Health Network Only

KelseyCare Select Plan

Booklet

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Third Party Administrative Services provided by Aetna Life Insurance Company

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Welcome

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

Welcome to Aetna

Introduction

This is your booklet. It describes your **covered services** – what they are and how to get them. The schedule of benefits tells you how we share expenses for **covered services** and explains any limits. Together, these documents describe the benefits covered by your Employer's self-funded health benefit plan. Each may have amendments attached to them. These amendments change or add to the document. This booklet takes the place of any others previously in use.

It's really important that you read the entire booklet, your schedule of benefits, and any riders attached If you need help or more information, see the *Contact us* section below.

How we use words

When we use:

- "You" and "your" we mean you and any covered dependents (if your plan allows dependent coverage)
- "Us," "we," and "our" we mean Aetna when describing administrative services provided by Aetna as Third-Party Administrator.
- Words that are in bold, we define them in the *Glossary* section

Contact us

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

- Calling the toll-free number on your ID card
- Logging on to the Aetna website at https://www.aetna.com/
- Writing us at 1425 Union Meeting Road, Blue Bell, PA 19422

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

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

Your ID card

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

Wellness and other rewards

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

- Modifications to **copayment**, **deductible**, or **payment percentage** amounts
- Merchandise
- Coupons
- Gift cards or debit cards
- Any combination of the above

Discount arrangements

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

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

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

Coverage and exclusions

Providing covered services

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

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

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

- **Physician** care generally is covered but **physician** care for cosmetic **surgery** is never covered. This is an exclusion.
- Home health care is generally covered but it is a **covered service** only up to a set number of visits a year. This is a limitation.
- Your **provider** may recommend services that are considered experimental or investigational services. But an experimental or investigational service is not covered and is also an exclusion unless it is recognized as part of an approved clinical trial when you have cancer or a terminal illness. See Clinical trials in the list of services below.
- Preventive services. Usually the plan pays more, and you pay less. Preventive services are designed to help keep you healthy, supporting you in achieving your best health. To find out what these services are, see the *Preventive care* section in the list of services below. To find out how much you will pay for these services, see *Preventive care* in your schedule of benefits.

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

The **covered services** and exclusions below appear alphabetically to make it easier to find what you're looking for. You can find out about limitations for **covered services** in the schedule of benefits. If you have questions, contact us.

Acupuncture

Covered services include acupuncture services provided by a **physician** if the service is provided as a form of anesthesia in connection with a covered **surgical procedure**.

The following are not **covered services**:

- Acupuncture, other than for anesthesia
- Acupressure

Ambulance services

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

Emergency

Covered services include emergency transport to a **hospital** by a licensed ambulance:

- To the first **hospital** to provide **emergency services**
- From one **hospital** to another if the first **hospital** can't provide the **emergency services** you need
- When your condition is unstable and requires medical supervision and rapid transport

Non-emergency

Covered services also include **precertified** transportation to a **hospital** by a licensed ambulance:

- 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; limited to 100 miles
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment

The following are not **covered services**:

- Non-emergency airplane transportation by an **out-of-network provider**
- Ambulance services for routine transportation to receive outpatient or inpatient services

Applied behavior analysis

Covered services include certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions that:

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

Important note:
Applied behavior analysis requires **precertification** by Aetna/Kelsey. The network provider is responsible for obtaining precertification. See the *How your plan works – Medical necessity and precertification* section.

Autism spectrum disorder

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

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

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

Behavioral health

Mental health treatment

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

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

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

Substance related disorders treatment

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

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense when appropriate because of your medical condition), and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**.

- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
    - Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
    - Individual, group, and family therapies for the treatment of **substance related disorders**
    - Other outpatient **substance related disorders** treatment such as:
        - Partial hospitalization treatment provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
        - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
        - Ambulatory or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
        - Observation
        - Peer counseling support by a peer support specialist

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

The following are not **covered services**:
Services for the following categories (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association):

- **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- 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

Birthing center and physician services

A birthing center is a freestanding facility specifically licensed by state and federal laws to provide pregnancy care, delivery, and immediate care after delivery.

Covered services include pregnancy and after delivery care from your birthing center **provider**. After delivery, this also includes:

- No less than 48 hours of care after a vaginal delivery
- No less than 96 hours of care after a cesarean delivery

Covered services also include charges made by:

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

Clinical trials

Routine patient costs

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

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

The following are not **covered services**:

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

Experimental or investigational therapies

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

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

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

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

Diabetic services, equipment, and self-care programs

Covered services include:

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

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

Important note:

Diabetic supplies are covered by EXPRESS SCRIPTS. Monitors (Glucometers), Insulin pumps and supplies related to the pump are covered under the Aetna plan. Supplies related to the monitor are not covered.

