

Preferred provider organization (PPO) medical plan

Certificate of coverage

Prepared for:

Policyholder: Caraday Healthcare, LLC
Policyholder number: GP-175291
Plan name: Open Access Managed Choice,
Booklet-certificate: 1
Group policy effective date: August 1, 2021
Plan effective date: August 1, 2021
Plan issue date: July 23, 2021

Underwritten by Aetna Life Insurance Company



Important note:

This insurance policy under which this certificate is issued is not a policy of workers' compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers' compensation system.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Aetna, Inc.

To get information or file a complaint with your insurance company or HMO:

Call: Aetna's toll-free telephone number at 1-888-416-2277

Toll-free: 1-888-416-2277

Online: www.aetna.com

Email: aetnamemberservices@aetna.com

Mail: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Aetna, Inc.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: al numero de teléfono gratis de Aetna al 1-888-416-2277

Teléfono gratuito: 1-888-416-2277

En línea: www.aetna.com

Correo electrónico: aetnamemberservices@aetna.com

Dirección postal: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Preferred Provider Disclosure Notice

- You have the right to an adequate network of preferred **providers** (also known as "network providers").
 - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
 - If you relied on materially inaccurate **directory** information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network **deductible** and out-of-pocket maximum.
- You have the right, in most cases, to obtain estimates in advance:
 - from **out-of-network providers** of what they will charge for their services; and
 - from your insurer of what it will pay for the services.
- You may obtain a current **directory** of preferred **providers** at the following website: www.aetna.com or by calling **Aetna** Member Services at the toll-free number on your ID card for assistance in finding available preferred **providers**. If the **directory** is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.
- If you are treated by a **provider** or **hospital** that is not a preferred **provider**, you may be billed for anything not paid by the insurer.
- If the amount you owe to an out-of-network **hospital**-based radiologist, anesthesiologist, pathologist, emergency department **physician**, neonatologist, assistant surgeon, out-of-network emergency care **provider** or any out-of-network **provider** working at a network facility is greater than \$500 (not including your **copayment**, **coinsurance**, and **deductible** responsibilities) for services received in a network **hospital**, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmmediation.html.

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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 certificate of coverage or "certificate." 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. Along with the group policy, they describe your Aetna plan. Each may have amendments attached to them. These change or add to the document. This certificate takes the place of any others sent to you before.

It's really important that you read the entire certificate and your schedule of benefits.

If your coverage under any part of this plan replaces coverage under another plan, your coverage for benefits provided under the other coverage may reduce benefits paid by this plan. See the *Coordination of benefits, Effect of prior plan coverage* section.

If you need help or 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
- 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 in to the Aetna website at <https://www.aetna.com/>
- Writing us at 151 Farmington Ave, Hartford, CT 06156

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

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

Your ID card

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, activity and outcomes such as:

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

The award of a participation incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health status. Rather, you can obtain these benefits simply by participating in a wellness or health improvement program that we offer you. Once you earn benefits, you can accept or decline them. And we won't charge you for choosing to accept any benefits you earn. You can earn benefits as long as we offer wellness and health improvement programs and you participate in them. If we stop offering a wellness and health improvement program or you stop participating in a program, you won't continue to earn these benefits. We will let you know at least 60 days in advance before we stop offering these benefits.

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 preauthorization requirements* section and the *Glossary* for more information.

For **covered services** under the outpatient **prescription** drug plan:

- You need a **prescription** from the prescribing **provider**
- You need to show your ID card to the network pharmacy when you get a **prescription** filled

This plan provides insurance coverage for many kinds of **covered services**, such as a doctor's care and **hospital stays**, but some services aren't covered at all or are limited. For other services, the 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 require **preauthorization** from us. For more information see the *How your plan works – Medical necessity and preauthorization 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

Alzheimer's disease

Covered services include the following services by a **physician** to diagnose Alzheimer's disease:

- A history and physical
- A neurological evaluation
- A psychological or psychiatric evaluation
- Lab services

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 preauthorized 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

Autism spectrum disorder

Autism spectrum disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder – not otherwise specified.

Covered services include the "generally recognized services provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder.

We will cover screenings of your dependent children for autism spectrum disorder. This is done at ages 18 months and 24 months.

Treatment for autism spectrum disorder is covered from the date of diagnosis.

We will cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan. You can receive treatment from a **provider** that meets at least one of the following criteria:

- Is licensed, certified or registered by an appropriate agency of Texas
- Has professional credentials that are recognized and accepted by an appropriate agency of the United States.
- Is certified as a **provider** under the TRICARE military health system.

You can also receive treatment from someone working under the supervision of a **provider** as described above. As used here, “generally recognized services” can include:

- Evaluation and assessment services
- Applied behavior analysis
- Behavior training and behavior management
- Speech therapy
- Physical therapy
- Occupational therapy
- Medications or nutritional supplements used to address symptoms 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, crisis stabilization unit, residential treatment center for children and adolescents, 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 or telehealth** consultation)
 - Individual, group, and family therapies for the treatment of **mental health disorders**
 - Other outpatient mental health treatment such as:
 - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
 - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
 - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
 - Your **physician** 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**.

Covered services will be covered under the same terms and conditions as medical and surgical benefits for any other physical illness.

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

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**.

Covered services will be covered under the same terms and conditions as medical and surgical benefits for any other physical illness.

Cardiovascular disease testing

Covered services include certain lab tests for the early detection of cardiovascular disease when a covered person has:

- Diabetes
- An intermediate or higher risk of getting coronary heart disease based on Framingham Heart Study prediction algorithms

The following lab tests may be done to screen for hardening and abnormal artery structure and function:

- Computed tomography (CT) scanning
- Ultrasonography

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in a phase I, phase II, phase III or phase IV approved clinical trial as a qualified individual for the prevention, detection, or treatment of cancer or other life-threatening disease or condition, as defined in the federal Public Health Service Act, Section 2709. An approved clinical trial must satisfy one of the following:

- Federally funded trials:
 - The study or investigation is approved or funded by one or more of the following:
 - The National Institutes of Health
 - The Centers for Disease Control and Prevention
 - The Agency for Health Care Research and Quality
 - The Centers for Medicare & Medicaid Services
 - Cooperative group or center of any of the entities described above or the Department of Defense or the Department Veterans Affairs
 - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
 - The Department of Veterans Affairs
 - The Department of Defense
 - The Department of Energy
 - The Food and Drug Administration
 - An institutional review board of a Texas institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

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
- Your **provider** determines, and we agree, that based on published, peer-reviewed scientific evidence you may benefit from the treatment

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

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

Dental care services and anesthesia in a hospital or surgery center

Covered services include anesthesia and facility costs for dental care. Your provider must certify that the dental care cannot be performed in the dentist's office due to a physical, mental, or medical condition.

The following are not **covered services**:

- The related dental services unless specifically listed as a covered service in this certificate.

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

Covered services include:

- Services
 - Foot care to minimize the risk of infection
- Supplies
 - Insulin and insulin analog preparation
 - Prescribed oral medications whose primary purpose is to influence blood sugar
 - Injection devices including syringes, needles and pens
 - Injection aids, including devices used to assist with insulin injection and needleless systems
 - Diabetic test agents, including but not limited to, visual reading and test strips (blood glucose, ketone and urine)
 - Blood glucose calibration liquid
 - Lancet devices and kits
 - Alcohol swabs
 - Injectible glucagon's
 - Glucagon emergency kit
 - Biohazard disposal containers
- Equipment
 - External and implantable insulin pumps and pump supplies
 - Repairs and necessary maintenance of insulin pumps if not covered by manufacturer's warranty or purchase agreement
 - Rental fees for pumps during repair and maintenance
 - Blood glucose monitors without special features, unless required due to blindness
 - Podiatric appliances, including therapeutic shoes to prevent complications of diabetes
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

Covered services also include new or improved diabetic treatment, equipment and supplies that become available. They must be:

- Approved by the United States Food and Drug Administration
- **Prescribed** by your **provider**
- Sent to us in writing by your **provider**

All supplies, including medications and equipment for diabetes will be dispensed as written, and are not subject to preauthorization or step therapy requirements.

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**.

The types of services that are eligible for coverage include:

- A medical screening examination or other evaluation required by state or federal law and provided to covered enrollees in a **hospital** emergency facility, freestanding emergency care facility or comparable facility, necessary to determine if an **emergency medical condition** exists.
- Treatment to stabilize your condition.
- Care in an emergency facility, freestanding emergency care facility or comparable facility after you become stable. But only if the treating **provider** asks us, and we approve the service. We will approve or deny the request within an hour after receiving the request.

As always, you can get **emergency services** from **network providers**. However, you can also get **emergency services** from **out-of-network providers**. When you are treated by an **out-of-network provider** when a **network provider** is not reasonably available or for an **emergency medical condition**, we will reimburse the **out-of-network provider** at the usual and customary rate or at an agreed rate. Please contact us if you receive a bill from the **out-of-network provider**. We will work to resolve the outstanding balance so that all you pay is the appropriate **network deductible**, **coinsurance**, or **copayments** under your plan.

