BENEFIT PLAN

Prepared Exclusively For
Northwestern University Postdoctoral Fellow Benefit Program

Open Choice

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

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

aetna™

Preferred Provider Organization (PPO) Medical Plan

Booklet-certificate

Prepared exclusively for:

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Underwritten by Aetna Life Insurance Company

151 Farmington Ave, Hartford, CT 06156
Telephone: Use the toll-free number on your ID card
www.aetna.com

Welcome

Thank you for choosing **Aetna**.

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

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

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

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

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

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

WARNING: LIMITED BENEFITS WILL BE PAID WHEN **OUT-OF-NETWORK PROVIDERS** ARE USED. When you choose to use the services of an **out-of-network provider** for an **eligible health service** in non-**emergency** situations, benefit payments to **out-of-network provider** are not based upon the amount billed. Your benefit payment will be based on the **recognized charge**.

YOU CAN EXPECT TO PAY MORE THAN THE **COINSURANCE** AMOUNT SHOWN IN THE SCHEDULE OF BENEFITS AFTER THE PLAN HAS PAID ITS PORTION. After the plan has paid its portion of the bill as provided in 215 ILCS 5/356z.3a, **out-of-network provider** may bill you for any amount up to the billed charge.

Other than **coinsurance** and **deductible**, **network providers** agree to accept discount payments for services without additional billing to you. You may obtain information about the participating status of professional providers and out-of-pocket expenses by calling the toll-free number on your ID card.

Table of Contents

Let's get started!

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

Some notes on how we use words

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

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

What your plan does – providing covered benefits

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

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

How your plan works – starting and stopping coverage

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

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

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

How your plan works while you are covered in-network

Your in-network coverage:

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

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

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

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

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

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

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

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

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

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

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

   The plan tells you how we will work through our differences. And if we still disagree, an independent group of experts called an "external review organization" or ERO for short, will make the final decision for us.

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

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

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

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

- Means that when you use out-of-network coverage, it is your responsibility to start the **precertification** process with **providers**.
- Means you will pay a higher cost share when you use an **out-of-network provider**.

You will find details on:

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

How to contact us for help

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

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

You can also contact us by:

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

Your member ID card

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

Remember, only you and your covered dependents can use your member ID card. If you misuse your card we may end your coverage.

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

Who the plan covers

You will find information in this section about:

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

Who is eligible?

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

When you can join the plan

As an employee you can enroll yourself and your dependents:

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

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

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

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

- Your legal spouse
- Your civil union partner. In accordance with the Illinois Religious Freedom Protection and Civil Union Act (750 ILCS 75/), a "civil union" means a legal relationship between 2 people of either the same or opposite sex
- Your dependent children – your own or those of your spouse or civil union partner
  - The children must be under 26 years of age, and they include:
    - Biological children
    - Stepchildren
    - Legally adopted children, including any children in your custody due to an interim court order of adoption or placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
    - Grandchildren in your court-ordered custody
    - Any other child with whom you have a parent-child relationship
    - Your military veteran dependent who:
      - Is unmarried
      - Is under age 30
      - Is a resident of Illinois
      - Served as a member of the active or reserve component of the United States Armed Forces, including the Illinois National Guard
      - Received a discharge release, other than a dishonorable discharge.

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

Adding new dependents

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

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 31 days of the date of your marriage.
- A civil union partner - If you enter a civil union, you can put your civil union partner on your health plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your civil union.
  - Ask the policyholder when benefits for your civil union partner will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 31 days of the date of your civil union.
- A newborn child - Your newborn child is covered on your health plan for the first 31 days from the moment of birth.
  - To keep your newborn covered, we must receive your completed enrollment information and any required **premium** contribution 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.
- An adopted child - A child that you, or that you and your spouse, civil union partner adopts is covered on your plan for the first 31 days after the adoption is complete.
  - To keep your adopted child covered, we must receive your completed enrollment information within 60 days after the adoption.
  - If you miss this deadline, your adopted child will not have health benefits after the first 60 days.
- A stepchild - You may put a child of your spouse, civil union partner on your plan.
  - You must complete your enrollment information and send it to us within 60 days after the date of your marriage, civil union with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage, civil union or the first day of the month following the date we receive your completed enrollment information.

Notification of change in status

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

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

Special times you and your dependents can join the plan

You can enroll in these situations:

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

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

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

Effective date of coverage

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

Medical necessity and precertification requirements

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

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

- The eligible health service is **medically necessary**.
- You or your **provider precertifies** the **eligible health service** when required.

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

Medically necessary; medical necessity

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

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

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.

Precertification

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

In-network

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

Out-of-network

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

Precertification should be secured within the timeframes specified below. For **emergency services**, **precertification** is not required, but you should notify us within the timeframes listed below. To obtain **precertification**, call us at the telephone number listed on your ID card. This call must be made:

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

We will provide a written notification to you and your **physician** of the **precertification** decision**,** where required by state law. If your **precertified** services are approved**,** the approval is valid for 180 days as long as you remain enrolled in the plan.

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

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

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

- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits *Precertification covered benefit reduction* section.
- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your out-of-network **deductibles** or **maximum out-of-pocket limits**.

What types of services require precertification?

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

Inpatient services and supplies	Outpatient services and supplies
Stays in a **hospital**	**Cosmetic** and reconstructive **surgery**
Stays in a **skilled nursing facility**	
Stays in a **rehabilitation facility**	
Stays in a **hospice** facility	
Stays in a **residential treatment facility** for treatment of **mental disorders** and **substance abuse**	
Bariatric **surgery** (obesity)	

Certain **prescription drugs** are covered under the medical plan when they are given to you by your doctor or health care facility. The following 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 **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

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

If you want to request an exception to a **medical necessity** or **step therapy** requirement, see the *How do I request a medical exception?* section or call the toll-free Member Services number on your member ID card for more information.

Important note:
Precertification and **step therapy** requirements do not apply to FDA-approved **prescription drugs** used for the treatment of **substance use disorders**, other than those established by applicable criteria.

How do I request a medical exception?

Sometimes you or your **provider** may seek a medical exception to request coverage for a **prescription drug** that is not covered or for which coverage is being discontinued (for reasons other than safety or drug manufacturer withdrawal) or from a *step therapy* requirement or dosage limitation.

You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. We will process your request through our standard medical exception process within 72 hours after receipt. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members. If the medical exception is approved by us, you will receive coverage for the **prescription drug** according to the terms of your **group policy**.

We will make a coverage determination for your urgent request within 24 hours after we receive your request and will tell you, someone who represents you and your **prescriber** of our decision. In the case of denial, we will provide you with:

- The reason for the denial
- An alternate covered medication (if applicable)
- Information for submitting an appeal of the denial

If you are denied a medical exception based on the above process, you, someone who represents you or your **prescriber** may have the right to have your original exception request and our denial of that request reviewed by an independent review organization. If our denial of your exception request is one that allows you to ask for an independent review, we will say that in the notice of adverse benefit determination we send you. We will also describe the independent review process. If allowed and requested, a determination on the external exception will be made and we will tell you, or someone who represents you, and your **prescriber** of the independent reviewer's coverage determination within 72 hours after we receive your request (or within 24 hours after receipt if your request is urgent). If we grant a standard external exception, we will provide coverage of the drug for the entire time of the **prescription**. If we grant an expedited external exception, we will provide coverage of the **prescription drug** for the entire time you have the urgent situation.

Eligible health services under your plan

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

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

For example,

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

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

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

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

Preventive care and wellness

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

Important notes:

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

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

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

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

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

Routine physical exams

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

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- 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 for everyone ages 15-65 and other ages at increased risk
  - Screening for gestational diabetes for women, including women 24-28 weeks pregnant and those at risk of developing gestational diabetes
  - Screening for diabetes (type 2) for adults with high blood pressure
  - High risk human papillomavirus (HPV) DNA testing for women age 30 and older
    30 and older
  - Bone density screenings for osteoporosis
  - Aspirin use to prevent cardiovascular disease for men and women of certain ages
  - Blood pressure screening
  - Cholesterol screening for adults of certain ages or at higher risk
  - Depression screening
  - Hepatitis B screening for people and adolescents ages 11-17 at high risk. This includes:
    - People from countries with 2% or more Hepatitis B prevalence
    - U.S. born people not vaccinated as infants and with at least 1 parent born in a region with 8% or more Hepatitis B prevalence
  - Hepatitis C screening for:
    - adults at increased risk
    - 1 time for everyone born 1945-1965
  - Fall prevention in community-dwelling adults age 65 and older who are at an increased risk for falls. This includes:
    - Vitamin D supplements
    - Exercise or physical therapy
  - Latent tuberculosis infection screening for populations at increased risk
  - Skin cancer behavioral counseling for fair skinned individuals ages 10-24
- Radiological services, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** checkup.

Preventive care immunizations

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

- Adults:
  - Herpes zoster
  - Shingles if you are 60 years of age or over
- Adults and children from birth to age 18:
  - Diphtheria
  - Hepatitis A
  - Hepatitis B
  - Human papillomavirus (HPV)
  - Influenza (flu shot)
  - Measles
  - Meningococcal
  - Pertussis (whooping cough)
  - Pneumococcal
  - Tetanus
  - Varicella (Chickenpox)
  - Mumps
  - Rubella
- Children from birth to age 18:
  - Haemophilius influenza type b
  - Inactive poliovirus
  - Rotavirus.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **physician,** obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes annual pap smears including ovarian cancer surveillance tests for woman at risk of ovarian cancer. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.
- Clinical breast exams as follows:
  - For women over 20 years of age but less than 40, at least every 3 years
  - For women 40 years of age and older, annually.
- Breast cancer chemoprevention counseling.
- Cervical cancer screening for sexually active woman.
- Chlamydia infection screening for younger women and other women at higher risk.
- HIV screening and counseling for sexually active woman.
- Osteoporosis screening for women over age 60 depending on risk factors.