Durable medical equipment (DME)

DME and the accessories needed to operate it are:

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

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

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

Covered services also include:

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

The following are not **covered services**:

- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump

- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

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

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

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

Non-emergency services

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

Foot orthotic devices

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

Gender affirming surgery

Covered services include certain medically necessary services and supplies for gender affirming (sometimes called sex change) surgery as described in our Clinical Policy Bulletin 615. You must be at least 18 years old to be eligible for this benefit.

Benefits are limited to a lifetime maximum of $50,000.

Important note:
Just log into your **Aetna** website at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html for detailed information about this **covered benefit,** including eligibility and medical necessity requirements. You can also call *Member Services* at the toll-free telephone number on the back of your I.D. card.

Habilitation therapy services

Habilitation therapy services 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). The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a:

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

Outpatient physical, occupational, and speech therapy

Covered services include:

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

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

The following are not **covered services**:

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

Hearing aids

Hearing aid means:

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

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

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

The following are <u>not</u> **covered services**:

- For covered persons 18 and over
- Replacement of a hearing aid that is lost, stolen, or broken
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Hearing exams

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

The following are not **covered services**:

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

Home health care

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

- You are homebound
- Your **physician** orders them

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

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

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

The following are not **covered services**:
- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

Hospice care

Covered services include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:
- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a **hospital**
- Psychological and dietary counseling
- Pain management and symptom control
- Bereavement counseling
- Respite care

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

Hospital care

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

- Semi-private **room and board**.
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge.
- Services of **physicians** employed by the **hospital**.
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.

The following are not **covered services**:

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

Infertility services

Covered services include seeing a **network provider**:

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

The following are not **covered services**:

- All **infertility** services associated with or in support of an injectable drug (menotropin) cycle, including, but not limited to, imaging, laboratory services, professional services.
- Intrauterine/intracervical insemination services.
- All **infertility** services associated with or in support of an Assisted Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, professional services
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers
  - Gestational carrier cycles
  - Any related services, products, or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery)
- Cryopreservation (freezing), storage or thawing of eggs, embryos, sperm, or reproductive tissue.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.

- Home ovulation prediction kits or home pregnancy tests.
  The purchase of donor embryos, donor oocytes or donor sperm.

Maternity and related newborn care

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

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

The following are not **covered services**:

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

Outpatient surgery

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

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

The following are not **covered services**:

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

Physician services

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

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

Important note:
Your plan covers **telemedicine** only when you get your consult through a **provider** that has contracted with Aetna to offer these services.

All in-person office visits and telemedicine visits with a behavior health provider are covered. **Telemedicine** may have a different cost sharing than an in-person office visit. See your 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

Covered services include the services of:

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

The following are not **covered services**:

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

Preventive care

Preventive **covered services** are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing, you may pay more as these services aren't preventive. If a **covered service** isn't listed here under preventive care, it still may be covered under other **covered services** in this section. For more information, see your schedule of benefits.

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

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

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

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

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

Breast-feeding support and counseling services

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

Breast pump, accessories, and supplies

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

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

Counseling services

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

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

Family planning services – female contraceptives

Covered services include family planning services as follows:

- Counseling services provided by a **physician** on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Contraceptive devices (including any related services or supplies) when they are provided, administered, or removed by a **physician** during an office visit.
- Voluntary sterilization including charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

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

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

Immunizations

Covered services include preventive immunizations for infectious diseases.

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

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

Prenatal care *(Please refer to your pharmacy coverage for additional information.)*

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

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

Prescription Drugs

Preventive care drugs *(Please refer to your pharmacy coverage for additional information.)*

Contraceptives (birth control)

For females who are able to become pregnant, **covered services** include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a prescription from your **provider** and must fill it at a network pharmacy. At least one form of each FDA-approved contraception methods is a **covered service**. You can access a list of covered drugs and devices. See the Contact us section for how.

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA at no cost to you. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drugs** or devices for that method at no cost. Contraceptive devices not obtainable at a pharmacy (includes coverage for contraceptive visits).

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

Brand-name prescription drug forms of contraception in each of the methods identified by the FDA

Important note:
You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive care are not medically appropriate for you. Your **provider** may request a medical exception and submit the exception for review.

Preventive care drugs and supplements *(Please refer to your pharmacy coverage for additional information.)*

Covered services include preventive care drugs and supplements, including OTC as required by the ACA, when you have a **prescription** and it is filled at a network pharmacy.

Risk reducing breast cancer prescription drugs *(Please refer to your pharmacy coverage for additional information.)*

Covered services include **prescription** drugs used to treat people who are at an increased risk for breast cancer and a low risk for adverse medication side effects. You will need a **prescription** from your **provider** and have it filled at a network pharmacy.

Tobacco cessation prescription and over-the-counter drugs *(Please refer to your pharmacy coverage for additional information.)*

Covered services include FDA-approved drugs and OTC aids, drugs to help stop the use of tobacco products, including nicotine replacement therapy. All OTC aids must be prescribed by a **provider**

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

Routine physical exams

A routine preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury. The primary purpose is to screen and conduct tests to detect early risk factors or disease. Also, included are:

- 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.