You will be credited for:

- Any amounts due to you that would have been paid if the **provider** were a **network provider**
- Any out-of-pocket amounts that you paid to the **provider**, in excess of the allowed amount. Such amounts will be credited to your Calendar Year **deductible** amount and plan **coinsurance** limits, as applicable

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 based on the usual and customary rate or at an agreed rate. 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 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 preauthorization requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your **network physician** or **primary care 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.

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 must be performed by a:

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

Outpatient physical, occupational, and speech therapy

Covered services include:

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

The following are not **covered services**:

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

Hearing aids, cochlear implants and related services

Covered services include hearing aids or cochlear implants and the following related services and supplies:

- Fitting and dispensing services and ear molds necessary to maintain optimal fit of hearing aids
- Treatment related to hearing aids and cochlear implants, including:
 - Habilitation and rehabilitation necessary for educational gain
 - For cochlear implants, an external speech processor and controller
- Internal replacement of cochlear implants as **medically necessary** or audiological necessary

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

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

The following are not **covered services**:

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

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:

- Your **physician** orders them
- The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**
- 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

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

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

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

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
 - Assisted living facilities, except if you have an acquired brain injury
 - Any place considered a person's main residence or providing mainly custodial or rest care
 - Health resorts
 - Spas
 - Schools or camps

Infertility services

Basic infertility

Covered services include seeing a **provider**:

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

The following are not **covered services**:

- All **infertility** services associated with or in support of an ovulation induction cycle while on injectable medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Artificial insemination services.

Jaw joint disorder treatment

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

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

The following are not **covered services**:

- Non-surgical medical and dental services, and therapeutic services related to **jaw joint disorder**

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services, including care and services for complications of pregnancy.

Complications of pregnancy are:

- Conditions requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as:
 - Acute nephritis
 - Nephrosis
 - Cardiac decompensation
 - Missed abortion
 - Similar medical and surgical conditions of comparable severity
- The following conditions that occur during a period of gestation in which a viable birth is not possible:
 - Non-elective cesarean section
 - Termination of ectopic pregnancy
 - Spontaneous termination of pregnancy

Complications of pregnancy do not include:

- False labor
- Occasional spotting
- Physician prescribed rest during the period of pregnancy
- Morning sickness
- Hyperemesis gravidarum
- Pre-eclampsia
- Similar conditions associated with the management of a difficult pregnancy not constitution a nosologically distinct complication of pregnancy.

Services and supplies for complications of pregnancy will be covered the same as any other illness or injury.

After your child is born, **covered services** include:

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

If the mother is discharged earlier, the plan will pay for home visits after delivery by a health care **provider**.

These time frames apply if your child is born without any problem. If your **provider** tells us that you had a problem during your pregnancy or during childbirth, we will cover the **stay** the same as we would for any other illness or injury.

Covered services for newborn care include:

- Services and supplies needed for circumcision by a **provider**
- Treatment of congenital defects. These services will be covered the same as any other illness or injury

The following are not **covered services**:

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

Nutritional support

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

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

We will cover these items to the same extent that the plan covers drugs that are available only on the orders of a physician.

The following are not **covered services**:

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

Oral and maxillofacial treatment (mouth, jaws and teeth)

Covered services include the following when provided by a **physician**, dentist and **hospital**:

- Cutting out:
 - Cysts, tumors, or other diseased tissues
- Cutting into gums and tissues of the mouth:
 - Only when not associated with the removal, replacement or repair of teeth

Orthotic devices

Covered services include the initial orthotic device and subsequent replacement that your **physician** orders and administers.

We will cover the same type devices that are covered by Medicare. Your **provider** will tell us which device best fits your need. But we cover it only if we **preauthorize** the device.

Orthotic device means a customized medical device applied to a part of the body to:

- Correct a deformity
- Improve function
- Relieve symptoms of a disease

Coverage Includes:

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

The following are not **covered services**:

- Services covered under any other benefit
- Repair and replacement due to loss, misuse, abuse or theft

Osteoporosis

Covered services include services to detect and prevent osteoporosis for:

- A postmenopausal woman not receiving estrogen replacement therapy
- An individual with:
 - Vertebral abnormalities
 - Primary hyperparathyroidism
 - A history of bone fractures
- An individual who is:
 - Receiving long-term glucocorticoid therapy
 - Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

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, PCP** services and not for a separate fee for facilities.

The following are not **covered services**:

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

Physician services

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

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

Important note:

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

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

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

Physician surgical services

Covered services include the services of:

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

The following are not **covered services**:

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

Prescription drugs - outpatient

Read this section carefully. This plan does not cover all **prescription** drugs and some coverage may be limited. This doesn't mean you can't get **prescription** drugs that aren't covered; you can, but you have to pay for them yourself. For more information about **prescription** drug benefits, including limits, see the schedule of benefits.

Important note:

A pharmacy may refuse to fill or refill a **prescription** when, in the professional judgement of the pharmacist, it should not be filled or refilled.

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

Covered services are based on the drugs in the **drug guide**. We exclude **prescription** drugs listed on the **formulary exclusions list** unless we approve a medical exception. The formulary exclusions list is a list of **prescription** drugs not covered under the plan. This list is subject to change. If it is **medically necessary** for you to use a **prescription** drug that is not on this **drug guide**, you or your **provider** must request a medical exception. See *the Requesting a medical exception* section or just contact us.

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

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

Partial fill dispensing for certain prescription drugs

We allow a partial fill of your **prescription** if:

- Your **pharmacy** or **prescriber** tells us that:
 - The quantity requested is to synchronize the dates that the **pharmacy** fills your **prescription drugs**
 - The synchronization of the dates is in your best interest
- You agree to the synchronization

Your out-of-pocket expenses will be prorated based on the number of days' supply.

How to access network pharmacies

You can find a network pharmacy either online or by phone. See the *Contact us* section for how.

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

Some **prescription** drugs are subject to quantity limits. This helps your **provider** and pharmacy ensure your **prescription** drug is being used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these limits.

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

The pharmacy may substitute a **generic prescription drug** for a **brand-name prescription drug**. Your cost share may be less if you use a **generic drug** when it is available.

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 90 day supply of **prescription** drugs. A network **retail pharmacy** will submit your claim. You will pay your cost share directly to the pharmacy. There are no claim forms to complete or submit.

Mail order pharmacy

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Each **prescription** and refill is limited to a maximum 90 day supply.

Prescription refills after the initial fill can be filled at a network **mail order pharmacy**.

Specialty pharmacy

We cover **specialty prescription drugs** when filled through a network **retail** or **specialty pharmacy**.

Each **prescription** is limited to a maximum 30 day supply. You can view the list of **specialty prescription drugs**. See the *Contact us* section for how.

Prescription drugs covered by this plan are subject to misuse, waste, or abuse utilization review by us, your **provider**, and/or your network pharmacy. The outcome of this review may include:

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

How to access out-of-network pharmacies

You can directly access an out-of-network pharmacy to get covered outpatient **prescription drugs**.

When you use an out-of-network pharmacy, you pay your in-network **copayment** or **coinsurance** then you pay any remaining **deductible** and then you pay your out-of-network **coinsurance**. If you use an out-of-network pharmacy to obtain outpatient **prescription drugs**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your in-network outpatient **prescription drug** cost share
- Paying your out-of-network outpatient **prescription drug deductible**
- Your out-of-network **coinsurance**
- Any charges over the **allowable amount**
- Submitting your own claims

How to get an emergency prescription filled

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

Type of pharmacy	Your cost share is
A network pharmacy	The plan cost share
Out-of-network pharmacy	The full cost of the prescription

When you pay the full cost of the **prescription** at an out-of-network pharmacy:

- You will fill out and send a **prescription** drug refund form to us, including all itemized pharmacy receipts
- Coverage will be limited to items obtained in connection with the out-of-area emergency or urgent situation
- Submission of the refund form doesn't guarantee a refund. If approved, you will be reimbursed the cost of the **prescription** less your network cost share

Prescription eye drops

You may refill **prescription** eye drops to treat a chronic eye disease or condition if:

- The original **prescription** states that additional quantities are needed
- The refill does not exceed the total quantity of dosage units stated on the original **prescription**, including refills
- The refill dispensed on or before the last day of the prescribed dosage period and not earlier than the:
 - 21st day after the date a 30-day supply is dispensed
 - 42nd day after the date a 60-day supply is dispensed
 - 63rd day after the date a 90-day supply is dispensed

Other covered services

Anti-cancer drugs taken by mouth, including chemotherapy drugs

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

Coverage for oral anti-cancer **prescription drugs** will not be less favorable than for intravenously or injected anti-cancer medications covered as a medical benefit rather than as a **prescription drug** benefit. Also, the cost sharing for anti-cancer **prescription drugs** will not exceed the coinsurance or copayment applicable to a chemotherapy visit or cancer treatment visit. Your **prescriber** or your pharmacist may need to get approval from us before we will agree to cover the drug for you. For more information see the *How your plan works – Medical necessity and preauthorization requirements* section.