Eligible health services for pregnant or women who may become pregnant include:

- Anemia screening on a routine basis
- Folic acid supplements for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening
- Urinary tract or other infection screening.

Well child preventive visits

Eligible health services include routine:

- Autism screening for children at 18 and 24 months
- For children ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years and 15-17 years, the following:
  - Behavioral assessments
  - Dyslipidemia screening for children at higher risk of lipis disorders
  - Height, weight and body mass index (BMI) measurements
  - Medical history throughout development
  - Tuberculin testing for children at higher risk of tuberculosis
- Cervical dysplasia screening for sexually active females
- Developmental screening for children under age 3
- Fluoride chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hematocrit or hemoglobin screening
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- Iron supplements for children ages 6-12 months at risk for anemia
- Lead screening for children at risk of exposure
- Oral health risk assessment for young children ages: 0-11 months, 1-4 years and 5-10 years
- Phenylketonuria (PKU) screening for newborns.

Preventive screening and counseling services

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

- **Obesity and/or healthy diet counseling**
  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

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

- **Use of tobacco products**
  Eligible health services include the following screening, education and counseling services to help you to stop the use of tobacco products:
  - Preventive education and counseling visits
  - Abdominal aortic aneurysm one-time screening for men of specified ages who have never smoked.
  - Treatment visits
  - Class visits;
  - Tobacco cessation prescription and over-the-counter drugs
    - **Eligible health services** when age 18 and over include FDA- approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

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

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

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

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Low dose mammography screening for woman age 35 and older, (including x-ray examination, digital mammography and breast tomosynthesis) for the presence of occult breast cancer as follows:
  - For women 35-39, a baseline mammogram
  - For women 40 years of age and older, annually
  - For woman under 40, with a family or prior personal history of breast cancer, positive genetic testing or other risk factors, at necessary age and intervals
  - Comprehensive ultrasound screening and MRI of the entire breast(s) when a mammogram demonstrates heterogeneous or dense breast tissue, as determined by your **physician**
  - Screening MRI, as determined by your **physician**
- Annual digital rectal exams and prostate specific antigen (PSA) tests as recommended by your **physician**. This includes:
  - Asymptomatic men age 50 and older
  - African-American men age 40 and over
  - Men age 40 and over with family history of prostate cancer
- Colorectal cancer screening for adults over 50
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)

- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings: adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years.

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

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

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

Prenatal care

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

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height
- Hepatitis B screening at their first visit
- Expanded tobacco intervention and counseling for pregnant tobacco users

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

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

Comprehensive lactation support and counseling services

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

Breast feeding durable medical equipment

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

Breast pump

Eligible health services include:

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

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

Breast pump supplies and accessories

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

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

Family planning services – female contraceptives

Eligible health services include family planning services such as:

Counseling services

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

Devices

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

Voluntary sterilization

Eligible health services include 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.

Important note:
See the following sections for more information:

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

Physicians and other health professionals

Physician services

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

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

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

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

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

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

Physician surgical services

Eligible health services include the services of:

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

Alternatives to physician office visits

Walk-in clinic

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

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

Hospital and other facility care

Hospital care

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

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

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

Anesthesia and associated hospitalization for certain dental care

Eligible health services include general anesthesia and associated **hospital** care for dental care if you are:

- A dependent child age 6 or under
- Have a medical condition that requires hospitalization or general anesthesia for care
- Disabled

As used in this section, you are "disabled" if you have a chronic condition that meets all of the following:

- It is due to a mental and/or or physical impairment
- It is likely to continue
- It results in substantial limitations in 1 or more of the following activities:
    - Self-care
    - Open and expressive language
    - Learning
    - Ability to move
    - Ability to live alone
    - Financial independence

Eligible health services also include dental anesthesia by a **dental provider** for an autism spectrum disorder or a developmental disability. You must:

- Be under 19 years of age
- Be diagnosed with autism spectrum disorder or a developmental disability before reaching age 22
- Make 2 visits to the dental provider before seeking other coverage

We define developmental disability as a disability that meets all of the following conditions:

- Is cerebral palsy, epilepsy, or any other condition, other than mental illness, that results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services that are similar. For purposes of this definition, autism is considered a related condition.
- It is likely to continue indefinitely.
- It results in substantial limitations in 3 or more areas of major life activity:
  - Self-care
  - Speech or self-expression
  - Learning
  - Being able to move
  - Self-direction
  - The ability to live alone

Eligible health services can be provided in a dental office, oral surgeon's office, **hospital**, or outpatient surgical treatment center.

Alternatives to hospital stays

Outpatient surgery and physician surgical services

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

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

Home health care

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

- You are homebound.
- Your **physician** orders them.
- The services take the place of your needing to **stay** in a **hospital** or a **skilled nursing facility**, or needing to receive the same services outside your home.
- The services are a part of a **home health care plan**.
- The services are **skilled nursing services**, home health aide services or medical social services, or are short-term speech, physical or occupational therapy.
- If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.
- 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 conditions and limitations imposed on therapy provided outside the home. See the *Short-term rehabilitation services and Habilitation therapy services* sections and the schedule of benefits.

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

Hospice care

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

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

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

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

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

Outpatient private duty nursing

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

Skilled nursing facility

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

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

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

Emergency services and urgent care

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

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

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

As it applies to in-network coverage, you are covered for follow-up care only when your **physician or PCP** provides the care or coordinates it.

If you use an **out-of-network provider** to receive follow up care, you are subject to a higher out-of-pocket expense.

In case of a medical emergency

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

Non-emergency condition

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

In case of an urgent condition

Urgent condition

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

Non-urgent care

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

Specific conditions

Autism spectrum disorder

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

Eligible health services include the services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder. We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan.

We will cover 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, and
- That is responsible for observable improvements in behavior.

Important note:
Applied behavior analysis requires **precertification** by **Aetna**. The **network provider** is responsible for obtaining **precertification**. You are responsible for obtaining **precertification** if you are using an **out-of-network provider**.

Birthing center

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

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery

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

Diabetic equipment, supplies and education

Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Alcohol swabs
  - Glucagon emergency kits
- Equipment
  - External insulin pumps
  - Blood glucose monitors without special features, unless required due to blindness
- Training
  - Self-management training provided by a health care **provider** certified in diabetes self-management training

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

Family planning services – other

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

- Voluntary sterilization for males
- Abortion

Maternity and related newborn care

Eligible health services include prenatal (including prenatal HIV testing) and postpartum care and obstetrical services. After your child is born, **eligible health services** include:

- 48 of inpatient care in a **hospital** after a vaginal delivery
- 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier. If discharged earlier, to verify the condition of the infant, a **physician** office visit or an in home nurse visit within 48 hours after discharge is available
- The mother could be discharged earlier. If so, the plan will pay for 1 post-delivery home visits by a health care **provider**.

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

Mental health treatment

Eligible health services include the treatment of **mental 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**, and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group and family therapies for the treatment of mental health
  - 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 the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23 hour observation
    - Peer counseling support by a peer support specialist
      - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider.**

Substance use disorders related treatment

Eligible health services include the treatment of **substance use 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** and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility.** Treatment of **substance use disorders** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance use disorders** section or unit, unless you are admitted for the treatment of medical complications of **substance use disorders**.

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

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

Oral and maxillofacial treatment (mouth, jaws and teeth)

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

- Non-surgical treatment of infections or diseases.
- **Surgery** needed to:
  - Treat a fracture, dislocation, or wound.
  - Cut out teeth partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- **Hospital** services and supplies received for a **stay** required because of your condition.
- Dental work, **surgery** and **orthodontic treatment** needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair, and are firmly attached to your jaw bone at the time of your **injury**.
  - Other body tissues of the mouth fractured or cut due to **injury.**

- Crowns, dentures, bridges, or in-mouth appliances only for:
  - The first denture or fixed bridgework to replace lost teeth.
  - The first crown needed to repair each damaged tooth.
  - An in-mouth appliance used in the first course of **orthodontic treatment** after an **injury**.
- Accidental **injuries** and other trauma. Oral **surgery** and related dental services to return sound natural teeth to their pre-trauma functional state. These services must take place no later than 24 months after the **injury**.
  - Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.
  - If a child needs oral **surgery** as the result of accidental **injury** or trauma, **surgery** may be postponed until a certain level of growth has been achieved.

Reconstructive surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast, physical complications of all stages of the mastectomy, including lymphedema and prostheses. It also includes a **physician** office visit or in home nurse visit within 48 hours after discharge.
- 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.

Transplant services

Eligible health services include transplant services provided by a **physician** and **hospital**.

Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage provided by the same insurer, each will have their benefits paid by their own program.
- If the transplant donor does not have medical coverage (from any source) for organ transplants services, **eligible health services** include organ transplant services provided to the donor.
- If you are the donor to an organ transplant, **eligible health services** include organ transplant services provided to you. In this case, **eligible health services** do not include those organ transplant services for the recipient.

This includes the following transplant types:

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

Network of transplant facilities

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

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 **IOE facility** we designate to perform the transplant you need. You may also get transplant services at a non-**IOE facility**, but your cost share will be higher.

Important note:

- If there is no **IOE facility** for your transplant type in your network, the National Medical Excellence Program® (NME) will arrange for and coordinate your care at an **IOE facility** in another one of our networks. If you don't get your transplant services at the **IOE 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. While your transplant care is being coordinated by the National Medical Excellence Program® (NME), all medical services must be managed through the NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the **eligible health service** is not directly related to your transplant.