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

Covered services include:

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

Well woman preventive visits

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

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

Prosthetic device

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

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

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

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

The following are not **covered services**:

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

Reconstructive breast surgery and supplies

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

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

Reconstructive surgery and supplies

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

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

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

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

These dental related services are limited to:

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

Important Note: Voluntary cosmetic surgery is not covered and not considered reconstructive surgery.

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation services

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

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

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

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

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

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

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

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

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language

- Vocational rehabilitation or employment counseling

Skilled nursing facility

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

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

Tests, images, and labs – outpatient

Diagnostic complex imaging services

Covered services include:

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

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

Diagnostic x-ray and other radiological services

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

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

Your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**. In most cases, chemotherapy is covered as outpatient care and the cost share depends upon where the treatment is received.

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

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

GCIT **covered services** include:

- Cellular immunotherapies.
- Genetically modified viral therapy.

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

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

Important note:
You must get GCIT **covered services** from the GCIT-designated facility/**provider**. If there are no GCIT-designated facilities/**providers** assigned in your network, we will arrange for and coordinate your care at a GCIT-designated facility/**provider**. If you don't get your GCIT services at the facility/**provider** we designate, they will not be **covered services**.

The following are not **covered services**:

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.
- Zolgensma® (Onasemnogene abeparvovec-xioi)

Key Terms

To help you understand this section, here are some key terms we use.

Cellular
Relating to or consisting of living cells.

GCIT
Any services that are:

- Gene-based
- Cellular and innovative therapeutics

We call these "GCIT services".

They have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence (IOE) programs.

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

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

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

Infusion therapy

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

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

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

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

Radiation therapy

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

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

Transplant services

Covered services include transplant services provided by a **physician** and **hospital**.
This includes the following transplant types:

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

Network of transplant facilities

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

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

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

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

The following are not **covered services**:

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

Urgent care services

Covered services include services and supplies to treat an **urgent condition** at an urgent care center. An "urgent care center" is a facility licensed as a freestanding medical facility to treat **urgent conditions**. **Urgent conditions** need prompt medical attention but are not life-threatening.

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

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

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

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

The following are not **covered services**:

- Non-urgent care in an urgent care center

General plan exclusions

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

Abortion

- Services and supplies provided for an abortion except when the pregnancy places the woman's life in serious danger, or it poses a serious risk of substantial impairment of a major bodily function.

Behavioral health treatment

Mental health and substance use disorders treatment

The following conditions/diagnoses (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association) are not covered by the behavioral health plan:

- Sexual deviations and disorders except for **gender identity disorders**
- Tobacco use disorders and nicotine dependence except as described in the Coverage and exclusions, Preventive care section
- Pathological gambling, kleptomania, and pyromania
- Specific developmental disorders of scholastic skills (Learning Disorders/Learning Disabilities)
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language
- Other disorders of psychological development

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 service of blood donors, including yourself, apheresis, or plasmapheresis
- The blood you donate for your own use, excluding administration and processing expenses

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, whether or not for psychological or emotional reasons, except where described in Coverage and exclusions under the Reconstructive breast surgery and supplies and Reconstructive surgery and supplies sections

Court-ordered services and supplies

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

Custodial care

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

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- Respite care, adult or child day care, or convalescent care
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform

Educational services

Examples of these are:

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

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Foot care

Routine services and supplies for the following:

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

Foot orthotic devices

Foot orthotics or other devices to support the feet, such as arch supports and shoe inserts, unless required for the treatment of or to prevent complications of diabetes

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

Jaw joint disorder treatment

Surgical and non-surgical medical, dental, diagnostic, or therapeutic services related to **jaw joint disorder**

Maintenance care

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

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to Diabetes and home test kits that do not require a prescription
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Missed appointments

Any cost resulting from a canceled or missed appointment

Nutritional support

- Any food item, including:
  - Infant formulas
  - Nutritional supplements
  - Vitamins
  - **Prescription** vitamins
  - Medical foods
  - Other nutritional items

Obesity surgery and services (See plan limitations)

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

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

Other non-covered services

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

Other primary payer

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

Personal care, comfort or convenience items

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

Private duty nursing

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

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

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

Strength and performance

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

Telemedicine

- Services given when you are not present at the same time as the **provider**
- Telephone calls except to discuss diagnosis and treatment
- **Telemedicine** kiosks
- Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

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

Treatment in a federal, state, or governmental entity

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

Voluntary sterilization

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

Wilderness treatment programs

See Educational services in this section

Work related illness or injuries

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

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

How your plan works

How your plan works while you are covered

Your Health Network Organization plan:

- Helps you get and pay for a lot of – but not all – health care services
- Generally, pays only when you get care from **network providers**

Providers

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

You may choose a **physician (primary care)** to oversee your care. Your **physician (primary care)** will provide routine care and send you to other **providers** when you need specialized care. You don't have to get care through your **physician (primary care)** nor do you need a referral to see a KelseyCare specialist. You may go directly to **network providers**. However, a referral by a KelseyCare clinic physician is required for access to affiliated specialists. For more information about the network and the role of your **physician (primary care)**, see the Who provides the care section.