Contraceptives (birth control)

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

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each method of birth control approved by the FDA at no cost to you when filled at a network pharmacy. If a generic drug or device is not available for a certain method, we will cover the **brand-name prescription drug** or device at no cost share.

Preventive contraceptives important note:

You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review.

Diabetic supplies

Covered services include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid
- Diabetic syringes, needles and pens
- Continuous glucose monitors
- Insulin infusion disposable pumps
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine

See the *Diabetic services, supplies, equipment, and self-care programs* section for medical **covered services**.

Immunizations

Covered services include preventive immunizations as required by the ACA when given by a network pharmacy. You can find a participating network pharmacy by contacting us. Check with the pharmacy before you go to make sure the vaccine you need is in stock. Not all pharmacies carry all vaccines.

Nutritional supplements

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease or disorder of amino and organic acids. This includes coverage for amino-acid based elemental formula.

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

Covered services are covered to the same extent that the plan covers drugs that are available only on the orders of a **physician**.

OTC drugs

Covered services include certain OTC medications when you have a **prescription** from your **provider**. You can see a list of covered OTC drugs by logging on to the Aetna website.

Preventive care drugs and supplements

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

Risk reducing breast cancer prescription drugs

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

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

Tobacco cessation prescription and OTC drugs

Covered services include FDA approved **prescription** and OTC drugs to help stop the use of tobacco products.

You must receive a **prescription** from your **provider** and submit the **prescription** to the pharmacy for processing.

The following are not **covered services**:

- Abortion drugs
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a **covered service**
- Drugs or medications
 - Administered or entirely consumed at the time and place it is prescribed or provided
 - Which do not require a **prescription** by law, even if a **prescription** is written, unless we have approved a medical exception
 - That include the same active ingredient or a modified version of an active ingredient as a covered **prescription** drug unless we approve a medical exception
 - That is therapeutically the same or an alternative to a covered **prescription** drug, unless we approve a medical exception
 - That is therapeutically the same or an alternative to an OTC drug unless we have approved a medical exception
 - Not approved by the FDA or not proven safe or effective
 - Provided under your medical plan while inpatient at a healthcare facility
 - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
 - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
 - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a **covered service**
 - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
 - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **preauthorization** and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
 - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate

- **Infertility:**
 - **Prescription** drugs used primarily for the treatment of **infertility**
- Injectables including:
 - Any charges for the administration or injection of **prescription** drugs
 - Needles and syringes except for those used for insulin administration
 - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription** drugs:
 - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or **prescription** drugs for the treatment to a dental condition
 - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
 - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which is illegal, unethical, imprudent, abusive, not **medically necessary** or otherwise improper and drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
 - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
 - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

Preventive care

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

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

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

These recommendations and guidelines may be updated periodically. When updated, they will apply to this 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 – 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 for children from birth to age 18

Covered services include:

- Diphtheria, tetanus, pertussis
- Haemophilus influenza type b
- Hepatitis A
- Hepatitis B
- Human papillomavirus
- Inactivated poliovirus
- Influenza
- Measles, mumps, rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella
- Any other immunization that is required for children by law

Covered services also include immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

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

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

Prenatal care

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

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

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms (All forms of low-dose mammography, including digital mammography and breast tomosynthesis)
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

Routine physical exams

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

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the 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 and the administration of the newborn screening tests as required by applicable Texas law including the cost of a newborn screening test kit in the amount provided by the Department of State Health Services

Well woman preventive visits

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

- Office visit to a **physician, PCP, OB, GYN or OB/GYN** for services including Pap smears
- Preventive care breast cancer (BRCA) gene blood testing (CA 125)
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

Private duty nursing - outpatient

Covered services include private duty nursing care, ordered by a **physician** and provided by an R.N. or L.P.N. when:

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

The following are not **covered services**:

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

Prosthetic device

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

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

We will cover the same type devices covered by Medicare. Your **provider** will tell us which device best fits your needs.

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

You may receive a prosthetic device as part of another **covered service** and therefore 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
 - Prosthesis
- Unless you or your **physician** decide that a shorter time period for inpatient care is appropriate, **covered services** for reconstructive breast **surgery** include:
 - 96 hours of inpatient care following a mastectomy
 - 48 hours of inpatient care in a network health care facility after lymph node dissection for treatment of breast cancer

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.
- Your **surgery** corrects a craniofacial abnormality. This includes an abnormal structure that is caused by developmental deformities, congenital defects, trauma, tumors, infections or disease. The **surgery** will be covered if:
 - The purpose of the **surgery** is to improve function or attempt to create a normal appearance.

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

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

These dental related services are limited to:

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

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation services

Short-term rehabilitation services 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 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**, except as described in the Speech or hearing loss impairment benefit below
 - 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

Inpatient and outpatient treatment for acquired brain injury

Covered services include treatment for an acquired brain injury. An acquired brain injury does not include a congenital or degenerative illness or injury. It means a neurological injury to the brain, after birth, that results in loss of:

- Physical function
- Sensory processing
- Cognition
- Psychological behavior

The therapy is coordinated with us as part of a treatment plan intended to:

- Maintain or restore previous cognitive function
- Slow further loss of function

Covered services include the following therapies related to an acquired brain injury:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment.
- Neurofeedback therapy
- Remediation
- Post-acute transition services
- Community reintegration services
- Post-acute care treatment due to, and related to, an acquired brain injury. If you have been unresponsive to treatment, this also includes checking from time to time to see if you become responsive.

Covered services also include care in an assisted living facility that is:

- Within scope of their license, and
- Within scope of the services provided under an accredited rehabilitation program for brain injury.

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 **preauthorized** 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

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 follow-up care related to newborn hearing screening

Covered services include necessary diagnostic follow-up care related to the newborn hearing screening test from birth through 24 months of age.

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.

Important note:

Once you have met your **deductible**, your cost share for diagnostic mammograms will be the same as mammograms performed for routine cancer screenings as described in the *Preventive Care* section. Diagnostic mammograms are not subject to any age limitations.

Therapies – chemotherapy, infusion, radiation

Chemotherapy

Covered services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

Covered services also include anti-cancer **prescription drugs** for chemotherapy. Coverage for oral anti-cancer **prescription drugs** will not be less favorable than for intravenously or injected anti-cancer medication covered as a medical benefit rather than as a **prescription drug** benefit. Also, the cost-sharing for anti-cancer prescription drugs will not exceed the **coinsurance** or **copayment** applicable to a chemotherapy visit or cancer treatment visit. Your prescriber or your pharmacist may need to get approval from us before we will agree to cover the drug for you. See the *Preauthorization* section for details.

Infusion therapy

Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions.

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

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

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

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

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

Radiation therapy

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

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

Transplant services

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

This includes the following transplant types:

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

Covered services also include:

- Travel and lodging expenses
 - If you are working with an Institutes of Excellence™ (IOE) facility that is 100 or more miles away from where you live, travel and lodging expenses are **covered services** for you and a companion, to travel between home and the IOE facility
 - Coach class air fare, train or bus travel are examples of **covered services**

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.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the network **copayment, coinsurance, deductible, maximum out-of-pocket** and limits, unless stated differently in this certificate and schedule of benefits. You may also get transplant services at a non-IOE facility, but your cost share will be higher. Transplant services received from a non-IOE facility are subject to the out-of-network **copayment, coinsurance, deductible, maximum out-of-pocket**, and limits, unless stated differently in this certificate 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 facility we designate, your cost share will be higher.

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, PCP**. If your **physician** is not reasonably available, you may access urgent care from an urgent care center that is in-network.
- **Urgent condition** outside the service area
 - You are covered for urgent care obtained from a facility that is out-of-network if you are temporarily unable to get services in-network and getting the health care service cannot be delayed.

The following are not **covered services**:

- Non-urgent care in an urgent care center

Vision care

Covered services include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not **covered services**:

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

Walk-in clinic

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

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

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

Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* of the American Psychiatric Association:

- Substance related disorders treatment
- **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
- 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 and except where described in the *Coverage and exclusions, Transplant services* section

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

Cost share waived

Any cost for a service when any **out-of-network provider** waives all or part of your **copayment, coinsurance, deductible**, or any other amount

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

Dental services

The following are not **covered services**:

- Services normally covered under a dental plan
- Dental implants

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

Except for complications of diabetes, 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}

See the *Diabetic services, supplies, equipment, and self-care programs* section.

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

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 where described in the *Coverage and exclusions - Habilitation therapy services* section and *Early intervention services for children with developmental delays* section

Medical supplies – outpatient disposable

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

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

Missed appointments

Any cost resulting from a canceled or missed appointment

Nutritional support

Any food item, including:

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

Obesity surgery and services

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

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

Other non-covered services

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

Prescription or non-prescription drugs and medicines - outpatient

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

Routine exams

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Coverage and exclusions* section

Services provided by a family member

Services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law, or any household member, except when that family member is a dentist who is licensed in the State of Texas to provide the service rendered

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 certificate.