Treatment of infertility

Basic infertility

Eligible health 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**.

Comprehensive infertility services

Eligible health services include comprehensive **infertility** care. The first step to using your comprehensive infertility health care services is enrolling with our National Infertility Unit (NIU). To enroll you can reach our dedicated NIU at 1-800-575-5999.

Infertility services

You are eligible for **infertility** services if:

- You are covered under this plan as an employee or the employee's legal spouse, civil union partner or as a covered dependent age 18 or above.
- There exists a condition that meets the definition of **infertility,** identified by your **physician** or **infertility specialist** and documented in your medical records.
- You have not had a voluntary sterilization, without a surgical reversal or you had a successful surgical reversal of the voluntary sterilization. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- You do not have **infertility** that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- You are unable to conceive or sustain a successful pregnancy through less costly infertility treatment for which coverage is available under this plan.

Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators with expertise in all areas of **infertility** who can help:

- Enroll in the **infertility** program.
- Assist you with precertification of eligible health services.
- Coordinate **precertification** for comprehensive **infertility** when these services are **eligible health services**.
- Evaluate your medical records to determine whether comprehensive **infertility** services are reasonably likely to result in success.
- Determine whether comprehensive **infertility** services are **eligible health services**.

Your **provider** will request approval from us in advance for your **infertility** services. We will cover charges made by an **infertility specialist** for the following **infertility** services**:**

- Ovulation induction cycle(s) with menotropins.
- Intrauterine insemination/artificial insemination.

Advanced reproductive technology

Eligible health services include Assisted Reproductive Technology (ART) services. ART services are more advanced medical procedures or treatments performed to help a woman achieve pregnancy.

ART services

ART services include:

- In vitro fertilization (IVF)
- Zygote intrafallopian transfer (ZIFT)
- Gamete intrafallopian transfer (GIFT)
- Cryopreserved embryo transfers (Frozen Embryo Transfers (FET))
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery
- Uterine embryo lavage
- Artificial insemination

You are eligible for ART services if:

- You are covered under this plan as an employee or as a covered dependent who is the employee's legal spouse, civil union partner or a covered dependent age 18 and above. Dependent children under age 18 are covered under this plan for ART services only in the case of fertility preservation due to planned treatment for medical conditions that will result in infertility.
- Your condition meets the definition of **infertility**, identified by your **physician** or **infertility specialist** and documented in your medical records.
- You have not had a voluntary sterilization without a surgical reversal or you had a successful surgical reversal of the voluntary sterilization. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- You do not have **infertility** that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- You are unable to conceive or sustain a successful pregnancy through reasonable less costly **infertility** treatment for which coverage is available under this plan.
- You have exhausted the comprehensive **infertility** services benefits or have clinical need to move on to ART procedures. You have met the requirement for the number of months trying to conceive through egg and sperm contact.
- If you were diagnosed with premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services through age 45 regardless of FSH level.

Oocyte retrieval limitation
For oocyte retrievals, **eligible health services** include treatment only if you are unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate **infertility** treatments. This requirement is waived if you or your partner has a medical condition that renders such treatment useless.

Eligible health services for oocyte retrievals do not include treatment if you already underwent four completed oocyte retrievals, except if a live birth follows a completed oocyte retrieval, then coverage is provided for two additional completed oocyte retrievals. Regardless of the source of payment, this is a lifetime maximum.

Following the final completed oocyte retrieval for which coverage is available, **eligible health services** include one subsequent procedure to transfer the oocytes or sperm to you is provided.

The maximum number of completed oocyte retrievals eligible for coverage is six.

Fertility preservation
Only cancer patients are eligible for fertility preservation. Fertility preservation involves or the retrieval of mature eggs and/or sperm or the creation of embryos that are frozen for future use. You are eligible for fertility preservation only when you:

- Are believed to be fertile
- Have planned services that will result in infertility such as:
  - Chemotherapy
  - Pelvic radiation
  - Other gonadtoxic therapies
  - Ovarian or testicular removal

Along with the eligibility requirements above, you are eligible for fertility preservation benefits if, for example:

- You, your partner or dependent child are planning cancer treatment that is demonstrated to result in **infertility**. Planned treatments include:
  - Bilateral orchiectomy (removal of both testicles).
  - Bilateral oophorectomy (removal of both ovaries).
  - Hysterectomy (removal of the uterus).
  - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**.
- The eggs that will be retrieved for use are reasonably likely to result in a successful pregnancy by meeting the criteria below:

You are	**You need to have an unmedicated day 3 FSH test done within the past:**	**The results of your unmedicated day 3 FSH test:**
A female under 35 years of age	12 months	Must be less than 19 mIU/mL in your most recent lab test to use your own eggs.
A female 35 years of age or older	6 months	**If you are less than age 40**, must be less than 19 mIU/mL in your most recent lab test **If you are age 40 and older**, must be less than 19 mIU/mL in all prior tests performed after age 40.

Eligible health services for fertility preservation will be paid on the same basis as other ART services benefits for individuals who are **infertile**.

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators with expertise in all areas of **infertility** who can help:

- Enroll in the **infertility** program.
- Assist you with **precertification** of **eligible health services**.
- Coordinate **precertification** for ART services and fertility preservation services when these services are **eligible health services.** Your **provider** should obtain **precertification** for fertility preservation services through the NIU either directly or through a reproductive endocrinologist.
- Evaluate your medical records to determine whether ART services and fertility preservation services are reasonably likely to result in success.
- Determine whether ART services and fertility preservation services are **eligible health services.**
- Case manage for the provision of ART services and fertility preservation services for an eligible covered person.

Your **provider** will request approval from us in advance for your ART services and fertility preservation services. We will cover charges made by an ART specialist for the following ART services**:**

- Any combination of the following ART services:
  - In vitro fertilization (IVF)
  - Uterine embryo lavage
  - Zygote intrafallopian tube transfer (ZIFT)
  - Gamete intrafallopian tube transfer (GIFT)
  - Low tubal ovum transfer (LTOT)
  - Cryopreserved embryo transfers (Frozen Embryo Transfer (FET)
  - **Prescription drug** therapy used during an oocyte retrieval cycle
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. The embryo transfer itself is not covered. (See the *What your plan doesn't cover - some eligible health services exceptions* section.)
- Charges associated with your care when you will receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Medical costs of oocytes or sperm donors for ART procedures used to retrieve oocytes or sperm and includes the cost of the procedure used to transfer oocytes or sperm to the covered recipient. We will also cover associated donor medical expenses, established by us, as a prerequisite to donation.
- The procedures are done while not confined in a **hospital** or any other facility as an inpatient.

Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

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

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work and radiological services

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

Breast cancer pain medication and therapy

Eligible health services include pain therapy. Pain therapy is medically based and includes reasonably defined goals to stabilize or reduce pain with breast cancer. Your **provider** will periodically evaluate the effectiveness of the pain therapy against these goals.

Pain medication related to the treatment of breast cancer is covered under the outpatient **prescription drug** section.

Chemotherapy

Eligible health services for chemotherapy depends 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**.

Outpatient infusion therapy

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

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

Eligible health services also include the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including but not limited to the use of intravenous immunoglobulin therapy.

Eligible health services include immune gamma globulin therapy if you are diagnosed with a primary immunodeficiency. Initial authorization will be for 3 months with reauthorization every 6 months thereafter. When you receive treatment for 2 years, reauthorization will be every 12 months, unless more frequently indicated by your **physician.**

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

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

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

Outpatient radiation therapy

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

- Radiological services
- Gamma ray
- Accelerated particles

- Mesons
- Neutrons
- Radium
- Radioactive isotopes

Specialty prescription drugs

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

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

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

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

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

Short-term cardiac and pulmonary rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

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

Short-term rehabilitation services

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

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

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

Outpatient cognitive rehabilitation, physical, occupational and speech therapy

Eligible health services include:

- Physical therapy, 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.** Massage therapy is covered treatment under physical therapy.
  - Significantly improve or restore physical functions lost as a result of an acute **illness**, **injury** or **surgical procedure**
  - Treat parts of the body affected by multiple sclerosis to maintain your level of function

  Massage therapy is covered treatment under physical therapy.
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness**, **injury** or **surgical procedure**, or
  - 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:
  - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute **illness, injury** or **surgical procedure**, or
  - 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 and
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Spinal manipulation

Eligible health 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.

Habilitation therapy services

Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).

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

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

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

Outpatient physical, occupational, and speech therapy

Eligible health services include:

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

Other services

Acupuncture

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

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

Ambulance service

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

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

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

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

Clinical trial therapies (experimental or investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an “approved clinical trial” only when you have cancer or terminal illnesses and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- Based on published, peer-reviewed scientific evidence you may benefit from the treatment.

An "approved clinical trial" is a clinical trial that meets all of these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

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

As it applies to in-network coverage, coverage is limited to benefits for routine patient services provided within the network.

Durable medical equipment (DME)

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

Coverage includes:

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

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

Hearing aids

Eligible health services include hearing instruments and related hearing aid services, if you are under age 18, as described below:

Hearing instrument means:

- Any wearable, non-disposable, nonexperimental instrument or device designed to aid or make up for impaired human hearing
- Parts, attachments or accessories for the instrument or device, including an ear mold

Hearing aid services include:

- Audiometric exams
- Selection, fitting and adjustments of ear molds
- Hearing instrument repairs

Non-routine/non-preventive care hearing exams

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

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

Nutritional supplements

Eligible health services include amino acid-based formula products order by a **physician** for the treatment of eosinophilic disorders or short bowel syndrome, regardless of the delivery method.