Service area

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

Who provides the care

Network providers

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

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

- **Emergency services** – see the description of **emergency services** in the Coverage and exclusions section.
- Urgent care – see the description of urgent care in the Coverage and exclusions section.
- **Network provider** not reasonably available – You can get services from an **out-of-network provider** if an appropriate **network provider** is not reasonably available. You must request approval from us before you get the care. Contact us for assistance.
- Transplants – see the description of transplant services in the Coverage and exclusions section.

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

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

Your Physician (primary care)

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

How you choose your Physician (primary care),

You can choose a **physician (primary care),** from the list of **physician** (primary care), in our directory.

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

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 network
- You are already an Aetna member and your **provider** stops being in network

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.

If this situation applies to you, contact us for details. If your request is approved to keep going to your current **provider**, you will be notified how long you can continue to see the **provider**. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery.

Coverage will be authorized only if the **provider** agrees to the usual terms and conditions for contracting **providers**.

Medical necessity and precertification requirements

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

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

Medically necessary, medical necessity

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

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

In some situations, your **physician** may refer you to a to an affiliated specialist and the network cost share applies.

What the plan pays and what you pay

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

The general rule

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

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

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

Negotiated charge

This is the amount a **network provider** has agreed to accept.

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

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

Some of these arrangements are called:

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

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

Paying for covered services – the general requirements

There are several general requirements for the plan to pay any part of the expense for a **covered service**. They are:

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

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

You pay the entire expense when:

- You get services or supplies that are not **medically necessary**.
- Your plan requires **precertification**, your **physician** requests it, we deny it and you get the services without **precertification**.
- You get care from someone who is not a **network provider**, except for emergency, urgent care, and transplant services. See Who provides the care in this section for details

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

Where your schedule of benefits fits in

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

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

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

Coordination of benefits

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

Key Terms

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

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

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

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

How COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
  - We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
  - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.

Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information.

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

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

How COB works with Medicare

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

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. If you are eligible but not covered, and Medicare would be your primary payer, we may still pay as if you are covered by Medicare and coordinate with the benefits Medicare would have paid. Sometimes,

this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered.

You are eligible for Medicare if you are covered under it. You are also eligible for Medicare even if you are not covered if you refused it, dropped it, or didn't make a request for it.

Other health coverage updates – contact information

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

Our rights

We have the right to:

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

Benefit payments and claims

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

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

Claim type and timeframes

Urgent care claim

An urgent claim is one for which the doctor treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 24 hours.

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

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. We will make a decision within 15 days.

Post-service claim

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

Concurrent care claim extension
A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

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

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

Filing a claim

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

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

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

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

Complaints, claim decisions, and, appeal procedures

The difference between a complaint and an appeal, a claim decision

Complaint

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

Appeal, Claim decision

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

Claim decisions and appeal procedures

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

Any time we deny even part of the claim, it is an “adverse benefit determination” or “adverse decision.” For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don’t agree, you can also appeal that decision. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an external review.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

Any other claim appeal

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

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

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

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

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

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

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

Exhaustion of appeal process

In most situations, you must complete the two levels of appeal with us before you can take these other actions:

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

Sometimes you do not have to complete the two levels of appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
- We did not follow all of the claim determination and appeal requirements of the Federal Department of Health and Human Services. But you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us

External review

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

You have a right to external review only if all the following conditions are met:

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

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the request for external review form at the final adverse determination level.

You must submit the request for external review form:

- To Aetna
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

Aetna will contact the ERO that will conduct the review of your claim

The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the ERO makes, unless we can show conflict of interest, bias, or fraud.

How long will it take to get an ERO decision?

We will give you the ERO decision not more than 45 calendar days after we receive your notice of external review form with all the information you need to send in.

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

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

For initial adverse benefit determinations

- Your **provider** tells us a delay in receiving health care services would:
  - Jeopardize your life, health, or ability to regain maximum function
  - Be much less effective if not started right away (in the case of **experimental or investigational** treatment)

For final adverse determinations

Your **provider** tells us a delay in receiving health care services would:

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

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

Recordkeeping

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

Fees and expenses

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

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

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

When you can join the plan

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

Important note:
The KelseyCare plan pays benefits ONLY when you receive care from KelseyCare network providers. If you seek care outside the network, you will pay the full cost of care.