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, except when used to treat an **illness** or injury

Telemedicine or Telehealth

- Services given when you are not present at the same time as the **provider**
- Services including:
 - Telephone calls
 - **Telemedicine** or **telehealth** 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

Tobacco cessation

Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:

- Counseling, except as specifically provided in the *Covered services and exclusions* section
- Hypnosis and other therapies
- Medications, except as specifically provided in the *Covered services and exclusions* section
- Nicotine patches
- Gum

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 medical plan works while you are covered in-network

Your in-network coverage:

- Helps you get and pay for a lot of – but not all – health care services

Your cost share is lower when you use a **network provider**.

Providers

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

You may choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care. You don't have to get care through your **PCP**. You may go directly to **network providers**. Your plan may pay a bigger share for **covered services** you get through a **PCP**, so choose a **PCP** as soon as you can.

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

Service area

Your 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 transplant services.

See the *Who provides the care* section below.

Important note for dependents under a qualified medical support: if you are required to cover a dependent who lives outside the **service area** under a qualified medical support order, we will provide your dependent with coverage that is comparable health or dental coverage to that provided to other dependents

Important note for other dependents (not under a qualified medical support order) outside the service area: If you have a dependent outside of the **service area**, their coverage outside of the **service area** will be limited to emergency and **urgent conditions** for both medical and **pharmacy** services.

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

With your out-of-network coverage:

- You can get care from **providers** who are not part of the Aetna network
- You may have to pay the full cost for your care, and then submit a claim to be reimbursed
- You are responsible to get any required **preauthorization**
- Your cost share will be higher

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

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

- You join the plan and the **provider** you have now is not in the network
- You are already an Aetna member and your **provider** stops being in our 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 you are a new enrollee and your provider is out of network provider	When your provider stops participation with Aetna
Request for approval	You need to complete a transition of coverage request form and send it to us. You can get this form by contacting us.	You or your provider should call us for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period for up to 90 days. This date is based on the date the provider terminated their participation with us.
How claim is paid	Your claim will be paid at the designated network cost sharing level during the transitional period.	Your claim will be paid at the designated network cost sharing level during the transitional period.

	If you have a terminal illness and your provider stops participation with us
Request for approval	Your provider should call us for approval to continue any care. You can call us for information on continuity of care.
Length of transitional period	Care will continue during a transitional period for up to 9 months. This date is based on the date the provider terminated their participation with us.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.

	If you are pregnant and have entered your second trimester and your provider stops participation with Aetna
Request for approval	Your provider should call us for approval to continue any care. You can call us for information on continuity of care.
Length of transitional period	Care will continue during a transitional period through delivery, including the time required for postpartum care directly related to delivery. This includes a post-delivery checkup within six weeks.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.

If this situation applies to you, contact us for details. If we approve your request to keep going to your current **provider**, we will tell you 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.

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

Who provides the care

Network providers

We have contracted with **providers** in the service area to provide **covered services** to you. These **providers** make up the network for your 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.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

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

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

Important note:

Even if you receive **covered services** at a health care facility that is a **network provider**, not all services may be in network. Other services you receive may be from a **physician** or facility that is an **out-of-network provider**. **Providers** that may not be **network providers** include anesthesiologists, radiologists, pathologists, and assistant surgeons. We will reimburse the **out-of-network provider** at the usual and customary rate or at an agreed rate. Please contact us if you receive a bill from the **out-of-network provider**. We will work to resolve the outstanding balance so that all you pay is the appropriate network **deductible, coinsurance, or copayments** under your plan.

Your PCP

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

How you choose your PCP

You can choose a **PCP** from the list of **PCPs** in our directory.

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

What your PCP will do for you

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

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

Changing your PCP

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

Medical necessity and preauthorization 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**
- For in-network benefits, you get the service from a **network provider**
- You or your **provider preauthorizes** 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.

Preauthorization

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

In-network

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

Out-of-network

When you go to an **out-of-network provider**, you are responsible to get any required **preauthorization** from us. If you don't **preauthorize**:

- Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details.
- You will be responsible for the unpaid bills.
- Your additional out-of-pocket expenses will not count toward your **deductible** or **maximum out-of-pocket limit**, if you have any.

Timeframes for **preauthorization** are listed below. For **emergency services, preauthorization** is not required, but you should notify us as shown.

To obtain **preauthorization**, contact us. You, your **physician** or the facility must call us within these timelines:

Type of care	Timeframe
Non-emergency admission	Call at least 3 days before the date you are scheduled to be admitted
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted
Urgent admission	Call before you are scheduled to be admitted
Outpatient non-emergency medical services	Call at least 3 days before the care is provided, or the treatment or procedure is scheduled

An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an illness, the diagnosis of an illness, or injury.

We will tell you and your **physician** in writing of the **preauthorization** decision, where required by state law. An approval is valid for 180 days as long as you remain enrolled in the plan.

For an inpatient **stay** in a facility, we will tell you, your **physician** and the facility about your **preauthorized** length of **stay**. If your **physician** recommends that you stay longer, the extra days will need to be **preauthorized**. You, your **physician**, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your **physician** in writing of an approval or denial of the extra days.

If you or your **provider** request **preauthorization** and we don't approve coverage, we will tell you why and explain how you or your **provider** may request review of our decision. See the *Complaints, claim decisions and appeal procedures* section.

Types of services that require preauthorization

Preauthorization is required for inpatient **stays** and certain outpatient services and supplies

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

Inpatient services and supplies	Outpatient services and supplies
Stays in a hospital	Applied behavior analysis
Stays in a skilled nursing facility	Complex imaging
Stays in a rehabilitation facility	Comprehensive infertility services and ART services
Stays in a hospice facility	Cosmetic and reconstructive surgery
Stays in a residential treatment facility for treatment of mental health disorders and substance related disorders	Emergency transportation by airplane
Obesity (bariatric) surgery	Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
	Kidney dialysis
	Outpatient back surgery not performed in a physician's office Knee surgery
	Private duty nursing services
	Sleep studies
	Knee surgery
	Wrist surgery
	Transcranial magnetic stimulation (TMS)
	Partial hospitalization treatment – mental health disorder and substance related disorders treatment diagnoses

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

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

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

Certain **prescription** drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following **preauthorization** information applies to these **prescription** drugs:

For certain drugs, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**

Step therapy is a type of **preauthorization** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. Step therapy will not apply to prescription drugs used for the treatment of stage-four advanced, metastatic cancer or associated conditions.

Contact us or go online to get the most up-to-date **preauthorization** requirements and list of **step therapy** drugs.

Requesting a medical exception

Sometimes you or your **provider** may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members. For directions on how you can submit a request for a review:

- Call the toll-free number on your ID card
- Log in to the Aetna website at <https://www.aetna.com/>
- Submit the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road, Richardson, TX 75081

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

See the *Complaints, claim decisions, and, appeal procedures* section for more information on your appeals rights in these situations.

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

When we say “expense” in this general rule, we mean the **negotiated charge** for a **network provider**, and **allowable amount** for an **out-of-network provider**.

Negotiated charge

For health coverage:

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

Some **providers** are part of Aetna's **network** for some Aetna plans but are not considered **network providers** for your plan. For those **providers**, the **negotiated charge** is the amount that **provider** has agreed to accept for rendering services or providing **prescription** drugs to members of your plan.

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.

*For **prescription** drug services:*

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

Allowable amount

This is the amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all charges above this amount. The **allowable amount** depends on the geographic area where you get the service or supply. **Allowable amount** doesn't apply to involuntary services. These are services or supplies that are:

- Provided at a network facility by an **out-of-network provider**
- Not available from a **network provider**
- An **emergency service**

The table below shows the method for calculating the **allowable amount** for specific services or supplies:

Service or supply:	Allowable amount is based on:
Professional services and other services or supplies not mentioned below	90% of Medicare allowed rate
Services of hospitals and other facilities	90% of Medicare allowed rate
Prescription drugs	110% of average wholesale price (AWP)
Dental expenses	

Important note:

See *Special terms* used, below, for a description of what the **allowable amount** is based on.

If the **provider** bills less than the amount calculated using a method above, the **allowable amount** is what the **provider** bills.

Special terms used:

- Average wholesale price (AWP) is the current average wholesale price of a **prescription** drug as listed in the Facts & Comparisons®, Medi-Span daily price updates or any other similar publication we choose to use.
- Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility **provider's** estimated costs for the service and leave the **provider** with a reasonable profit. This means for:
 - **Hospitals** and other facilities that report costs or cost to charge ratios to The Centers for Medicare & Medicaid Services (CMS), the FCR rate is based on what the facilities report to CMS
 - Facilities that don't report costs or cost to charge ratios to CMS, the FCR rate is based on a statewide average of these facilities

We may adjust the formula as needed to maintain the reasonableness of the **allowable amount**. For example, we may make an adjustment if we determine that in a state the charges of a specific type of facility are much higher than charges of facilities that report to CMS.

- Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific **provider** performance. We update our system with these when revised within 180 days of receiving them from CMS. If Medicare doesn't have a rate, we use one or more of the items below to determine the rate for a service or supply:
 - The method CMS uses to set Medicare rates
 - How much other **providers** charge or accept as payment
 - How much work it takes to perform a service
 - Other things as needed to decide what rate is reasonable

We may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) programs
- Our rate may exclude other payments that CMS may make directly to **hospitals** or other **providers** and backdated adjustments
- For anesthesia, our rate may be at least 105% of the rate CMS establishes
- For lab, our rate may be 75% of the rate CMS establishes
- For DME, our rate may be 75% of the rate CMS establishes

For medications that are paid as a medical benefit instead of a pharmacy benefit, our rate may be 100% of the rates CMS establishes.

When the **allowable amount** is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to **providers** under Medicare programs.

Our reimbursement policies

We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the **allowable amount**. When we do this, we consider:

- The length and difficulty of a service
- Whether additional expenses are needed, when multiple procedures are billed at the same time
- Whether an assistant surgeon is needed
- If follow up care is included
- Whether other conditions change or make a service unique
- Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
- The educational level, licensure or length of training of the **provider**

We base our reimbursement policies on our review of:

- CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and aren't appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in relevant clinical areas

We use commercial software to administer some of these policies. Policies may differ for professional services and facility services.

Get the most from your benefits:

We have online tools to help you decide whether to get care and if so, where. Log in to your member website. The website contains additional information that can help you determine the cost of a service or supply.

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**. For in-**network** coverage, **covered services** they are:

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

For **out-of-network** coverage:

- The service is **medically necessary**
- You get your care from an **out-of-network provider**
- You or your **provider preauthorizes** the service when required

For outpatient **prescription** drugs, your costs are based on:

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

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

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 **preauthorization**, your **physician** requests it, we deny it and you get the services without **preauthorization**.
- You get care from an **out of-network provider** and the **provider** waives all or part of your cost share.

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**.

Important Note:

"ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN UNLESS BALANCE BILLING FOR THOSE SERVICES IS PROHIBITED."

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 **coinsurance**.

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

Coordination of benefits

The Coordination of Benefits (“COB”) provision applies when a person has health care 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). A plan is defined below under Key terms.

Order of benefit determination rules

When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows:

<ul style="list-style-type: none">• The primary plan pays according to its terms of coverage and without regard to the benefits under any other plan
<ul style="list-style-type: none">• A plan does not have a COB provision is always primary unless the provisions of both plans state that the complying plan is primary, except:<ul style="list-style-type: none">- Coverage that you have because of membership in a group that is designed to supplement part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are:<ul style="list-style-type: none">○ Major medical coverages that are superimposed over base plan hospital and surgical benefits○ Insurance type coverages that are written in connection with a closed panel to provide out-of-network benefits.
<ul style="list-style-type: none">• A plan may consider the benefits paid by another plan in calculating payment of its benefits only when it is secondary to that other plan.
<ul style="list-style-type: none">• If the primary plan is closed panel plan and the secondary plan is not, the secondary plan must pay benefits as if it were the primary plan when a covered person uses an out-of-network provider or physician except for emergency services or authorized referrals that are paid or provided by the primary plan.
<ul style="list-style-type: none">• When multiple contracts providing coordinated coverage are treated as a single plan, this applies only to the plan as a whole. Coordination among the component contract is governed by the terms of the contracts. If more than one carrier pays or provided benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan’s compliance with these rules.
<ul style="list-style-type: none">• If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans’ benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of the secondary plan.

Key Terms

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

Plan:

A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

<ul style="list-style-type: none"> • A plan includes: 	<ul style="list-style-type: none"> • Group blanket or franchise accident and health insurance policies, excluding disability income protection coverage • Individual and group health maintenance organization evidences of coverage • Individual accident and health insurance policies • Individual and group preferred provider benefit plans and exclusive provider benefit plans • Group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care • Medical care components of individual and group long-term care contracts • Limited benefit coverage that is not issued to supplement individual or group in-force policies • Uninsured arrangements of group or group-type coverage • The medical benefits coverage in automobile insurance contracts • Medicare or other governmental benefits as permitted by law
<ul style="list-style-type: none"> • A plan does not include: 	<ul style="list-style-type: none"> • Disability income protection coverage • The Texas Health Insurance Pool • Workers' compensation insurance coverage • Hospital confinement indemnity coverage or other fixed indemnity coverage • Specified disease coverage • Supplemental benefit coverage • Specified accident coverage • School accident-type coverages that cover students for accidents only, including athletic injuries, either on "24-hour" or a "to and from school" basis • Benefits provided in Long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services,

	<p>assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services</p> <ul style="list-style-type: none"> • Medicare supplement policies • A state plan under Medicaid • A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan • Other nongovernmental plan • An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible
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Each plan for coverage is a separate plan, If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan

This plan:

This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans

<ul style="list-style-type: none"> • How this plan coordinates with like benefits: 	<p>Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.</p>
<ul style="list-style-type: none"> • The order of benefit determination rules for this plan: 	<p>The order of benefit determination rules determines whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.</p> <ul style="list-style-type: none"> • When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits • When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100% of the total allowable expense

Allowable expense:

Allowable expense is a health or dental care expense, including **deductibles**, coinsurance and **copayments**, that is covered at least in part by any plan covering the person.

<ul style="list-style-type: none">• Allowable expense for benefits provided in the form of services:	<p>When a plan provides benefits in the form of services the reasonable cash value of each service will be considered an allowable expense and a benefit paid.</p>
<ul style="list-style-type: none">• Expenses that are not allowable expenses:	<p>An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.</p> <p>Some expenses and services are not allowable expenses. Here are some examples:</p> <ul style="list-style-type: none">• The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.• If a person is covered by two or more plans that don't have a negotiated charge and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for specific benefit is not an allowable expense.• If a person is covered by two or more plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.• If a person is covered by one plan that does not have negotiated charges and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides it benefits or services based on negotiated charges, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician has contracted

	<p>with the secondary plan to provide the benefit or service for a specific negotiated charge or payment amount that is different than the primary plan's payment arrangement and if the health care provider or physician contract permits, the negotiated charge or payment must be the allowable expense used by the secondary plan to determine its benefits.</p> <ul style="list-style-type: none"> • The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, preauthorization of admissions, and network provider and physician arrangements.
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Allowed amount:

Allowed amount is the amount of a billed charge that a carrier determines to be covered for services by an **out-of-network provider**. The amount includes both the carrier's payment and any applicable **deductible, copayment,** or coinsurance amounts for which the insured is responsible.

Closed panel plan:

Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care **providers** and **physicians** that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care **providers** and **physicians**, except in cases of emergency or referral by a panel member.

Custodial parent:

Custodial parent is the parent with the right to designate the primary residence of a child by court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation

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	<p>Plan covering you as an employee, policyholder, retired employee or subscriber (not as a dependent)</p> <p>If you or your spouse have Medicare coverage, this may be reversed so that the plan covering you or your spouse as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee. If you have any questions about this you can contact us.</p>	<p>Plan covering you as a dependent</p> <p>If you or your spouse have Medicare coverage, this may be reversed so that the plan covering you or your spouse as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee. If you have any questions about this you can contact us.</p>
Child – parents married or living together, whether or not they have ever been married	Plan of parent whose birthday (month and day) is earlier in the (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together, whether or not they have ever been married	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Plan of other parent Birthday rule applies (later in the year) Non-custodial parent’s plan
Child – covered by individuals who are not his or her parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Child of: Persons who are not his or her parents	The rules shown for parents will apply, as if the persons were parents of the child	The rules shown for parents will apply, as if the persons were parents of the child
Child of: Parents, who is also covered under a spouses plan	<p>The plan has covered the person longer is primary</p> <p>If the coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse.</p>	<p>The plan has covered the person longer is primary</p> <p>If the coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse.</p>

<p>Active or inactive employee</p> <p>This rule does not apply if:</p> <ul style="list-style-type: none"> • The plan that covers you as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits • The “Non-dependent or Dependent” paragraph, above can determine the order of benefits 	<p>Plan covering you as an active employee (or dependent of an active employee)</p>	<p>Plan covering you as a laid off or retired employee (or dependent of a former employee)</p>
<p>Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation</p> <p>This rule does not apply if:</p> <ul style="list-style-type: none"> • The other plan does not have the rule, and as a result, the plans do not agree on the order of benefits • The “Non-dependent or Dependent” paragraph, above can determine the order of benefits 	<p>Plan covering you as an employee or retiree (or dependent of an employee or retiree)</p>	<p>COBRA or state continuation coverage</p>
<p>Longer or shorter length of coverage</p>	<p>Plan that has covered you longer</p>	<p>Plan that has covered you for a shorter period of time</p>
<p>Other rules do not apply</p>	<p>Plans share expenses equally</p> <p>This plan will not pay more than it would have paid had it been the primary plan.</p>	<p>Plans share expenses equally</p> <p>This plan will not pay more than it would have paid had it been the primary plan.</p>

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. Your current and prior plan must be offered through the same policyholder.