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

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.

Orthotic devices

Eligible health services include customized orthotic devices and mechanical supportive devices ordered by your **physician** for the treatment of weak or muscle deficient feet. Customized orthotic device means a prosthetic device based on your physical **illness**.

Osteoporosis

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

Prosthetic devices

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

Prosthetic device means:

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

Coverage includes:

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

Vision care

Routine vision exams

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

Outpatient prescription drugs

What you need to know about your outpatient prescription drug plan

Read this section carefully so that you know:

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

Some **prescription drug**s may not be covered or coverage may be limited. This does not keep you from getting **prescription drug**s that are not **covered benefits**. You can still fill your **prescription**, but you have to pay for it yourself. For more information see the *Where your schedule of benefits fits in* section, and see the schedule of benefits.

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

How to access network pharmacies

How do you find a network pharmacy?

You can find a **network pharmacy** in two ways:

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

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

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 our **recognized charge**
- Submitting your own claims

Eligible health services under your plan

What does your outpatient prescription drug plan cover?

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

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

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

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

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

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

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

Prescription drug refill synchronization

You have the right to request synchronization of your **prescription drug** refills once a year when those **prescription drugs**:

- Are covered under your plan
- Are maintenance medications and have refills available when the request is made
- Are not schedule II, III, or IV controlled substances
- Have met any applicable utilization management criteria at the time of the request
- Are of a type that can be safely split into short-fill periods
- Do not have special handling or sourcing needs that require a single, designated **pharmacy** to fill or refill

"Synchronization" means the coordination of **prescription drug** refills if you take 2 or more **prescription drugs** for 1 or more chronic conditions. This will keep your **prescription drug** refills on the same schedule for a given time period.

We will apply a prorated daily cost share rate, when needed, to synchronize **prescription drugs** that meet all of the above criteria and are dispensed by a **network pharmacy**. Any dispensing fees will not be prorated and will be based on the number of **prescriptions** filled or refilled at the time of synchronization.

What outpatient prescription drugs are covered

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

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

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

Retail pharmacy

Generally, **retail pharmacies** may be used for up to a 90 day supply of **prescription drugs**. You should show your ID card to the **network pharmacy** every time you get a **prescription** filled. The **network pharmacy** will submit your claim. You will pay any cost sharing directly to the **network pharmacy**.

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

Mail order pharmacy

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

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

Specialty pharmacy

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

You are encouraged to fill all covered **specialty prescription drugs** through a network **specialty pharmacy** or network **retail pharmacy.**

Other services

Preventive Contraceptives

For females who are able to reproduce, your outpatient **prescription drug** plan covers, for up to a 12 month supply at one time, certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. Your outpatient **prescription drug** plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive drugs by logging onto your Aetna secure member website at https://www.aetna.com/ or calling the number on your ID card.

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

Important Note: You may qualify for a medical exception if your **provider** determines that the contraceptives covered standardly as preventive are not medically appropriate. Your **prescriber** may request a medical exception and submit the exception to us.

Diabetic supplies

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

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

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

Immunizations

Eligible health services include preventive immunizations as required by the ACA guidelines. You are encouraged to have them administered at a **network pharmacy**. You may call the number on your ID card to find a participating **network pharmacy**. You should contact the **pharmacy** for availability, as not all **pharmacies** will stock all available vaccines.

Infertility drugs

Eligible health services include oral and injectable synthetic ovulation stimulant **prescription drugs** used primarily for the purpose of treating the underlying cause of **infertility**.

Off-label use

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

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

Health care services related to off-label use of these drugs may be subject to **precertification**, **step therapy** or other requirements or limitations.

Orally administered anti-cancer drugs, including chemotherapy drugs

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

Over-the-counter drugs

Eligible health services include certain over-the-counter medications, as determined by the plan. Coverage of the selected over-the-counter medications requires a **prescription**. You can access the list by logging onto your secure member website at www.aetna.com.

Preventive care drugs and supplements

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

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

- Statin preventive medication: The United States Preventive Task Force (USPSTF) recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met:
  - They are ages 40 to 75 years
  - They have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking)
  - They have a calculated 10-year risk of a cardiovascular event of 10% or greater.

  Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.
- Preeclampsia prevention aspirin: The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
- Dental caries prevention: infants and children up to age 5 years. The USPSTF recommends:
  - Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices.
  - Primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.

Risk reducing breast cancer prescription drugs

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

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

Tobacco cessation

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

Eligible health services include charges made by a **pharmacy** for **prescription drugs** and aids, that are approved by the U. S. Food and Drug Administration, to stop the use of tobacco products by a person 18 years of age or over. You are encouraged to obtain these products at a **network pharmacy**. The **prescription drug** or aid must be prescribed by a **prescriber.**

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

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

Over-the-counter (OTC) tobacco cessation aids

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

How you get an emergency prescription filled

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

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

Where your schedule of benefits fits in

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

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

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

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

How your copayment/coinsurance works

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

What precertification requirements apply

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

There is another type of **precertification** for **prescription drugs**, and that is **step therapy**. **Step therapy** is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

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

If you want to request an exception to a **medical necessity** or **step therapy** requirement, see the *How do I request a medical exception?* section or call the toll-free Member Services number on your member ID card for more information.

Important note:
Precertification and **step therapy** requirements do not apply to FDA-approved **prescription drugs** used for the treatment of **substance use disorders**, other than those established by applicable criteria.

How do I request a medical exception?

Sometimes you or your **prescriber** may seek a medical exception to request coverage for a **prescription drug** that is not covered or for which coverage is being discontinued (for reasons other than safety or drug manufacturer withdrawal), from a **step therapy** requirement or dosage.

You, someone who represents you or your **prescriber** can contact us and will need to provide us with the required clinical documentation. We will process your request through our standard medical exception process within 72 hours after receipt. Any exception granted is based upon an individual, case by case decision, and will not apply to other members. If the medical exception is approved by us, you will receive the coverage for the **prescription drug** according to the terms of your **group policy**.

You, someone who represents you or your **prescriber** may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a **non-preferred drug**. You, someone who represents you or your **prescriber** may submit a request for a quicker review for an urgent situation by:

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

We will make a coverage determination for your urgent request within 24 hours after we receive your request and will tell you, someone who represents you and your **prescriber** of our decision. In the case of denial, we will provide you with:

- The reason for the denial
- An alternate covered medication (if applicable)
- Information for submitting an appeal of the denial

Prescribing units

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

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

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

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

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

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

- Under "General exceptions" we've explained what general services and supplies are not covered under the entire plan.
- Below the general exceptions, in "Exceptions under specific types of care," we've explained what services and supplies are exceptions under specific types of care or conditions.

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

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

General exceptions

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

Examples of these are:

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

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

Cosmetic services and plastic surgery

- Any treatment, **surgery** (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons. This **cosmetic** services exclusion does not apply to **surgery** after an accidental **injury** when performed as soon as medically feasible. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected. This exclusion does not apply to the removal of breast implants due to an **illness** or **injury**.

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

Counseling

- Marriage, religious, family, career, social adjustment, pastoral, or financial counseling.

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding. This exclusion does not apply to court-orders U.S. FDA approved **prescription drugs** for the treatment of **substance use disorders** and any associated counseling or wraparound services.

Custodial care
Examples are:

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

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

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

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

Early intensive behavioral interventions
Examples of those services are:

- Early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions.

Educational services
Examples of those services are:

- Any service or supply for education, training or retraining services or testing.
- Special education, remedial education, wilderness treatment program, job training and job hardening programs

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

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

Facility charges
For care, services or supplies provided in:
- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

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

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

Jaw joint disorder
- Non-surgical treatment of **jaw joint disorder** (TMJ)

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. See the *Eligible health services under your plan – Habilitation therapy service*s section.

Medical supplies – outpatient disposable

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

Other primary payer

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

Outpatient prescription or non-prescription drugs and medicines

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

Personal care, comfort or convenience items

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

Pregnancy charges

- Charges in connection with pregnancy care other than for complications of pregnancy and other covered expenses as specifically described in the *Eligible health services under your plan* section

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 *Eligible health services under your plan* section

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

- Any treatment, **prescription drug**, service, 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 or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

This exclusion does not include **surgery** and prosthetic devices for erectile dysfunction resulting from natural causes, trauma, infection or congenital disease or defects.

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

Telemedicine

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

Therapies and tests

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

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 *Eligible health services under your plan – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* 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, except to the extent coverage is required by applicable laws

Wilderness treatment programs

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

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be 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.

Additional exceptions for specific types of care

Preventive care and wellness

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

Family planning services

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

Physicians and other health professionals

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

Hospital and other facility care

Alternatives to facility stays

Outpatient surgery and physician surgical services

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

Home health care

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

Hospice care

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

Outpatient private duty nursing

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

Specific conditions

Family planning services - other

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

Maternity and related newborn care

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

Mental health treatment

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

Obesity (bariatric) surgery

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity** except as described in the *Eligible health services under your plan – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of 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

Oral and maxillofacial treatment (mouth, jaws and teeth)

- Dental implants

Transplant services

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

Treatment of infertility

- All charges associated with:
  - Cryopreservation (freezing) of eggs, embryos or sperm. However, subsequent non-**experimental or investigational** procedures that use the cryopreserved substance are covered.
- Reversal of voluntary sterilizations, including follow-up care. However, if a voluntary sterilization is successfully reversed, **infertility** benefits are available if your diagnosis meets the definition of **infertility**.
- Travel costs within 100 miles of your home or travel cost required by **Aetna**.
- **Infertility** treatment for covered dependents under age 18.
- Non-medical costs of an egg or sperm donor.
- Selected termination of an embryo, unless the life of the mother would be in danger if all embryos were carried to full term.
- **Experimental or investigational infertility** treatment as determined by the American Society for Reproductive Medicine.
- Services to the surrogate. If you choose to use a surrogate, this does not apply to the cost for procedures to obtain the eggs, sperm or embryo from a covered individual.