You can enroll:

- Within your enrollment window upon receiving your enrollment invitation
- During your employer's annual enrollment period
- At other special times during the year (see the Special times you can join the plan section below)

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

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Dependent children – yours or your spouse's
    - Dependent children must be:
        - Under 26 years of age
    - Dependent children include:
        - Natural children
        - Stepchildren
        - Adopted children including those placed with you for adoption
        - Foster children
        - Children you are responsible for under a qualified medical support order or court order
        - Grandchildren in your court-ordered custody
        - A grandchild whose parent is already covered as a dependent on this plan

Adding new dependents

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

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

- A newborn child - Your newborn child is not automatically covered on your health plan.
  - Your Employer 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 contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits.
- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

Your Employer must receive your completed enrollment information within 31 days after the event date.

Special times you can join the plan

You can enroll in these situations:

- You didn't enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan

Your Employer must receive your completed enrollment information within 31 days after the event date.

You can also enroll in these situations:

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

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

Notification of change in status

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

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

You may change coverage any time during the year because of a change in your status. A change in status is:

- Your marriage, divorce, legal separation or annulment
- The birth or adoption of a child or legal guardianship of a child
- The death of your spouse or child
- A change in employment status for you, your spouse or your dependent

For a complete list or status changes, please contact the HISD Benefits Department at 1-877-780-4473 or you may visit the HISD Benefits website at: www.hisdbenefits.org

Whenever you have a qualified status change, you must report the change within 31 days of the event, otherwise you must wait until HISD's next open enrollment period. You may report the status change by calling the HISD Benefits Department: 1-877-780-4473 or by visiting the website, www.hisdbenefits.org > click on Enrollment, then Enroll Now (you must log on through the HISD employee portal in OneSource to single sign on to the Benefits Enrollment site.

Starting coverage

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

Stopping coverage

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

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

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage due to an approved family status change or elect coverage on an after tax basis.
- The Employer asks to end coverage
- You are no longer eligible for coverage, including when you move out of the service area
- Your work ends
- You stop making required contributions if any apply
- We end your coverage
- You start coverage under another medical plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

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

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

What happens to your dependents if you die?
Coverage for dependents may continue for some time after your death. See the Special coverage options after your coverage ends section for more information.

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

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

Special coverage options after your coverage ends

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

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

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

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

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

Continuation of coverage for other reasons
To request an extension of coverage, just contact your Employer.

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

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

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

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

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

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

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

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

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

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet
We prepared this booklet according to federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet when we administer your coverage.

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

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

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

Coverage and services

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

Legal action
You must complete the internal appeal process, if your plan has one, before you take any legal action against us for any expense or bill. See the Complaints, claim decisions, and appeal procedures section. You cannot take any action until 60 days after we receive written submission of a claim.

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

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

Records of expenses

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

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

Honest mistakes and intentional deception

Honest mistakes

You or the Employer may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception

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

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

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

You have special rights if we rescind your coverage:

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

Some other money issues

Assignment of benefits

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

Financial sanctions exclusions

If coverage provided under this booklet violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **covered services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC).

You can find out more by visiting https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Recovery of overpayments

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

When you are injured

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

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

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

We don't have to reduce the amount we're due for any reason, even to help pay your lawyer or pay other costs you incurred to get a recovery.

Your health information

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

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

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

Glossary

Behavioral health provider

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

Brand-name prescription drug (Please refer to your pharmacy coverage for additional information)

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

Copay, copayment

Copays are flat fees for certain visits. A copay can be a dollar amount or percentage

Covered service

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

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

Deductible

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

Detoxification

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

Emergency medical condition

A severe medical condition that:

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

Emergency services

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

Experimental or investigational

Drugs, treatments, or tests not yet accepted by **physicians** or by insurance plans as standard treatment. They may not be proven as effective or safe for most people.

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

- 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**.

Health professional

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

Home health care agency

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

Hospital

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

Jaw joint disorder

This is:

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

Maximum out-of-pocket limit

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

Medically necessary, medical necessity

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

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

Generally accepted standards of medical practice means:

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

Mental health disorder

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

Negotiated charge

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

Network provider

A provider listed in the directory for your plan. A National Advantage Program provider listed in the National Advantage Program directory is not a network provider.

Payment Percentage (Copayment)

The specific percentage the plan pays for a health care service listed in the schedule of benefits.

Physician

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

Precertification, precertify

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

Provider

A **physician**, **health professional**, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare.

Psychiatric hospital

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

Residential treatment facility

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

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

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

For substance related 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**
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For **detoxification** programs within a residential setting:

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

Room and board

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

Semi-private room rate

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

Skilled nursing facility

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

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

Skilled nursing facility does not include institutions that provide only:

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

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

Skilled nursing services

Services provided by a registered nurse or licensed practical nurse within the scope of their license.

Specialist

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

Stay

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

Substance related disorder

This is a physical or psychological dependency, or both, on a drug or alcohol. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include an addiction to nicotine products, food, or caffeine.

Surgery, surgical procedure

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

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

Telemedicine

A consultation between you and behavioral health service that can be provided electronically by:

- Two-way audiovisual teleconferencing
- Any other method required by law

Terminal illness

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

Urgent condition

An illness or injury that requires prompt medical attention but is not a life-threatening **emergency medical condition**.

