the California Department of Insurance

You have a right to request an independent medical review (IMR) from the California Department of Insurance only if:

- Our claim decision involved medical judgment
- We decided the service or supply is not **medically necessary** or not appropriate
- We decided the service or supply is **experimental or investigational** (we will notify you of IMR within 5 business days of our decision)
- You have received urgent or emergency care denials

You must submit the request for IMR within 6 months of the date you received the decision from us. This deadline can be extended by the Commissioner of Insurance.

The IMR system will assign a neutral, independent **physician** with the proper expertise to review your case.

How long will it take to get an IMR decision?

The IMR decision generally takes 30 calendar days after you provide all the information you need to send in.

But sometimes you can get a faster IMR decision. Your **provider** must certify that a delay in your receiving health care services would jeopardize your health.

Once the review is complete, we will abide by the decision of the independent reviewer.

You can contact the California Department of Insurance at:

California Department of Insurance
Consumer Services Division
300 Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4833)
www.insurance.ca.gov

You can also request IMR online by accessing California's website: https://www.insurance.ca.gov/01-consumers/110-health/60-resources/01-imr/index.cfm

Recordkeeping

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

Fees and expenses

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

Coordination of benefits

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

Key terms

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

Allowable expense means:

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

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

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

Here's how COB works

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

Determining who pays

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

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

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or dependent	The plan covering you as an employee or retired employee	The plan covering you as a dependent
Exception to the rule above when you are eligible for Medicare	If you or your spouse have Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us: • **Online:** Log on to your Aetna Navigator® secure member website at www.aetna.com. Select Find a Form, then select Your Other Health Plans. • **By phone:** Call the toll-free number on your ID card.	
COB rules for dependent children		

Child of: • Parents who are married or living together	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the **calendar year**. *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*. *Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together • With court-order	The plan of the parent whom the court said is responsible for health coverage But if that parent has no coverage then their spouse's plan is primary.	The plan of the other parent But if that parent has no coverage, then their spouse's plan is primary
Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule	
Child of: • Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
• Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination: See *Child of* content above	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee)	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee)
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary	

Other rules do not apply	If none of the above rules apply, the plans share expenses equally

How are benefits paid?

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

How COB works with Medicare

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

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

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

- Age, disability, or
- End stage renal disease

When you are enrolled in Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid had you been covered.

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	**Primary plan**	**Secondary plan**
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan
If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.	Medicare Your plan

A disability other than ESRD and the employer has more than 100 employees	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary **plan** and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

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

Other health coverage updates – contact information

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

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

Right to receive and release needed information

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

Right to pay another carrier

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

Right of recovery

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

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

When coverage ends

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

When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued
- You voluntarily stop your coverage
- The **group policy** ends
- You are no longer eligible for coverage
- Your employment ends
- You do not make any required contributions
- We end your coverage
- You become covered under another medical plan offered by your employer

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of **illness, injury**, sabbatical or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue, until stopped by the policyholder, but not beyond 30 months from the start of your absence.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage will stop on the date that your employment ends.
Your employment ends because: • Your job has been eliminated • You have been placed on severance, or • This plan allows former employees to continue their coverage.	You may be able to continue coverage. See the *Special coverage options after your plan coverage ends* section.
Your employment ends because of a paid or unpaid medical leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 30 months from the start of the absence.
Your employment ends because of a leave of absence that is not a medical leave of absence	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree

	to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 1 month from the start of the absence.
Your employment ends because of a military leave of absence.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 24 months from the start of the absence.

It is your policyholder's responsibility to let us know when your employment ends. The limits above may be extended only if we and the policyholder agree in writing to extend them.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage.
- You do not make the required contribution toward the cost of dependents' coverage.
- Your coverage ends for any of the reasons listed above, other than:
  - Exhaustion of your overall maximum benefit
  - If you enroll under a group Medicare plan that we offer. However, dependent's coverage will end if your coverage ends under the Medicare plan

What happens to your dependents if you die?

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

Why would we end you and your dependents coverage?

We may immediately end your coverage if:

- You commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *A bit of this and that - Intentional deception of a material fact under the terms of coverage* section for more information on rescissions.

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

When will we send you a notice of your coverage ending?

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends. Here is how the date is determined (other than the circumstances described in "*Why would we end your coverage*").

Your coverage will end on either the date you stop active work, or the day before the first **premium** contribution due date that occurs after you stop active work.