Specific therapies and tests

Acupuncture

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Specialty prescription drugs

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

Other services

Ambulance services

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

Clinical trial therapies (experimental or investigational)

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

Clinical trial therapies (routine patient costs)

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

Durable medical equipment (DME)

Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Massage table
- Sauna baths
- Message devices (personal voice recorder)
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Hearing aids

If you are under age 18, the following services or supplies:

- A replacement of:
    - A hearing aid that is lost, stolen or broken
    - A hearing aid installed within the prior 36 month period
- Replacement parts for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any hearing aid prescribed by someone other than a hearing care professional
- Any tests, appliances and devices to:
    - Improve your hearing. This includes hearing aid batteries and auxiliary equipment.
    - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

Hearing aids and exams

The following services or supplies:

- A replacement of:
    - A hearing aid that is lost, stolen or broken
    - A hearing aid installed within the prior 12 month period

- 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
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist
- Any hearing aid furnished or ordered because of a hearing exam that was done before the date you became covered under this plan
- Hearing exams given during a stay in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries and auxiliary equipment.
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

Nutritional supplements

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

Prosthetic devices

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Vision Care

Adult vision care

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

Vision care services and supplies

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

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

Outpatient prescription drugs

Abortion drugs

Allergy sera and extracts administered via injection

Any services related to the dispensing, injection or application of a drug

Biological sera

Cosmetic drugs

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

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

- Including compounded bioidentical hormones

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

Dietary supplements including medical foods

Drugs or medications

- Administered or entirely consumed at the time and place it is prescribed or dispensed
- Which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
- That includes the same active ingredient or a modified version of an active ingredient as a covered **prescription drug** (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to a covered **prescription drug** including **biosimilars** (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved)
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan while an inpatient of a healthcare facility
- Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by **Aetna's** Pharmacy and Therapeutics Committee
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
- 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
- That are used for the purpose of weight gain or reduction, 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 **precertification** and clinical policies.

Duplicative drug therapy (e.g. two antihistamine drugs)

Genetic care

- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

Immunizations related to travel or work

Immunization or immunological agents except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section.

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

Injectables:

- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by us
- Needles and syringes, except for those used for self-administration of an injectable drug
- 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. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as specifically provided in the *Eligible health services under your plan – Diabetic equipment, supplies and education* section.

Prescription drugs:

- Dispensed by other than a **mail order** and **specialty pharmacies** except as specifically provided in the *What prescription drugs are covered* section.
- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this plan.
- Dispensed by a **mail order pharmacy** that include **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
- That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug as determined by the plan.
- That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **preferred drug guide**.

- That are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
- That are 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 would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper; and drugs obtained for use by anyone other than the member identified on the ID card.

Refills

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

Replacement of lost or stolen prescriptions

Test agents except diabetic test agents

We reserve the right to exclude:

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

Who provides the care

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

Network providers

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

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section
- Urgent care – refer to the description of emergency services and urgent care in the *Eligible health services under your plan* section
- Transplants – see the description of transplant services in the *Eligible health services under your plan – specific conditions* section

You may select a **network provider** from the **directory** through your Aetna secure member website at www.aetna.com. You can search our online provider search for names and locations of **providers**.

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

Your PCP

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

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

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

How do you choose your PCP?

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

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

What will your PCP do for you?

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

Your **PCP** can also:

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

How do I change my PCP?

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

Out-of-network providers

You also have access to **out-of-network providers.** This means you can receive **eligible health services** from an **out-of-network provider.** If you use an **out-of-network provider** to receive **eligible health services**, you are subject to a higher out-of-pocket expense and are responsible for:

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

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

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

- You join the plan and the **provider** you have now is not in the network
- You are already a member of **Aetna** 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 an out-of-network provider	**When your provider stops participation with Aetna**
Request for approval	You need to complete a transition coverage request form and send it to us. You can get this form by calling the toll-free number on your ID card.	You or your **provider** should call us for approval to continue any care.
Length of transitional period	Care will continue during a transitional, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. This date is based on the date the **provider** terminated their participation with us.

If you are pregnant and have entered your second trimester, the transitional period will include the time required for postpartum care directly related to the delivery.

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

What the plan pays and what you pay

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

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

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

The general rule

When you get **eligible health services**:

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

  And then

- The plan and you share the expense. The schedule of benefits lists how much your plan pays and how much you pay for each type of health care service. Your share is called a **copayment/ coinsurance.**

  And then

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

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

Important exception – when your plan pays all

Under the in-network level of coverage, your plan pays the entire expense for all **eligible health services** under the preventive care and wellness benefit.

Important exceptions – when you pay all

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

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

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the **negotiated charge**

Where your schedule of benefits fits in

How your deductible works

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

How your copayment/coinsurance works

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

How your maximum out-of-pocket limit works

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

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

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

For claims involving **providers**:

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from the policyholder. • The claim form will provide instructions on how to complete and where to send the form(s).	• You must send us notice and proof as soon as reasonably possible. • If you are unable to complete a claim form, you may send us: – A description of services – Bill of charges – Any medical documentation you received from your **provider**
Proof of loss (claim)	• A completed claim form and any additional information required by us.	• You must send us notice and proof as soon as reasonably possible.
Benefit payment	• Written proof must be provided for all benefits. • If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss	• Benefits will be paid within 30 days after the necessary proof to support the claim is received. • If benefits are not paid within 30 days after proof of loss is received, you are entitled to 9% interest. Interest will be calculated from the 30th day until the date the benefits are paid. However, interest less than $1 may not be paid.

Types of claims and communicating our claim decisions

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

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim

An urgent claim is one for which the doctor treating you decides 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.

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

Pre-service claim

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

Post-service claim

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

Concurrent care claim extension

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

Concurrent care claim reduction or termination

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

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

For treatment of **substance use disorders**: If we determine that benefits are no longer **medically necessary**, we will provide you written notice within 24 hours of the adverse determination and advise you of your right to request an external review.

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

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

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

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

Adverse benefit determinations

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

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

The difference between a complaint and an appeal

A complaint

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

When a complaint is received from the Department of Insurance, we will respond within 21 days of receiving the complaint.

You may contact the Department of Insurance at any time. However, you are encouraged to contact Member Services as directed above before filing a complaint with the Illinois Department of Insurance. Complaints to the Department of Insurance may be submitted in the following ways:

- On-line at https://mc.insurance.illinois.gov/messagecenter.nsf
- By email at consumer_complaints@ins.state.il.us
- By fax to (217) 558-2083
- Office of Consumer Health hotline telephone number: (877) 527-9431

- By mail to:
  Illinois Department of Insurance
  Consumer Assistance
  320 W. Washington Street,
  Springfield, IL 62767

An appeal

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

Appeals of adverse benefit determinations

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

The deadline for filing an appeal will not be postponed or delayed by a **provider** appeal unless the **provider** is acting as your authorized representative.

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

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

You may also contact **Aetna** at the following address and telephone numbers:
Aetna
Middle Market (ISM) CRT
P.O. Box 14002
Lexington, KY 40512
Toll-free telephone number: (877) 204-9186
Fax number: (859) 425-3379

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

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

Urgent care or pre-service claim appeals

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

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

Timeframes for deciding appeals

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	24 hours	15 business days	15 business days	As appropriate to type of claim
Extensions	None	None	None	

Exhaustion of appeals process

You are encouraged to complete the two levels of appeal with us before you can take these other actions:

- Contact the Illinois Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Illinois Department of Insurance
- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding
- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process
- You filed an appeal under the internal appeal process and we did not provide a written decision within:
  - 30 days from the date you filed an appeal of a concurrent or preservice claim
  - 60 days from the date you filed an appeal of a post-service claim

  except to the extent you agreed to a delay
- You filed a request for an expedited internal review and we did not provide a decision within 48 hours, except to the extent you requested or agreed to a delay
- Your **provider** certifies in writing that the recommended health care service or treatment is **experimental or investigational** would be significantly less effective if delayed
- We did not follow all of the claim determination and appeal requirements of the Federal Department of Health and Human Services. But, you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us

External review

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

You have a right to external review only if:

- You claim is denied, reduced or terminated because we determined that it was **experimental or investigation** or it did not meet our requirements for:
  - **medical necessity**
  - appropriateness
  - health care setting
  - level of care
  - effectiveness
- Coverage was rescinded. This does not include a cancellation of coverage due to failure to pay any required **premium**
- You have received an adverse determination

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

You must submit the request for external review form:

- To the Illinois Department of Insurance
- Within 123 calendar days of the date you received the final adverse determination from us
- And you must include a copy of the notice from us and all other important information that supports your request

The deadline for filing an external review will not be postponed or delayed by a **provider** external review unless the **provider** is acting as your authorized representative.

The address and toll-free number for the Office of Consumer Health Information at the Illinois Department of Insurance is:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 West Washington Street
Springfield, Illinois 62767
Toll-free telephone number: (877) 527-9431
E-mail: Doi.externalreview@illinois.gov
http://insurance.illinois.gov/ExternalReview/ExternalReviewMain.html

You will pay for any cost associated with obtaining documentation (i.e. medical record fees, copying fees, etc.) for additional information that you send and want reviewed by the ERO. We will pay for information we send to the ERO plus the cost of the review.