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments,** or **payment percentage**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The **deductibles**, **copayments,** and **payment percentage**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- You are responsible to pay any **deductibles**, **copayments,** and **payment percentage** if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the Using your Aetna benefits section under Individuals & Families at https://www.aetna.com/.

Important note:
Covered services are subject to the contract year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **payment percentage** unless otherwise noted in this schedule of benefits.

Under this plan, you will:

1. Pay your **copayment**
2. Then pay any remaining **deductible**
3. Then pay your **payment percentage**

Your **copayment** does not apply to any **deductible**.

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from an in-network **provider**. This schedule of benefits shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentage**, if any, for **covered services** after you meet your **deductible**.

How your physician office visit cost share works

You will pay the physician cost share when you get **covered services** from any **physician**.

How your maximum out-of-pocket works

This 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 services** for the remainder of that year.

Contact us

We are here to answer questions. See the Contact us section in your booklet.

Aetna Health Inc.'s HNO group agreement provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

Plan features

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	In-network
Individual	$500 per calendar year
Family	$1,000 per calendar year

Deductible waiver

There is no network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

Deductible waiver provisions for chronic and preventive prescription drugs

No **deductible** will apply to chronic and preventive covered **prescription** drug expenses:
Preventive:
Preventive drugs as defined in guidance issued by the U.S. Department of the Treasury and Internal Revenue Service (IRS) for Health Savings Accounts (HSAs) and qualified High Deductible Health Plans (HDHPs). This list will be reviewed periodically and is subject to change as federal guidelines change.

Chronic:
Chronic drugs are those prescribed to treat conditions that are commonly considered unending or long term. These conditions typically require regular, daily use of medicines. This list will be reviewed periodically and is subject to change as federal guidelines change.

See Pharmacy plan to chronic condition language.

Please refer to your pharmacy coverage for additional information.

Maximum out-of-pocket limit

Excludes the **deductible**

Maximum out-of-pocket type	In-network
Individual	$4,900 per calendar year
Family	$9,800 per calendar year

General coverage provisions

This section explains the **deductible**, **maximum out-of-pocket limit**, and limitations listed in this schedule.

Deductible provisions

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **payment percentage**, if any, for these **covered services**.

Individual deductible

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

Family deductible

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

Copayment

This is a flat fee you pay for certain visits or **covered services**. A copay can be a dollar amount or percentage. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Payment percentage (Copayment)

This is the percentage of the bill you pay after you meet your **deductible**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Maximum out-of-pocket limit provisions

Maximum out-of-pocket limit

Family maximum out-of-pocket limit

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

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

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

- All costs for non-**covered services** which are identified in the booklet and the schedule
- Charges, expenses, or costs in excess of the **allowable amount**
- Costs for non-emergency use of the emergency room
- Costs for non-urgent use of an urgent care **provider**

Your financial responsibility and decisions regarding benefits

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

Covered services

Acupuncture

Description	In-network
Acupuncture in lieu of anesthesia	30% per visit after **deductible**

Ambulance services

Description	In-network
Emergency services	30% per trip after **deductible**
Non-emergency services	30% per trip

Applied behavior analysis

Description	In-network
Applied behavior analysis	30% per visit after **deductible**

Autism spectrum disorder

Description	In-network
Diagnosis and testing	30% per visit after **deductible**
Treatment	30% per visit after **deductible**
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	$65 per visit no **deductible** applies

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services-**room and board** including **residential treatment facility**	30% per admission after **deductible**
Outpatient office visit to a **physician** or **behavioral health provider**	$65 per visit no **deductible** applies
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program	30% per visit after deductible

Substance related disorders treatment

Includes **detoxification**, rehabilitation, and **residential treatment facility**

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services – **room and board** during a **hospital stay**	30% per admission after **deductible**
Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** consultation	$65 per visit no **deductible** applies
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program	30% per visit after **deductible**

Clinical trials

Description	In-network
Experimental or investigational therapies	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received

Diabetic services, equipment, and self-care programs

Description	In-network
Diabetic services	Covered based on type of service and where it is received
Diabetic equipment	Covered based on type of service and where it is received
Diabetic self-care programs	Covered based on type of service and where it is received

Important note:
Diabetic supplies are covered by EXPRESS SCRIPTS. Monitors (Glucometers), Insulin pumps and supplies related to the pump are covered under the Aetna plan. Supplies related to the monitor are not covered.