Effect on the benefits of this plan

- When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan:
 - Will calculate the benefits it would have paid in the absence of other health care coverage. The calculated amount will be applied to any allowable expense under its plan that is unpaid by the primary plan.
 - May reduce its payment so that the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim.
 - Must credit to its plan **deductible** any amounts it would have credited to its **deductible** in the absence of other health care coverage.
- If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel **provider**, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with federal and state laws concerning confidential information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give us any facts it needs to apply those rules and determine benefits.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid. Or, we may recover from any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of the benefits provided in the form of services.

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.

Recovery rights related to workers' compensation

If we pay more than we should have because workers' compensation benefits paid for the same illness or injury we may recover the excess from any of the following:

- Any person we paid or for whom we paid
- Any workers' compensation plan that is responsible for payment
- Any fund designed to provide benefits for workers' compensation claims

The recovery rights will be applied even if:

- The benefits are in dispute or are paid by means of settlement or compromise
- No decision has been made that the illness or injury was in the course of, or due to, your employment
- No agreement has been made by you, or the workers' compensation plan, about the amount of benefits due to health care
- The health care benefits are excluded from the workers' compensation settlement or compromise

By accepting benefits under this plan, you or your representatives agree to:

- Notify us of any workers' compensation claim made
- Reimburse us as described

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 **preauthorize** them.

Retrospective claim

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

Concurrent care claim extension

A concurrent care claim extension occurs when you 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**. We will notify you when we make a determination for such a request. If we make an adverse 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 independent review organization, if the situation is eligible for independent review.

We will not reduce or deny coverage for services that we have already approved. During this concurrent claim extension period, you are still responsible for your share of the costs, such as **copayments** that apply to the service or supply. If your request for extended services is not approved after your adverse determination, and we uphold the decision to reduce or terminate such services, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows how much time we have to tell you about decisions for different types of claims we **preauthorize**.

Type of notice	Initial determination (us)	Extensions	Additional information request (us)	Response to additional information request (you)
Pre-service claim*	No later than 3 calendar days after we receive the request	Not applicable	Not applicable	Not applicable
Concurrent care claim* If you are hospitalized (may include concurrent care claim of hospital stays)	No later than 24 hours after we receive the request followed by written notification within 3 business days	Not applicable	Not applicable	Not applicable
If you are not hospitalized	No later than 3 calendar days after we receive the request	Not applicable	Not applicable	Not applicable
If you are currently receiving prescription drugs or intravenous infusions	No later than the 30 th day before the date on which the prescription drugs or intravenous infusions will be discontinued	Not applicable	Not applicable	Not applicable

Care to make sure you are stable following emergency treatment (post-stabilization) or for life threatening condition	No later than one (1) hour after we receive request	Not applicable	Not applicable	Not applicable
Requests for step therapy exception (non-emergency)	No later than 72 hours after we receive the request	Not applicable	Not applicable	Not applicable
Requests for step therapy exception (emergency)	No later than 24 hours after we receive request	Not applicable	Not applicable	Not applicable
Acquired brain injury	No later than 3 business days after we receive the request	Not applicable	Not applicable	Not applicable
Retrospective review	30 days	15 days	30 days	45 days

*If we approve the care and services, we will send you a letter no later than 2 business days after we receive the request. The *Adverse determinations* section explains how and when we tell you about an adverse determination.

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 **coinsurance**, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and 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

Complaint

A complaint is any oral or written expression of dissatisfaction regarding any aspect of our operation. You, someone who represents you, or your provider may file the 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. If your complaint is for services that you have not already received, we will provide you with a written response within 15 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

It is not a complaint if:

- We resolve a misunderstanding or misinformation, to your satisfaction, by providing an explanation or more information.
- You or your **provider** call or write to tell us you are unhappy with, or disagree with, an adverse determination. Instead, this is an appeal of the adverse determination. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determination* sections for more information

Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know that we have received your complaint within 5 business days. Our letter will tell you about our complaint procedures and timeframes. If you call us to complain, we will send you a complaint form to complete and return

If your complaint concerns an emergency, or denial of continued hospitalization or **prescription drugs** and intravenous infusions, we will do an expedited appeal review. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determinations* sections for more information.

Adverse determinations

An adverse determination is our determination that the health care services you have received, or may receive are:

- **Experimental or investigational**
- **Not medically necessary**

If we deny health care services because your **provider** does not request **preauthorization** or a concurrent claim extension, it is not an adverse determination.

If we make an adverse determination, we will tell you in writing. Our written decision will tell you:

- The main reason for denial
- The clinical reason for denial
- The source of the screening criteria used as a guideline to make the decision
- How to ask for an appeal of the denial, including your right to appeal to an independent review organization (IRO) and how to obtain an independent review
- How to obtain an immediate review by the IRO when the claim denial involves:
 - A life threatening condition
 - The provision of **prescription drugs** or intravenous infusions for which the patient is receiving health benefits under the policy
 - Requests for **step therapy** exception

The chart below shows how much time we have to tell you about an adverse determination.

Type of notice	When you need care to make sure you are stable following emergency treatment (post-stabilization)	While you are in the hospital	When not hospitalized at the time of the decision	Prescription drugs or other intravenous infusions that you are currently receiving	Retrospective
Initial decision	No later than 1 hour after the request to the treating provider	Within 1 business day by phone or email to your provider followed by written notice within 3 business days to you and your provider	Within 3 business days to you and your provider	No later than 30 th day before on which the prescription drugs or intravenous infusions will be discontinued	Within 30 days after the date on which the claim is received
Extensions	Not applicable	Not applicable	Not applicable	Not applicable	15 days
Additional Information Request (us)	Not applicable	Not applicable	Not applicable	Not applicable	30 days
Response to additional information request (you)	Not applicable	Not applicable	Not applicable	Not applicable	45 days

Important note:

We will tell you about an adverse determination within the time appropriate to the circumstances relating to the delivery of the services and your condition. We will always tell no later than the times shown in the chart above.

Appeal

Your request to reconsider an adverse determination is an appeal of an adverse determination. It is also an appeal if you ask us to re-review a complaint because you are not happy with our initial response. The *Appeal of a complaint* and *Appeal of adverse determinations* sections below explain the appeal.

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 we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an “adverse 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 determination. This is the internal appeal process. If you still don’t agree, you can also appeal that decision.

Appeal of a complaint

You can ask us to re-review your complaint. You can appeal by contacting us.

We will let you know that we have received your appeal within 5 business days. This notice will describe the appeals process and your rights. Part of this process is that we will assign a panel to review your appeal. You will have the opportunity to provide additional information for the panel to consider in the review your appeal. You or an authorized representative can attend the appeal hearing in person or by telephone.

The panel will include an equal number of:

- Non-employee members.
- Texas Health Aetna representatives who were not involved in making the initial decision.
- **Providers** (including **specialists**) who were not involved in making the decision. We will use a **provider** with experience in the area of care that is disputed.

We will send you the following information at least 5 days before the appeal panel hearing, unless you agree otherwise:

- A copy of any documentation to be presented by our staff
- The specialties of the **physician** or **providers** consulted during the review
- The name and affiliation of all Texas Health Aetna representatives on the appeal panel

You may respond to this information. The appeal panel will consider your response in their review.

The panel will review the information and provide us with their decision. We will send you the final decision in writing within 30 calendar days of receiving the appeal. If your appeal is for services that you have not already received, we will send you the final decision in writing within 15 calendar days of receiving the appeal. The letter will include:

- The date we received the appeal request
- The panel's understanding of your complaint and the facts
- The clinical basis and criteria used to make the decision
- Documents supporting the decision
- If applicable, a statement of your right to request an independent review
- A statement of your right to appeal to the department of insurance at:
Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439

If you ask, we will give you or your representative reasonable access to appeal information. This includes all documents, records and other information we used to decide the claim, or appeal. We will not charge you for the information.

Appeal of an adverse 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.

Any other claim appeal

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

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

- Your name
- The policyholder's name
- A copy of the adverse 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.

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.

We will let you know that we have received your appeal of the adverse determination within 5 business days. This notice will describe the appeals process and your rights. If you call us to appeal, we will send you an appeal form to complete and return.

The review and decision of your appeal will be made by personnel not involved in making the initial adverse decision.

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 determination. You can respond to the information before we tell you what our final decision is.

Expedited internal appeal

You are entitled to an expedited internal appeal process for emergency care denials, denials of care for life-threatening conditions, and denials of continued stays in a **hospital**. You can also ask for an expedited internal appeal if we deny a request for **step therapy** exception or a request for **prescription drugs** or intravenous infusions you are currently receiving.