The Illinois Department of Insurance will:

- Contact the ERO that will conduct the review of your claim.

The ERO will:

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

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

How long will it take to get an ERO decision?

Within 5 days, but no more than 45 days after receiving all necessary information, the ERO will notify you of their decision.

But sometimes you can get a faster external review decision. Your **provider** must request an expedited external review from the Illinois Department of Insurance. Your request for an expedited external review must be initiated within 24 hours after you receive our notice of our adverse determination. Upon receipt from the Department of Insurance, we will respond to the eligibility request for an expedited external review within 24 hours. If your request for an expedited review meets the requirements for an expedited external review, the ERO will make their decision within 72 hours. For **substance use disorder** decisions, if the ERO upholds an adverse determination, we will provide **covered benefits** through the day following the determination by the ERO.

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

For initial adverse determinations

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

- Jeopardize your life, health or ability to regain maximum function, or
- Be much less effective if not started right away

For final adverse determinations

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

Recordkeeping

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

Fees and expenses

Except for fees associated with the external review, we do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Coordination of benefits

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

Key terms

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

Allowable expense means:

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

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

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

Here's how COB works

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

Determining who pays

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

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

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or dependent	The plan covering you as an employee or retired employee	The plan covering you as a dependent
Exception to the rule above when you are eligible for Medicare	If you or your spouse has Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us: • **Online:** Log on to your Aetna member website at www.aetna.com. Select Find a Form, then select Your Other Health Plans. • **By phone:** Call the toll-free number on your ID card.	
Dependent under your spouse's plan and your parent's plan	The plan that has covered the person longer* *Same length of coverage, then the "birthday rule" applies.	The other plan covering you as a dependent* *Same length of coverage, then the "birthday rule" applies.
COB rules for dependent children		
Child of: • Parents who are married or living together	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the **calendar year**. *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)* *Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together • With court-order	The plan of the parent whom the court said is responsible for health coverage But if that parent has no coverage then their spouse's plan is primary	The plan of the other parent But if that parent has no coverage, then their spouse's plan is primary
Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule	

Child of: • Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
Child covered by: • Individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination: See *Child of* content above	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee)	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee)
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally	

How are benefits paid?

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

How COB works with Medicare

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

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

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

- Age, disability, or
- End stage renal disease

You are also eligible for Medicare even if you are not covered if you:

- Refused it
- Dropped it, or
- Did not make a proper request for it

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

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	**Primary plan**	**Secondary plan**
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan
If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.	Medicare Your plan
A disability other than ESRD and the policyholder has more than 100 employees	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

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

Other health coverage updates – contact information

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

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

Right to receive and release needed information

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

Right to pay another carrier

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

Right of recovery

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

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

When coverage ends

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

When will your coverage end?

Your coverage under this plan will end if:

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

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of **illness, injury**, sabbatical or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue, until stopped by the policyholder, but not beyond 3 months from the start of your absence.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage will stop on the date that your employment ends.
Your employment ends because: • Your job has been eliminated • You have been placed on severance, or • This plan allows former employees to continue their coverage.	You may be able to continue coverage. See the *Special coverage options after your plan coverage ends* section.
Your employment ends because of a paid or unpaid medical leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 3 months from the start of the absence.

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

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

When will coverage end for any dependents?

Coverage for your dependent will end if:

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

What happens to your dependents if you die?

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

Why would we end you and your dependents coverage?

We may immediately end your coverage if:

- You commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

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

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

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

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

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

Special coverage options after your plan coverage ends

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

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

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

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

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

When do I receive COBRA information?
The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

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

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

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

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

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

When is your first premium payment due?
Your first **premium** payment must be made within 45 days after the date of the COBRA election.

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

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

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

When does COBRA coverage end?
COBRA coverage ends if:

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

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

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

You are “totally disabled” if:

- You cannot work at your own occupation or
- After 24 months, you cannot perform the duties of any gainful occupation for which you are reasonably fitted by training, education or experience.

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

You may extend coverage until the earliest of:

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

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

If your coverage ends while you are not totally disabled**,** your plan will cover hearing services and supplies within 30 days after your coverage ends if:

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

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

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

- Is not able to be self-supporting because of mental or physical disability, and
- Depends mainly on you or another care provider for lifetime care and supervision.

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

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

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

To extend coverage the leave of absence must:

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

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

How can you extend coverage for a dependent after you die?

Your dependent~~s~~ can continue coverage after your death:

- For 90 days. Continuation is subject to the *When will coverage end for any dependents? section*,
- If your dependent is your spouse, with or without dependent children, please refer to the *How can you extend coverage for your former spouse if you die or retire?* section
- If your dependent is a dependent child, please refer to the *How can you extend coverage for a dependent child after you die?* section.

How can you extend coverage for a dependent child after you die?

Your dependents can continue coverage after your death.

Your dependent's coverage will end on the earliest date:

- 2 years after the continuation begins
- Dependent coverage would otherwise stop under the plan
- The dependent becomes covered by another health benefits plan
- Any required contributions stop, including any grace period

To extend coverage the dependent must not be eligible for coverage under the *How can you extend coverage for your former spouse if you die or retire (spousal continuation privilege)?* section.

To request extension of coverage the dependent or their representative can just call the toll-free Member Services number on their ID card.

How can you extend coverage for your former spouse if you die or retire (spousal continuation privilege)?

You have the right to extend coverage for your spouse if coverage would end because:

- Your marriage ends
- You retired or died.

To extend coverage, your former spouse must:

- Apply for continuation of coverage
- Pay the required contribution

within 30 days of the date they receive notice of the right to continue.

If your former spouse is under age 55, the right to continue coverage will be extended until the earliest to happen:

- 2 years from the date continuation started
- The date coverage starts under another plan.
- The date coverage would otherwise end if the marriage had not ended. This will not apply for the first 120 days following the end of the marriage or your death unless the plan ends due to a change in the plan.
- The date the spouse remarries.
- The date contributions are not paid.

If your former spouse is age 55 or older, the right to coverage will be extended until the earliest to happen:

- The date coverage starts under another plan.
- The date coverage would otherwise end if your marriage didn't end, you didn't retire or die. This will not apply for the first 120 days following the end of the marriage, your retirement or your death unless the plan ends due to a change in the plan.
- The date the spouse remarries.
- The date contributions are not paid.
- The date they reach the qualifying Medicare age or establish Medicare eligibility.

The right to continue coverage also includes dependents whose coverage began prior to the end of the marriage or death.

How can you extend coverage for your dependent child when they reach the limiting age?
You can extend coverage for your dependent child after they reach the limiting age.

Your dependent child's coverage will end on the earliest date:

- 2 years after the continuation begins
- Dependent coverage would otherwise stop under the plan
- The dependent becomes covered by another health benefits plan
- Any required contributions are not paid, including any grace period

How can you extend coverage in the event of termination of employment or membership?
You have the right to extend coverage if coverage ends because your employment or membership is terminated.

To extend coverage, you must:

- Be enrolled under this plan for 3 months prior to termination
- Apply for continuation of coverage within 30 days after the later of:
  - The date of termination
  - The date you are given written notice of the right to continuation by the policyholder. You must elect continuation within 60 days after the date of termination.
- Pay the required contribution

Continuation is not available if your employment ended due to commission of a felony or theft in connection with your work and you admit to, or are convicted of, the felony or theft.

The right to continue coverage will be extended until the earliest to happen:

- The end of the 12 month period which starts on the date coverage would otherwise stop
- The date you reach the qualifying Medicare eligible age
- The date coverage starts under another plan
- The date contributions are not paid
- The date coverage ends as to employees of policyholder
- The date coverage would otherwise end as set forth elsewhere in this plan.

Coverage for dependents will be extended until the earliest to happen:

- The date the child reaches the limiting age
- The date coverage would otherwise end
- The date the child is covered under another plan

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet-certificate

We prepared this booklet-certificate according to federal laws and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet-certificate when we administer your coverage, so long as we use reasonable discretion.

How we administer this plan

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

Who's responsible to you?

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

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

Coverage and services

Your coverage can change

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

If a service cannot be provided to you

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

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

Legal action

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

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

Physical examinations and evaluations

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

Records of expenses

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

Things that would be important to keep are:

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

Honest mistakes 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 before we learned of it.

Intentional deception

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

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage.

- We will give you 30 days advanced 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 external review organization.

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. Unless we agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** or facility under this group policy**.** This may include:

- The benefits due
- The right to receive payments or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this group policy.

To request assignment you must complete an assignment form. The assignment form is available from the employer. The completed form must be sent to us for consent.

Financial sanctions exclusions

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

Premium contribution

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

Recovery of overpayments

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

Right of recovery

Subrogation

Aetna has the right to recover from a negligent third party, or their insurer, benefits we paid for an **injury** or **illness**.

To help us get paid back, you are agreeing to provide us with any requested:

- Information or assistance
- Documentation

This provision applies whether or not the third party admits liability.

Reimbursement

If you recover expenses for an **illness** or **injury** that due to the negligence of a third party, **Aetna** has the right to first reimbursement for all benefits we paid. This includes any and all damages collected from the negligent third party for those expenses whether by:

- Action at law
- Settlement
- Compromise

by you (or your parents if you are a minor or your legal representative) as a result of that **illness** or **injury**.

To help us get paid back, you are agreeing to provide us with any requested:

- Information or assistance
- Documentation

This provision applies whether or not the third party admits liability.