Durable medical equipment (DME)

Description	In-network
DME	30% per item after **deductible**

Emergency services

Description	In-network
Emergency room	$300 plus 30% per visit after **deductible**
Complex imaging, lab, and radiology services	No charge
Description	**In-network**
Non-emergency care in a **hospital** emergency room	Not covered

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

Foot orthotic devices

Description	In-network
Orthotic devices to support the feet	Covered based on type of service and where it is received

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

Description	In-network (GCIT-designated facility/provider)
Services and supplies	Covered based on type of service and where it is received

Habilitation therapy services

Physical (PT), occupational (OT) and speech (ST) therapies

Description	In-network
PT, OT therapies	$65 per visit no **deductible** applies

Speech therapy

Description	In-network
ST	$65 per visit no **deductible** applies

Hearing aids

Description	In-network
Hearing aids	30% per visit after **deductible**
Age limit	Covered persons through age 17
Limit	One per ear every 36 months

Hearing exams

Description	In-network
Hearing exams	$65 per visit no **deductible** applies
Visit limit	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	In-network
Home health care	30% per visit after **deductible**
Visit limit per day	3 intermittent visits
Limit per year	100

Home health care important note:
Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge.

Hospice care

Description	In-network
Inpatient services - **room and board**	30% per admission after **deductible**
Day limit per year	unlimited days
Day limit per lifetime	unlimited
Outpatient services	30% per visit after **deductible**
Visit limit per year	unlimited
Limit per year	unlimited
Limit per lifetime	unlimited

Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8-12 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8-12 hours a day.

Hospital care

Description	In-network
Inpatient services – **room and board**	30% per admission after **deductible**
Other inpatient services	No charge

Infertility services

Description	In-network
Treatment of **underlying condition**	Covered based on type of service and where it is received.

Maternity and related newborn care

Includes complications

Description	In-network
Inpatient services – **room and board**	30% per admission after **deductible**
Initial visit performed in **physician** or **specialist** office or a facility	$65 per visit no **deductible** applies
Subsequent visits performed in **physician** or **specialist** office or a facility, including delivery and post-partum care	0%; no deductible applies
Other services and supplies	Covered based on type of service and where it is received

Maternity and related newborn care important note:
Review the Maternity section of the booklet. It will give you more information about coverage for maternity care under this plan.

Outpatient surgery

Description	In-network
At **hospital** outpatient department	30% per visit after **deductible**
At facility that is not a **hospital**	30% per visit after **deductible**
At the **physician** office	Covered based on type of service and where it is received.

Physician and Physician and specialist services including surgical services

Description	In-network
Physician (Primary Care) office hours (not surgical, not preventive)	$30 per visit no **deductible** applies
Immunizations that are not considered preventive care	Covered based on type of service and where it is received.
Physician visit during inpatient **stay**	30% per visit after **deductible**
Physician surgical services	30% per visit after **deductible**

Specialist

Description	In- network
Specialist office hours (not surgical, not preventive)	$65 per visit no **deductible** applies
Specialist surgical services	30% per visit after **deductible**

Preventive care

Description	In- network
Preventive care services	$0 no **deductible** applies
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit

Description	In- network
Breast pump, accessories and supplies limit	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse visit limit per day	1
Counseling for alcohol or drug misuse visit limit	5 visits/calendar year
Counseling for obesity, healthy diet visit limit per day	1
Counseling for obesity, healthy diet visit limit	Age 0-22: unlimited visits Age 22 and older: 26 visits per calendar year, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection visit limit	2 visits/calendar year
Counseling for tobacco cessation visit limit per day	1
Counseling for tobacco cessation visit limit	8 visits/calendar year
Family planning services (female contraception and counseling) limit	Contraceptive counseling limited to 2 visits/calendar year in a group or individual setting
Immunization limit	Covered persons age 0-99 Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Preventive care contraceptives (birth control)	$0 no **deductible** applies

Description	In- network
Preventive care drugs and supplements including: • Risk reducing breast cancer **prescription** drugs • Tobacco cessation **prescription** and OTC drugs	$0 no **deductible** applies Refer to pharmacy coverage for additional information
Preventive care drugs and supplements limit	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF For a current list of covered preventive care drugs and supplements or more information, Refer to pharmacy coverage for additional information
Preventive care risk reducing breast cancer **prescription** drugs limit	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF For a current list of covered risk reducing breast cancer drugs or more information, Refer to pharmacy coverage for additional information
Preventive care tobacco cessation **prescription** and OTC drugs limit	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF For a current list of covered tobacco cessation drugs or more information, Refer to pharmacy coverage for additional information
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section of your booklet

Description	In- network
Routine lung cancer screening limit	1 screening every calendar year Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year 3 exams every 12 months age 1-2 3 exams every 12 months age 2-3 and 1 exam every calendar year after that age, up to age 22 1 exam every calendar year after age 22 1 exam every calendar year High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman routine GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Prosthetic devices

Includes medical wigs

Description	In-network
Prosthetic devices	30% per item after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network
Surgery and supplies	Covered based on type of service and where it is received

Short-term rehabilitation services

Cardiac rehabilitation

Description	In-network
Cardiac rehabilitation	Covered based on type of service and where it is received

Pulmonary rehabilitation

Description	In- network
Pulmonary	Covered based on type of service and where it is received

Cognitive rehabilitation

Description	In-network
Cognitive rehabilitation	Covered based on type of service and where it is received

Physical and occupational therapies

Physical, occupational and speech therapies

Description		In-network
PT, OT, and ST		$65 per visit no **deductible** applies
Visit limit per year		60

Spinal manipulation

Description	In-network
Spinal manipulation	$65 per visit no **deductible** applies
Visit limit per year	20

Rehabilitation services important note:
A visit is equal to no more than 1 hour of therapy.