Important note:

You can skip our standard and expedited internal appeal process and instead appeal to an independent review organization (IRO) in some situations. See the *Exhaustion of appeals process* section.

Timeframes for deciding appeals of adverse determination

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision. We may tell you about our decision orally or in writing. If we tell you orally, we will send you a letter within 3 calendar days after the oral notice.

Type of claim	Our response time from receipt of appeal
Urgent care claim	As soon as possible (based on the medical urgency of the case) but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received
Emergency medical condition	As soon as possible but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received
When you need care to make sure you are stable following emergency treatment (post-stabilization)	No later than 1 hour after the request
If you are hospitalized at the time of the adverse determination (may include concurrent care claim of hospital stays)	No later than 1 business day from the date all information to complete the review is received*
If you are receiving prescription drugs or intravenous infusions	As soon as possible but no later than 1 business day from the date all information to complete the review is received*

Pre-service claim requiring preauthorization	As soon as possible but no later than 15 calendar days*
Requests for step-therapy exception (non-emergency)	No later than 72 hours after we receive the request
Requests for step-therapy exception (emergency)	No later than 24 hours after we receive the request
Acquired brain injury	No later than 3 business after the request
Retrospective claim	As soon as possible, but no later than 30 calendar days from receipt of the request for appeal*
Expedited internal appeal	As soon as possible (based on the medical or dental immediacy of the condition, procedure, or treatment under review) but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received

*If your appeal is denied, your **provider** may ask us in writing to have a certain type of specialty **provider** review your case. The request must be made no later than 10 business days after the appeal was denied. A **provider** of the same or a similar specialty who would typically manage this type of condition will do the review. A decision will be made within 15 working days of the date we receive such a request.

Exhaustion of appeal process

In most situations, you must complete an appeal with us before you can appeal through an external review process.

We encourage you to complete an appeal with us before you pursue voluntary arbitration, litigation or other type of administrative proceeding.

Sometimes you do not have to complete the 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 independent review process at the same time.
- We did not follow all of the claim determination and appeal requirements of the Texas and the federal Department of Health and Human Services. But you will not be able to proceed directly to independent 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
- You have a life-threatening condition. You can have your appeal reviewed through the independent review process.
- If you are receiving **prescription drugs** or intravenous infusion treatment and we deny them. You can have your appeal reviewed through the independent review process.
- Your request for a **step therapy** exception was denied. You can have your appeal reviewed through the independent review process.

Independent review

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

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

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

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

You must submit the request for independent review form:

- To Texas Health 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 IRO. We will pay for information we send to the IRO plus the cost of the review.

Texas Health Aetna will contact the IRO that will conduct the review of your claim. If your request is based on exigent circumstances your request will be sent as soon as possible. An “exigent circumstance means when you are:

- Experiencing a health condition that may seriously jeopardize your life, health or ability to regain maximum function
- Undergoing a current course of treatment using a non-formulary drug

The IRO 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 IRO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an IRO decision?

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

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

You may be able to get a faster independent review after an adverse determination if:

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

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request or within 24 hour if your request is for an exigent circumstance.

Utilization review

Prescription drugs covered under this plan are subject to misuse, waste or abuse utilization review by us, your **provider** or your network pharmacy. The outcome of the review may include:

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

Recordkeeping

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

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal. But we will pay the fees or expenses incurred for the review of the IRO.

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

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

When you can join the plan

You can enroll:

- At the end of any waiting period the policyholder requires
- Once each year during the 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 any children placed with you for adoption*
 - Foster children
 - Children you are responsible for under a qualified medical support order or court order
 - Grandchildren in your legal custody
 - Grandchild who is your dependent for federal tax purposes at the time application for coverage of the grandchild is made
 - A grandchild whose parent is already covered as a dependent on this plan

*Your adopted child may be enrolled as shown in the *When you can join the plan* section, after the date:

- You become a party in a suit for adoption, or
- The adoption becomes final

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:

- Birth:
 - Your newborn child is covered on your health plan for the first 31 days after birth.
 - To keep your newborn covered, we must receive your completed enrollment information. Or, you can call to notify us. You must provide the information within 31 days of birth.
 - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
 - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- Adoption or placement for adoption:
 - A child that you, or that you and your spouse adopts is covered on your plan for the first 31 days after you become a party in a suit for adoption or the adoption is complete.
 - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after you become a party in a suit for adoption or the adoption is complete.
 - If you miss this deadline, your adopted child will not have health benefits after the first 31 days.
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 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
- When your dependent moves outside the service area for your employee plan

We must receive the completed enrollment information within 31 days of the date when coverage ends.

You can also enroll in these situations:

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

We 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

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 policyholder 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.

When will your coverage end

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The policyholder asks to end coverage
- You are no longer eligible for coverage
- Your work ends
- You stop making required premium contributions, if any apply
- We end your coverage for one of the reasons shown in this section
- 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.

Your employer will notify Aetna of the date your coverage ends. You and your dependents will be covered until the end of the month after we receive the notice, unless any of the following occur:

- Your employer notifies you at least 30 days before coverage ends
- You and your dependents are covered under COBRA or state continuation
- You and your dependents are enrolled in another health plan that starts before the end of the month after we receive the notice

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.

We will not end your coverage based on your health care status or needs, we also will not end your coverage because you used your rights under the *Complaints, claim decisions, and appeal procedures* section.

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 policyholder 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 policyholder and we have agreed to do so. It is the policyholder's responsibility to let us know when your work ends. If the policyholder and we agree in writing, we will extend the limits.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

What are your COBRA rights?

The federal COBRA law usually applies to employers of group sizes of 20 or more and gives employees and 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 – State of Texas

Continuation privilege for certain dependents

There are events that may cause your dependents to lose coverage. For some events, certain dependents are eligible to continue their coverage for a time. Here are the events, eligible dependents and time periods:

Qualifying event causing loss of coverage:	Covered persons eligible for continued coverage:	Length of continued coverage (starts from the day you lose current coverage):
<ul style="list-style-type: none">• Death of employee• Retirement of employee• Retirement of employee	<ul style="list-style-type: none">• Dependent who has been covered under the plan for at least one year• An infant under one year of age	3 years

When do I receive state continuation information?

The chart below lists who must give notice, the type of notice required, and the time period to give the notice.

Notice	Requirement	Deadline
You or your covered spouse	Send written notice to your employer	Within 15 days of the qualifying event
Your employer	Will provide you with an enrollment form to continue coverage	No later than 15 days after they receive notification
You or your covered spouse	Complete the enrollment form to continue coverage	Within 60 days of the qualifying event.

You must send the completed enrollment form from within 60 day of the qualifying event. If you don't, you will lose the right to continue coverage. We will cover your dependent during this period as long as the premiums and administrative charges are paid.

Group continuation privilege

You may continue coverage if your coverage ends for any reason except:

- Involuntary termination for cause
- Discontinuance of the group agreement

To continue coverage, you must be covered for at least 3 months in a row right before your coverage ends.

You must give your employer written election of continuation no more than 60 days following the later of the date:

- Your coverage ends or
- You are given notice by the contract holder

Your first **premium** payment must be made within 45 days after the date of the coverage election. After that, **premium** payments are due no later than the end of the grace period after the **premium** due date.

You can continue coverage until the earliest of:

- Six months after the end of the COBRA continuation period, if you are eligible for COBRA
- Nine months after the date election is made, if you are not eligible for COBRA
- The date you fail to pay premiums
- The date the group coverage terminates in its entirety
- The date you are covered for similar benefits by another health insurance policy or program
- The date you are covered (other than COBRA) for similar benefits by another plan

Continuation of coverage for other reasons

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

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

You are "totally disabled" if you cannot perform all of the substantial and material duties and functions of your occupation and any other gainful occupation in which you earn substantially the same compensation you earned before the disability.

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

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:

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

How 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 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 90 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
- 12 months of coverage

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

If you are not totally disabled when your coverage ends, coverage for hearing services and supplies may be extended for 30 days after your coverage ends:

- If the **prescription** for the hearing aid is written during the 30 days before your coverage ends
- If the hearing aid is ordered during the 30 days before your coverage ends

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

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

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

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious **illness** or **injury**,
- Cause the dependent child to lose status as a full-time student under the plan
- Be certified by the treating **physician** as **medically necessary** due to serious illness or injury. The **physician** treating your child will be asked to keep us informed of any changes.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this certificate

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

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

Your coverage is defined by the group policy. This document may have amendments and riders too. Under certain circumstances, we, the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive **preauthorization**, **prescription** quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the policyholder or **provider**, can do this. Any modifications made will be no less favorable than the current plan requirements.

Legal action

You are encouraged to 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.

Notice of claim

You must give us written notice of claim within 20 days (or as soon as reasonably possible) after you have incurred expenses for **covered services**. You can send the claim to us or to one of our authorized agents. We will send you a claim form within 15 days after we receive your notice of a claim. If we do not send you a claim form within those 15 days, you will automatically be considered to have met the proof of loss requirements. See the *Proof of loss* section below.