Coverage will end for you and any dependents on the earlier of the date the **group policy** terminates or at the end of the period defined by the policyholder following the date on which you no longer meet the eligibility requirements.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

COBRA gives some people the right to keep their health coverage for 18, 29 or 36 months after a "qualifying event". COBRA usually applies to employers of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, which is eligible for continuation and how long coverage can be continued.

Qualifying event causing loss of coverage	Covered persons eligible for continued coverage	Length of continued coverage (starts from the day you lose current coverage)
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy	You and your dependents	18 months

When do I receive COBRA information?

The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

Employer/Group health plan notification requirements		
Notice	**Requirement**	**Deadline**
General notice – employer or **Aetna**	Notify you and your dependents of COBRA rights.	Within 90 days after active employee coverage begins
Notice of qualifying event – employer	• Your active employment ends for reasons other than gross misconduct • Your working hours are reduced • You become entitled to benefits under Medicare • You die • You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – employer or **Aetna**	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA **–** employer **or Aetna**	Notify you and your dependents if you are not entitled to COBRA coverage.	Within 14 days after notice of the qualifying event
Termination notice **–** employer or **Aetna**	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period	As soon as practical following the decision that continuation coverage will end

You/your dependents notification requirements		
Notice of qualifying event – qualified beneficiary	Notify the employer if: • You divorce or legally separate and are no longer responsible for dependent coverage • Your covered dependent children no longer qualify as a dependent under the plan	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify the employer if: • The Social Security Administration determines that you or a covered dependent qualify for disability status	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends
Notice of qualified beneficiary's status change to non-disabled	Notify the employer if: • The Social Security Administration decides that the beneficiary is no longer disabled	Within 30 days of the Social Security Administration's decision
Enrollment in COBRA	Notify the employer if: • You are electing COBRA	60 days from the qualifying event. You will lose your right to elect, if you do not: • Respond within the 60 days • And send back your application

How can you extend the length of your COBRA coverage?
The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
• You die • You divorce or legally separate and are no longer responsible for dependent coverage • You become entitled to benefits under Medicare • Your covered dependent children no longer qualify as dependent under the plan	You and your dependents	Up to 36 months

How do you enroll in COBRA?

You enroll by sending in an application and paying the **premium**. The employer has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the **premium**. If this is completed on time, you have enrolled in COBRA.

When is your first premium payment due?

Your first **premium** payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?

For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% is added to cover administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

Can you add a dependent to your COBRA coverage?

You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent.
- You notified the employer within 31 days of their eligibility.
- You pay the additional required **premiums**.

When does COBRA coverage end?

COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become covered under another group health plan that does not exclude coverage for pre-existing conditions or the pre-existing conditions exclusion does not apply.
- You or a covered dependent become entitled to benefits under Medicare.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Continuation of coverage for other reasons

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

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

Your coverage may be extended if you or your dependents are totally disabled when coverage ends.

You are “totally disabled” if you cannot work at your own occupation or any other occupation for pay or profit.

Your dependent is “totally disabled” if that person cannot engage in most normal activities of a healthy person of the same age and gender.

You may extend coverage until the earliest of:

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

How can you extend coverage when getting inpatient care when coverage ends?

Your coverage may be extended if you or your dependents are getting inpatient care in a **hospital** or **skilled**

nursing facility when coverage ends.

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

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

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

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

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

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

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

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

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

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

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

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

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

To extend coverage the leave of absence must:

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

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

A bit of this and that

We gathered a number of provisions here. They talk about several different things, so we call this part “a bit of this and that.”

Administrative provisions

How you and we will interpret this booklet-certificate
We prepared this booklet-certificate according to ERISA, and according to other federal laws and state laws that apply. This booklet-certificate will be interpreted according to these laws.

How we administer this plan
We apply policies and procedures to administer this plan.

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

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

Coverage and services

Your coverage can change

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

If a service cannot be provided to you

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

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

Legal action

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

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

Physical examinations and evaluations

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

Records of expenses

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

Things that would be important to keep are:

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

Honest mistakes

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

Intentional deception of a material fact under the terms of coverage

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

- Loss of coverage, starting on the date the act of fraud or intentional misrepresentation of a material fact happened
- Loss of coverage, from its effective date in the past. This is called rescission. If we paid claims for your past coverage, we will want the money back.
- Loss of coverage going forward
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to criminal authorities.