Your health information

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

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

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

Effect of benefits under other plans

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

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

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

Extension of benefits for pregnancy

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

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

Effect of prior coverage - transferred business

Prior coverage means:

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

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

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

Glossary

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

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

Behavioral health provider
An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for **mental disorders** and **substance use disorders,** under the laws of the jurisdiction where the individual practices.

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

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

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

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

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

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

1. They are **medically necessary.**
2. You received **precertification** if required.

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

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

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

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

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

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

Durable medical equipment (DME)
Equipment and the accessories needed to operate it, that is:

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

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

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

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

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

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus

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

Experimental or investigational

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

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

Formulary exclusions list

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

Generic prescription drug

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

Group policy

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

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

Health professional

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

Home health care agency

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

Home health care plan

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

Hospice care

Care designed to give supportive care to people in the final phase of a **terminal illness** and focus on comfort and quality of life, rather than cure.

Hospice care agency

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

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

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

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

Hospital does not include a:

- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility** for **substance use disorders**
- **Residential treatment facility** for **mental disorders**
- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

A **hospital** also includes **hospitals** providing **surgery**, etc., on a formal arrangement basis with another institution.

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

Infertile/infertility
The inability to:

- Conceive after 1 year of unprotected heterosexual sexual intercourse or 6 months of unprotected heterosexual sexual intercourse if the female partner is over age 35
- Conceive after 1 year or attempts to produce conception
- Conceive after diagnosed with a condition affecting fertility
- Sustain a successful pregnancy

Women without a male partner may be considered **infertile** if they are unable to conceive or produce conception after 1 year of donor insemination (6 cycles for women aged 35 or older).

Injury
Physical damage, independent of disease or bodily infirmity, to a person or part of their body.

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

Intensive Outpatient Program (IOP)
Clinical treatment provided must be no more than 5 days per week, no more than 19 hours per week and a minimum of 2 hours each treatment day of **medically necessary** services delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a **mental disorder** or **substance use disorder** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder
This is:

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

L.P.N.
A licensed practical nurse or a licensed vocational nurse.

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

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

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

Morbid obesity/morbidly obese

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

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

Negotiated charge

For health coverage, this is either:

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

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

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

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

Network pharmacy

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

Network provider

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

Non-preferred drug

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

Other health care

Eligible health services that are neither network services or supplies nor out-of-network services or supplies. **Other health care** can include care given by a **provider** who does not fall into any of the categories in the **provider directory**.

Out-of-network pharmacy

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

Out-of-network provider

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

Partial hospitalization treatment

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

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

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

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

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

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

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

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

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

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

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

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

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

Provider(s)
A **physician**, other **health professional**, **hospital**, **skilled nursing facility**, **home health care agency** or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

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

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

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

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

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

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Involuntary services are services or supplies that are one of the following:
  - Performed at a network facility by an **out-of-network provider**, unless that **out-of-network provider** is an assistant surgeon for your **surgery**
  - Not available from a **network provider**
  - **Emergency services**

  We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply

  We 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).
  - Our rate may also exclude other payments that CMS may make directly to **hospitals** or other **providers**. It also may exclude any backdated adjustments made by CMS.
  - For anesthesia, our rate may be at least 100% of the rates CMS establishes for those services or supplies.

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

Our reimbursement policies
We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the recognized charge. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider

Our reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits
We have online tools to help decide whether to get care and if so, where. Use the "Estimate the Cost of Care" tool on **Aetna's** secure member website. **Aetna's** secure member website at www.aetna.com may contain additional information that can help you determine the cost of a service or supply. Log on to **Aetna's** secure member website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools.

R.N.

A registered nurse.

Residential treatment facility (mental disorders)

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

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

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

Residential treatment facility (substance use disorders)

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

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

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming.
- The medical director must be a **physician**.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

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

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

Retail pharmacy

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

Room and board

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

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, **Aetna** 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 state and federal laws to provide skilled nursing care.

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

Skilled nursing facility does not include institutions that provide only:

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

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

Skilled nursing services

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

Specialist

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

Specialty prescription drugs

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

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

Specialty pharmacy

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

Stay

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

Step therapy

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

Substance use disorders

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

Surgery center

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

Surgery or surgical procedures

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

Telemedicine

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

Services can be provided by:

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

Terminal illness

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

Therapeutic drug class

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

Urgent care facility

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

Urgent condition

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

Walk-in clinic

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

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

Discount programs

Discount arrangements

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

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

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

Wellness and other incentives

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

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

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.

Preferred Provider Organization (PPO) Medical Plan

Schedule of Benefits

Prepared exclusively for:

Policyholder:	Northwestern University Postdoctoral Fellow Benefit Program
Group policy number:	GP-836990
	Schedule of Benefits 1A
Group policy effective date:	January 1, 2018
Plan effective date:	January 1, 2018
Plan issue date:	November 15, 2019
Plan revision effective date:	January 1, 2020

Underwritten by Aetna Life Insurance Company in the state of Illinois.

*See *How to read your schedule of benefit and important notice* at the beginning of this schedule of benefits

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/coinsurance**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/coinsurance** and any limits that apply to the services.

How to read your schedule of benefits

- When we say:
  - "In-network coverage", we mean you get care from **network providers**.
  - "Out-of-network coverage", we mean you can get care from **out-of-network providers**.
  - "Other health care coverage", we mean you can get care from an **out-of-network provider** when you could not reasonably get the services and supplies needed from a **network provider**. This includes when you get care from **out-of-network providers** during your **stay** in a **network hospital**.
- The **deductibles** and **copayments/coinsurance** listed in the schedule of benefits below reflect the **deductibles** and **copayment/coinsurance** amounts under your plan.
- You are responsible to pay any **deductibles, copayments and coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums. They are combined maximums between **network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule you will find detailed explanations about your:
  - **Deductible**
  - **Maximum out-of-pocket limits**
  - Maximums

Important note:
All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/coinsurance** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna secure member website at www.aetna.com or at the toll-free number on your ID card.

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company's group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

*See *How to read your schedule of benefit and important notice* at the beginning of this schedule of benefits

Plan features	Deductible/Maximums		
	In-network coverage*	**Out-of-network coverage***	**Other health care***
Deductible			
You have to meet your Calendar Year **deductible** before this plan pays for benefits.			
Individual	$500 per Calendar Year	$500 per Calendar Year	$500 per Calendar Year
Family	$1,500 per Calendar Year	$1,500 per Calendar Year	$1,500 per Calendar Year
Deductible waiver			
The Calendar Year in-network **deductible** is waived for all of the following **eligible health services:** • Preventive care and wellness • Family planning services - female contraceptives			
Maximum out-of-pocket limit			
Maximum out-of-pocket limit per Calendar Year.			
Individual	$1,500 per Calendar Year	$4,500 per Calendar Year	$1,500 per Calendar Year
Family	$3,000 per Calendar Year	$9,000 per Calendar Year	$3,000 per Calendar Year
Precertification covered benefit reduction			
This only applies to out-of-network coverage. The booklet-certificate contains a complete description of the **precertification** program. You will find details on **precertification** requirements in the *Medical necessity and precertification requirements* section. In addition to the applicable plan cost sharing, failure to **precertify** your **eligible health services** when required will result in the following benefits reduction: • **Covered benefits** will be reduced by the lesser of 50% of the benefit that would otherwise have been payable and $1,000. The additional percentage or dollar amount of the **recognized charge** which you may pay as a penalty for failure to obtain **precertification** is not a **covered benefit**, and will not be applied to the **deductible** amount or the **maximum out-of-pocket limit**, if any.			

*See *How to read your schedule of benefit and important notice* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Preventive care and wellness			

Routine physical exams			
Performed at a **physician's** office	100% per visit No **deductible** applies.	60% (of the **recognized charge**) per visit	100% per visit No **deductible** applies.
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per 12 months	1 visit	1 visit	1 visit
Covered persons age 65 and over: Maximum visits per 12 months	1 visit	1 visit	1 visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Preventive care immunizations			
Performed in a facility or at a **physician's** office	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.

Well woman preventive visits **routine gynecological exams (including pap smears)**			
Performed at a **physician's**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit	1 visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Preventive screening and counseling services			
Office visits • Obesity and/or healthy diet counseling • **Substance use disorders** • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Obesity and/or healthy diet counseling maximums:			
Maximum visits per 12 months (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Substance use disorders maximums:			
Maximum visits per 12 months	5 visits*	5 visits*	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Use of tobacco products maximums:			
Maximum visits per 12 months	8 visits*	8 visits*	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Sexually transmitted infection counseling maximums:			
Maximum visits per 12 months	2 visits*	2 visits*	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.			

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Genetic risk counseling for breast and ovarian cancer maximums:			
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations

Routine cancer screenings (applies whether performed at a physician's, specialist office or facility)			
Routine cancer screenings	100% per visit No **deductible** applies.	60% (of the **recognized charge**) per visit	100% per visit No **deductible** applies.
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*	1 screening every 12 months*	1 screening every 12 months*
***Important note**: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.			

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**			
Preventive care services only	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.			
Comprehensive lactation support and counseling services			
Lactation counseling services – facility or office visits	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	6 visits*	6 visits*
***Important note:** Any visits that exceed the lactation counseling services maximum are covered under **Physician** services office visits.			
Breast feeding durable medical equipment			
Breast pump supplies and accessories	100% per item No **deductible** applies	60% (of the **recognized charge**) per item	100% per item No **deductible** applies
Important note: See the *Breast feeding durable medical equipment* section of the booklet-certificate for limitations on breast pump and supplies.			
Family planning services – female contraceptives			
Counseling services			
Female contraceptive counseling services office visit	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*	2 visits*	2 visits*
***Important note:** Any visits that exceed the contraceptive counseling services maximum are covered under **Physician** services office visits.			