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.

Proof of loss

You must submit written proof of loss you within 90 days after your loss occurs. If you couldn't reasonably provide this proof within 90 days, we will still accept your claim. But you must provide the proof as soon as possible, but no later than one year after the 90 days ends (unless you were legally incapacitated).

Time of payment of claims

We will pay benefits to you or your assignee. After we receive your timely proof of loss, we will pay claims within 60 days after we receive the proof of loss. Please see the *Proof of loss* section above.

Records of expenses

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

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

Honest mistakes and intentional deception

Honest mistakes

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

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 IRO

We won't rescind your coverage due to an intentional deception if the deception happened more than 2 years after the effective date of this certificate.

In the absence of fraud, any statement made on your application for coverage is considered a representation and not a warranty. We will only use a statement during a dispute if it is shared with you and your beneficiary, or the person making the claim.

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 certificate 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 <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Premium contribution

Your plan requires that the policyholder make premium contribution payments. We will not pay for benefits if premium contributions are not made by the end of the grace period. Any decision to not pay benefits can be appealed.

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 by a third party

If a third party caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money for your injuries. If you have a legal right to get money from a third party for causing your injuries, we are entitled to that money, up to the amount we pay for your care.

When you have a legal right to get money from one or more third parties for causing your injuries and you pursue that legal right, you are:

- Agreeing to repay us from money you receive from those third parties because of your injury.
- Giving us the right to seek money in your name, from those third parties because of your injuries.
- Agreeing to cooperate with us so we can get paid back in full, up to the applicable amount noted below. For example, you'll tell us within 30 days of when you seek money from those third parties 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 our portion of the 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. Notify us by contacting us.

We will only seek money from your own uninsured/underinsured motorist or medical payments coverage (if any) if you or your immediate family member did not pay premiums for the coverage.

If you are not represented by an attorney, then we can recover the lesser of:

- One-half of the money you receive, or
- The total amount paid by us

If you are represented by an attorney, then we can recover the lesser of:

- One-half of the money you receive, less attorney's fees and costs for the recovery, or
- The total amount paid by us, less attorney's fees and costs for the recovery

How will Attorney's fees be determined?

If we do not use an attorney:

- We (and any other payors) will pay your attorney a fee agreed to between us (and other payors) and your attorney plus a pro rata share of the recovery expenses
- If no agreement exists, then the court will award your attorney a reasonable fee payable for our (and any other payors) share of the recovery not to exceed 1/3 of the recovery

If we use an attorney:

- The court will award attorney's fees to our attorney and your attorney based on the benefit accruing as a result of each attorney's service. The total attorney's fees may not exceed 1/3 of our (and any other payors) recovery.

Payor means a plan issuer that:

- Has a contractual right of subrogation, and
- Pays benefits to you or on your behalf as a result of personal injuries caused by someone else's tortious conduct

A payor includes, but is not limited to, an issuer of:

- A health benefit that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness
- A disability benefit plan
- An employee welfare benefit plan

Payment to a conservator, other than you

Sometimes a court order gives another person certain rights and duties to act on behalf of your dependent child. Such a person is called a managing or possessory conservator. We may pay that person benefits on behalf of your dependent child. To receive benefits, they must send us a written certified copy of the court order with the claim form. But they are not entitled to benefits if:

- We received a valid assignment of benefits on a unpaid medical bill
- You sent us a claim for benefits for covered services that you paid

Reimbursement to Texas Department of Human Services

We will repay the actual costs of medical expenses the Texas Department of Human Services pays through medical assistance for you or your dependent if you or your dependent are entitled to payment for the medical expenses.

Repayment of these medical expenses for your dependent child will be paid to the Texas Department of Human Services if, when you submit proof of loss, you notify us in writing that:

- Your dependent child is covered under the financial and medical assistance service program in Texas and you either:
 - Have possession or access to the child through a court order; or
 - Are not entitled to possession of our access to the child and are required by the court to pay child support

You will need to ask us to make direct payment to the Texas Department of Human Services.

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.

Effect of benefits under other plans

Health Maintenance Organization (HMO) plan

If you are eligible for and enrolled in coverage under an HMO plan offered by the policyholder, you will not have coverage under this plan (except for vision coverage if there is any) on the date that your HMO plan coverage starts. If you are pregnant when you change plans, you may be eligible for an extension of benefits. Contact us for more information.

Glossary

Allowable amount

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

Behavioral health provider

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

Brand-name prescription drug

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

Coinsurance

Coinsurance is the percentage of the bill you pay after you meet your **deductible**.

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 in this 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 preauthorization requirements* section and the *Glossary* for more information

Crisis stabilization unit

An institution licensed or certified by the Texas Department of Mental Health and Mental Retardation to provide 24-hour residential program to treat a moderate to severe psychiatric crisis. The program is prescribed by a **physician** or other **health professional** to provide short-term, intensive, structured care.

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.

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

Drug guide

A list of **prescription** drugs and devices established by us or an affiliate. It does not include all **prescription** drugs and devices. This list can be reviewed and changed by us or an affiliate only upon renewal and with 60 days' notice to you. A copy is available at your request. Go to <https://www.aetna.com/individuals-families/find-a-medication.html>.

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 a fetus
 - Serious disfigurement

Emergency services

Treatment given in a **hospital's** emergency room, freestanding emergency facility, or comparable emergency facility. 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**.

Formulary exclusions list

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

Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product. It offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance
- It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Health professional

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

Home health care agency

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

Hospital

An institution licensed as a **hospital** by applicable law. This is a place that offers medical care. 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.

Infertile, infertility

A disease defined by the failure to become pregnant:

- For a female with a male partner, after:
 - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
 - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
 - At least 12 cycles of donor insemination if under the age of 35
 - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
 - At least 2 abnormal semen analyses obtained at least 2 weeks apart
- For a an individual or their partner who has been clinically diagnosed with gender identity disorder

Jaw joint disorder

This is:

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

Mail order pharmacy

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

Maximum out-of-pocket limit

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

Medically necessary, medical necessity

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

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 NAP **provider** listed in the NAP directory is not a **network provider**. A **network provider** can also be referred to as an in-network provider.

Out-of-network provider

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

Physician

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

Preauthorization, preauthorize

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.

Preferred drug

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

Prescription

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

Primary care physician (PCP)

A **physician** who:

- The directory lists as a **PCP**
- Is selected by a covered person from the list of **PCPs** in the directory
- Supervises, coordinates and provides initial care and basic medical services to a covered person
- Shows in our records as your **PCP**

A **PCP** can be any of the following **providers**:

- General practitioner
- Family **physician**
- Internist
- Pediatrician
- OB, GYN, and OB/GYN
- Medical group (primary care office)

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**

Retail pharmacy

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

Room and board

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

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If 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.

Specialty prescription drugs

These are **prescription** drugs that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration. You can contact us to access the list of specialty drugs.

Specialty pharmacy

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

Stay

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

Step therapy

A form of **preauthorization** under which certain **prescription** drugs are excluded from coverage, unless a first-line therapy drug is used first by you. The list of **step therapy** drugs is subject to change by us or an affiliate. An updated copy of the list of drugs subject to **step therapy** is available upon request or on our website at <https://www.texashealthaetna.com/individuals-families/find-a-medication.html>.

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

Telehealth

A health service, other than a **telemedicine** medical service, delivered by a **health professional** licensed, certified or otherwise entitled to practice in the State of Texas and acting within the scope of their license, certification or entitlement to a patient at a different physical location than the **health professional** using telecommunications or information technology.

Telemedicine

A health care service delivered by a **physician** licensed, certified or otherwise entitled to practice in the State of Texas and acting within the scope of their license, certification or entitlement to a patient at a different physical location than the **health professional** using telecommunications or information technology.

A consultation between you and a **provider** who is performing a clinical medical or 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 12 months.

Urgent condition

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

Walk-in clinic

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near or within a:

- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- **Hospital**
- Outpatient department of a **hospital**
- Physician's office
- Urgent care facility

Additional Information Provided by

Caraday Healthcare, LLC

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

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

Name of Plan:

Caraday Healthcare, LLC Welfare Benefit Plan

Employer Identification Number:

84-3394616

Plan Number:

501

Type of Plan:

Welfare

Type of Administration:

Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

Caraday Healthcare, LLC
102 Whitetail Dr.
San Marcos, TX 78666
Telephone Number: (737) 221-5058

Agent For Service of Legal Process:

Caraday Healthcare, LLC
102 Whitetail Dr.
San Marcos, TX 78666

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

End of Plan Year:

July 31

Source of Contributions:

Employer and Employee

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the Senior Vice President and/or Human Resources.

ERISA Rights

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

Receive Information about Your Plan and Benefits

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

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- (1) all stages of reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, <http://www.cms.gov/home/regsguidance.asp>, and this U.S. Department of Labor website, <https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans>.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

Confidentiality Notice

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

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

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

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

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.