You have special rights if we rescind your coverage.

- We will give you written notice, via certified mail at least 30 days prior to the effective date of any rescission of coverage. The notice will explain the reason we are rescinding your coverage.
- You have the right to an **Aetna** appeal.
- You have the right to a third party review conducted by an independent external review organization.
- You have the right to appeal to the California Department of Insurance

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

Some other money issues

Assignment of benefits

When you direct us to pay your benefits to someone you name, that's assigning your benefits. When you see a **provider** they will usually bill us directly. When you assign your benefits to your **out-of-network provider**, we will pay them directly. A direction to pay a **provider** is not an assignment of any legal rights.

Financial sanctions exclusions

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

Premium contribution

This plan requires the policyholder to make **premium** payments. If payments are made through a payroll deduction with the policyholder, the policyholder will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** payments are not made. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

Recovery of overpayments

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

When you are injured

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

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

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

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

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

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

Your health information

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

You can get a free copy of our Notice of Privacy Practices. Just call the toll-free number on your ID card.

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

Effect of benefits under other plans

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

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

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

Extension of benefits for pregnancy

If you are:	Evidence you must provide:	Extension:	Extension will end the earlier of:
In a hospital not affiliated with the HMO plan	The HMO plan provides an extension of benefits for pregnancy	Same length of time and for the same conditions as the HMO plan provides	• The end of a 90 day period, or • The date the person is not confined

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

Effect of prior coverage - transferred business

Prior coverage means:

- Any plan of group coverage that has been replaced by coverage under part or this entire plan.
- The plan must have been sponsored by the policyholder (e.g., transferred business).
- If you are eligible, the replacement can be complete, or in part for your eligible class. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

If your coverage under any part of this plan replaces any prior coverage, any benefits provided under such prior coverage may reduce benefits payable under this plan. See the *General coverage provisions* section of the schedule of benefits.

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

Glossary

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

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

Behavioral health provider
An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for **mental disorders** and **substance abuse** under the laws of the jurisdiction where the individual practices. Also includes qualified autism service providers, qualified autism service professionals and qualified autism service paraprofessionals.

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

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

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

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

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

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

- They are **medically necessary.**

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

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

Detoxification

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

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

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

Directory

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

Durable medical equipment (DME)

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

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

Effective date of coverage

The date your and your dependents' coverage begins under this booklet-certificate as noted in **Aetna's** records.

Eligible health services

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

Emergency admission

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

Emergency medical condition

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

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus (including a pregnant woman in active labor)

A mental health condition is also an **emergency medical condition** when either of the following is true:

- You are an immediate danger to yourself or to others

- You are immediately unable to provide for or use food, shelter, or clothing due to the mental disorder

Emergency services

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

Experimental or investigational

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

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

Formulary exclusions list

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

Generic prescription drug

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

Group policy

The **group policy** consists of several documents taken together. These documents are:

- The group application
- The **group policy**
- The booklet-certificate(s)
- The schedule of benefits
- Any amendments to the **group policy**, booklet-certificate, and schedule of benefits

Health professional

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

Home health care agency

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

Home health care plan

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

Hospice care

Care designed to give supportive care to people in the final phase of a **terminal illness** and focus on comfort and

quality of life, rather than cure.

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

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

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

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

Hospital does not include a:
- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility** for **substance abuse**
- **Residential treatment facility** for **mental disorders**
- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

Illness
Poor health resulting from disease of the body or mind.

Infertile or infertility
A disease defined by either:
- The presence of a condition recognized by a physician as a cause of infertility
- The failure to conceive a pregnancy or carry a pregnancy to a live birth after 12 months or more of regular intercourse without contraception.

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

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

Intensive outpatient program (IOP)
Clinical treatment provided must be no more than 5 days per week, no more than 19 hours per week and a minimum of 2 hours each treatment day of **medically necessary** services delivered by an appropriately licensed

or credentialed practitioner. Services are designed to address a **mental disorder** or **substance abuse** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder

This is:

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

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

Mail order pharmacy

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

Maximum out-of-pocket limit

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

Medically necessary/medical necessity

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

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

Generally accepted standards of medical practice means:

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

Mental disorder

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

Morbid obesity/morbidly obese

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

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

- Diabetes

Negotiated charge

For health coverage, this is either:

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

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

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

We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may change the **negotiated charge** under this plan.