Skilled nursing facility

Description	In-network
Inpatient services – **room and board**	30% per admission after **deductible**
Day limit per year	60

Tests, images, and labs - outpatient

Diagnostic complex imaging services

Description	In-network
At facility that is not a **hospital**	30% per visit after **deductible**
At **hospital** outpatient department	30% per visit after **deductible**

Diagnostic lab work

Description	In-network
At facility that is not a **hospital**	30% per visit after **deductible**
At **hospital** outpatient department	30% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network
At facility that is not a **hospital**	30% per visit after **deductible**
At **hospital** outpatient department	30% per visit after **deductible**

Therapies

Chemotherapy

Description	In-network
Chemotherapy services	Covered based on type of service and where it is received

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

Description	In-network (GCIT-designated facility/provider)	Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**)
Services and supplies	Covered based on type of service and where it is received	Not covered

Infusion therapy

Outpatient services

Description	In-network
In **physician** office	Covered based on type of service and where it is received
At an infusion location	Covered based on type of service and where it is received
In the home	Covered based on type of service and where it is received
At **hospital** outpatient department	Covered based on type of service and where it is received
At facility that is not a **hospital**	Covered based on type of service and where it is received

Radiation therapy

Description	In-network
Radiation therapy	Covered based on type of service and where it is received

Transplant services

Description	Network (IOE facility)	Out-of-network (Including **providers** who are otherwise part of Aetna's network but are non-IOE **providers**)]
Inpatient services and supplies	30% per admission after **deductible**	Not covered
Outpatient services performed at **hospital** outpatient department	See Inpatient services, above	Not covered
Outpatient services performed at facility other than **hospital** outpatient department	See Inpatient services, above	Not covered
Physician services	See Inpatient services, above	Not covered

Transplant important note:
See the Transplant services benefit in the Coverage and exclusions section of the booklet for more information. The limit applies to all transplant services received while you are a member of an Aetna plan or one associated with Aetna. The plan **lifetime maximum**, if any, will not apply to transplant services. The transplant limit will apply.

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

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

Description	In-network
Urgent care facility	30% per visit after **deductible**
Non-urgent use of an urgent care facility or **provider**	Not covered

Aetna Health, Inc. Rider

Obesity surgery

Rider effective date: 01/01/2023

This obesity surgery rider is added to your booklet. It describes your obesity **surgery** benefit. Obesity **surgery** is also known as bariatric and weight loss **surgery**. This rider is subject to all other requirements described in your booklet, including general exclusions and defined terms.

What you need to know about obesity surgery benefit

Read this rider carefully so you will know:

- How to find an obesity **surgical** facility
- Coverage and exclusions
- What **precertification** requirements apply
- Where your schedule of benefits fits in
- How to read your schedule of benefits

How to find an obesity surgical facility

You may go to any network facility that performs obesity **surgery**. Contact us to find a network facility.

Coverage and exclusions

Covered services

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

Covered services include:

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

Exclusions

The following are not **covered services:**

- Weight management treatment
- Drugs intended to decrease or increase body weight, control weight, or treat obesity except as described in the booklet or this rider
- Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis, or other forms of therapy

- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

What precertification requirements apply

Your **provider** will request approval from us before your obesity **surgery**. See the Medical necessity and precertification section of the booklet for more information.

Where your schedule of benefits fits in

How you share in the cost

This schedule of benefits lists the **deductibles**, limits and **copayments** or **payment percentage**, if any apply to the **covered services** you receive under this rider. This rider is subject to the requirements described in your plan schedule of benefits unless otherwise noted below.

How your cost share works

- The **deductibles**, **copayments,** and **payment percentage**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- You are responsible to pay any **deductibles**, **copayments,** and **payment percentage**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

Important note:
Covered services are subject to the calendar year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **payment percentage** described in the medical plan schedule of benefits unless otherwise noted below.

Covered services

Obesity surgery

Description	In-network
Inpatient services – **room and board**	50% per admission after **deductible**
Other inpatient services and supplies	50% per admission after **deductible**

Outpatient obesity surgery services

Description	In-network
At **specialist** office	50% per visit after **deductible**
At **hospital** outpatient department	50% per visit after **deductible**
At facility that is not a **hospital**	50% per visit after **deductible**
Limit per lifetime	$10,000

Obesity surgery important note:
The cost shares that apply to obesity **surgery** do not apply to the annual **maximum out-of-pocket limit**. For the purposes of this benefit, 'lifetime' means **covered services** paid under this plan or another plan underwritten or administered by Aetna or an affiliate for this contract holder.