Network pharmacy

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

Network provider

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

Non-preferred drug

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

Out-of-network pharmacy

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

Out-of-network provider

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

Partial hospitalization treatment

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

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

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

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

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

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

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

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

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

Premium
The amount you or the policyholder are required to pay to **Aetna** to continue coverage.

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

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

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

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

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

Provider(s)
A **physician**, other **health professional**, **hospital**, **skilled nursing facility**, **home health care agency** or other entity or person licensed or certified under applicable state and federal law to provide health care services to

you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric hospital

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

Psychiatrist

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

Recognized charge

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

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

Service or supply	**Recognized charge**
Professional services and other services or supplies not mentioned below	105% of the Medicare allowable rate
Services of **hospitals** and other facilities	140% of the Medicare allowable rate
Prescription drugs	110% of the average wholesale price (AWP)
Dental expenses	
Important note: If the **provider** bills less than the amount calculated using the method above, the **recognized charge** is what the **provider** bills.	

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply

  We also permit:
  - Exclusion of the amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
  - Exclusion of other payments that CMS makes directly to **hospitals** or other **providers**, including any backdated adjustments made by CMS.
  - For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.

- For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies.
- For **DME**, our rate is 75% of the rates CMS establishes for those services or supplies.
- For medications payable/covered as medical benefits rather than **prescription drug** benefits, our rate is 100% of the rates CMS establishes for those medications.

Additional information:
Get the most value out of your benefits. Use the "Estimate the Cost of Care" tool on **Aetna's** secure member website to help decide whether to get care in network or out-of-network. **Aetna's** secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna's** secure member website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools.

R.N.

A registered nurse.

Residential treatment facility (mental disorders)

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

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

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

Residential treatment facility (substance abuse)

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

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

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming.
- The medical director must be a **physician**.

- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

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

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

Retail pharmacy

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

Room and board

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

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If you take a private room when a semi-private room is available, we will only pay the rate charged for a semi-private room. You will be responsible for the difference between the two.

Service area

The geographic area where **network providers** for this plan are located as found in the **directory**.

Skilled nursing facility

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

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

Skilled nursing facility does not include institutions that provide only:

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

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

Skilled nursing services

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

Specialist

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

Specialty prescription drugs

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

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

Specialty pharmacy

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

Stay

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

Step therapy

A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.aetna.com/formulary.

Substance abuse

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

Surgery center

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

Surgery or surgical procedures

The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Telemedicine

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

Services can be provided by:

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

Terminal illness

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

Therapeutic drug class

A group of drugs or medications that have a similar or identical mode of action. Or are used for the treatment of the same or similar disease or **injury**.

Urgent care facility

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

Urgent condition

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

Walk-in clinic

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

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

Discount programs

Discount arrangements

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

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We have the right to change or end the arrangements at any time.

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

Wellness and other incentives

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

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

Additional Information Provided by

TW Ventures Inc.

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

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

Name of Plan:
Refer to your Plan Administrator for this information

Employer Identification Number:
13-3719008

Plan Number:
501

Type of Plan:
Health and Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
TW Ventures Inc.
3500 West Olive Avenue, Suite 1000
Burbank, CA 91505
Telephone Number: (818) 972-0787

Agent For Service of Legal Process:
TW Ventures Inc.
3500 West Olive Avenue, Suite 1000
Burbank, CA 91505

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

End of Plan Year:
July 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the Board of Directors.

ERISA Rights

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

Receive Information about Your Plan and Benefits

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

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

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

Assistance with Your Questions

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

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

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

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

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

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

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

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

Notice Regarding Women's Health and Cancer Rights Act

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

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

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

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

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

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

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

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

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

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

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

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-877-287-0117 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-877-287-0117 . Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-877-287-0117번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-877-287-0117. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-877-287-0117 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-877-287-0117. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-877-287-0117までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-877-287-0117 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-877-287-0117 'ਤ ਸਾਨ ਫ਼ਨ ਕਰੋ। ਵਧੇਰ ਮਦਦ ਲਈ ਕੇਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੇਂਟ ਆਫ਼ ਇਨਸੋਰੇਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអាចឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានាការ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-877-287-0117 . للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-877-287-0117. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

CDI Notice of Language Assistance-Trad

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Confidentiality Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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