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Devices			
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	100% per item No **deductible** applies	80% (of the **recognized charge**) per item	100% per item No **deductible** applies
Female voluntary sterilization			
Inpatient	100% per admission No **deductible** applies	60% (of the **recognized charge**) per admission	100% per admission No **deductible** applies
Outpatient	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Eligible health services	**In-network coverage***	**Out-of-network coverage***	**Other health care**
Physicians and other health professionals			
Physicians and **specialists** office visits (non-surgical)			
Physician services			
Office hours visits (non-surgical) non preventive care	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Telemedicine consultation by a **physician**	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Maximum visits per day	1	1	1
Telemedicine consultation by a **specialist**	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Maximum visits per day	1	1	1

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Allergy injections			
Performed at a **physician's** or **specialist** office when you do not see the **physician**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Immunizations that are not considered preventive care			
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specialist			
Specialist office visits			
Office hours visits (non-surgical)	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Physician surgical services			
Physicians and **specialists** office visits			
Performed at a **physician's** office	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Performed at a **specialist's** office	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Alternatives to physician office visits			
Walk-in clinic visits			
Walk-in clinic non-emergency visit *(includes coverage for immunizations)*	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Hospital and other facility care			
Hospital care			
Inpatient **hospital**	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Alternatives to hospital stays			
Outpatient surgery and physician surgical services			
	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Home health care			
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Maximum visits per Calendar Year	120 Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge	120 Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge	120 Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge
Hospice care			
Inpatient facility	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Maximum days per lifetime	Unlimited	Unlimited	Unlimited

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Hospice care			
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
	Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day	Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day	Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day
Outpatient private duty nursing			
Outpatient private duty nursing	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Maximum visits/shifts per Calendar Year	70 shifts Up to eight hours equal one shift.	70 shifts Up to eight hours equal one shift.	70 shifts Up to eight hours equal one shift.
Skilled nursing facility			
Inpatient facility	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Maximum days per Calendar Year	60	60	60
Eligible health services	**In-network coverage***	**Out-of-network coverage***	**Other health care**
Emergency services and urgent care			
Emergency services			
Hospital emergency room	$100 then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **deductible** applies	Paid the same as in-network coverage	Paid the same as in-network coverage
Emergency services resulting from a criminal sexual assault or abuse	100% (of the **negotiated charge**) per visit	Paid the same as in-network coverage	Paid the same as in-network coverage

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Non-emergency care in a **hospital** emergency room	50% (of the **negotiated charge**) per visit after the **deductible**	50% (of the **recognized charge**) per visit after the **deductible**	50% (of the **recognized charge**) per visit after the **deductible**

Important Note:

- As **out-of-network providers** do not have a contract with us the **provider** may not accept payment of your cost share (**deductible, copayment,** and **coinsurance**) as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill.
- A separate hospital emergency room **copayment/coinsurance** will apply for each visit to an emergency room. If you are admitted to a **hospita**l as an inpatient right after a visit to an emergency room, your emergency room **copayment/coinsurance** will be waived and your inpatient **copayment/coinsurance** will apply.

Urgent care

Urgent medical care (at a non-**hospital** free standing facility)	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge)** per visit	$35 then the plan pays 80% (of the balance of the **recognized charge**) per visit thereafter No **deductible** applies
Non-urgent use of **urgent care provider** (at a non-**hospital** free standing facility)	50% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit	50% (of the **recognized charge**) per visit

A separate urgent care **deductible** or **copayment/coinsurance** will apply for each visit to an **urgent care provider**.

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Specific conditions			
Autism spectrum disorder			
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Autism spectrum disorder diagnosis and testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Physical, occupational, and speech therapy associated with treatment of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Birthing center			
Inpatient	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Diabetic equipment, supplies and education			
Diabetic equipment, supplies and education	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Family planning services - other			
Voluntary sterilization for males			
Outpatient	100% (of the **negotiated charge**) per visit No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Abortion			
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit

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Maternity and related newborn care			
Inpatient	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Delivery services and postpartum care services			
Performed in a facility or at a **physician's** office	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Mental health treatment - inpatient			
Inpatient mental health treatment Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Mental health treatment - outpatient			
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** consultation Coverage is provided under the same terms, conditions as any other **illness**.	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavior therapy consultation	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies

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Other outpatient mental health treatment (includes skilled behavioral health services in the home) **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services	100% (of the **negotiated charge**) per visit No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Substance related disorders treatment - inpatient			
Inpatient **substance use disorder detoxification** during a **hospital** confinement Inpatient **substance use disorder** rehabilitation during a **hospital** confinement Inpatient **residential treatment facility** during a **hospital** confinement Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Substance related disorders treatment - outpatient: detoxification and rehabilitation			
Outpatient **substance use disorder** office visits to a **physician** or **behavioral health provider** includes **telemedicine** consultation Coverage is provided under the same terms, conditions as any other **illness**.	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies

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Outpatient **substance use disorder** office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavioral therapy consultations	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Other outpatient **substance use disorder** services **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services	100% of the **negotiated charge**) per visit No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Oral and maxillofacial treatment (mouth, jaws and teeth)			
Oral and maxillofacial treatment (mouth, jaws and teeth)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Reconstructive breast surgery			
Reconstructive breast **surgery**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Reconstructive surgery and supplies			
Reconstructive **surgery**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	Network (IOE facility)	Network (Non-IOE facility)	Out-of-network coverage*	Other health care
Transplant services facility and non-facility				
Inpatient **hospital** transplant services	80% (of the **negotiated charge**) per transplant	60% (of the **negotiated charge**) per transplant	60% (of the **recognized charge**) per transplant	60% (of the **recognized charge**) per transplant
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Treatment of infertility			
Basic infertility			
Basic **infertility**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient comprehensive infertility services			
	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Outpatient ART services			
	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Lifetime oocyte retrieval maximum	Refer to the *Ooctye retrieval limitation* in the *Advance reproductive technology* section of your booklet-certificate.		

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Specific therapies and tests			
Outpatient diagnostic testing			

Diagnostic complex imaging services			
	80% (of the **negotiated** charge) per visit	60% (of the **recognized** charge) per visit	80% (of the **recognized** charge) per visit
Diagnostic lab work			
	80% (of the **negotiated** charge) per visit.	60% (of the **recognized** charge) per visit.	80% (of the **recognized** charge) per visit.
Diagnostic radiological services			
	80% (of the **negotiated charge**) per visit.	60% (of the **recognized charge**) per visit.	80% (of the **recognized charge**) per visit.
Chemotherapy			
Chemotherapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient infusion therapy			
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient radiation therapy			
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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Short-term cardiac and pulmonary rehabilitation services			
Cardiac rehabilitation			
Cardiac rehabilitation	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Pulmonary rehabilitation			
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Short-term rehabilitation services			
Outpatient Physical and Occupational Therapies			
	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Outpatient Speech Therapy			
	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Spinal manipulation			
Spinal manipulation	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Habilitation therapy services			
	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Other services			

Acupuncture			
Acupuncture	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Ambulance service			
Ground, air or water **ambulance**	80% (of the **negotiated charge**) per trip	60% (of the **recognized charge**) per trip	80% (of the **recognized charge**) per trip
Clinical trial therapies (experimental or investigational)			
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Clinical trials (routine patient costs)			
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Durable medical equipment (DME)			
DME	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item	80% (of the **recognized charge**) per item
Hearing aids and exams			
Hearing aids Covered persons under age 18	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item	80% (of the **recognized charge**) per item
Hearing aid exams	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Hearing aids	One per ear every 36 months	One per ear every 36 months	One per ear every 36 months

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Non-preventive hearing exams			
For adults and children	100% (of the **negotiated charge**) per visit No **deductible** applies.	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies.
Maximum	One exam in any 24 consecutive month period.		
Nutritional supplements			
Nutritional supplements	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Orthotic devices			
Orthotic devices	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item	80% (of the **recognized charge**) per item
Osteoporosis			
Physician's office visits	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Prosthetic devices			
Prosthetic devices	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item	80% (of the **recognized charge**) per item
Vision care			
Routine vision care			
Routine vision exams (including refraction)			
Performed by a legally qualified ophthalmologist or optometrist	100% of the **negotiated charge** per visit No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Maximum visits per 24 consecutive month period	1 visit	1 visit	1 visit
All other outpatient services for which cost sharing is not shown above			
All other outpatient services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
Outpatient prescription drugs		
Plan features	**Deductible/Copayment/Coinsurance/Maximums**	
Deductible waiver		
The Calendar Year **deductible** is waived for all **prescription drugs**.		
Deductible and copayment/coinsurance waiver for risk reducing breast cancer prescription drugs		
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to risk reducing breast cancer **prescription drugs** when obtained at a **network pharmacy**. This means that such risk reducing breast cancer **prescription drugs** will be paid at 100%.		
Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs		
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to the first two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. Your Calendar Year **deductible** and any **prescription copayment/coinsurance** will apply after those two regimens have been exhausted.		
Deductible and copayment/coinsurance waiver for contraceptives		
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means that the following will be paid at 100%: • Certain over-the-counter (OTC) and generic contraceptive **prescription drugs** and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drugs** for that method paid at 100%. The Calendar Year **deductible** and the per **prescription copayment/coinsurance** continue to apply to **prescription drugs** that have a generic equivalent or generic alternative available within the same **therapeutic drug class** obtained at a **network pharmacy** unless you are granted a medical exception.		
Important note: Review the *How to access out-of-network pharmacies* section of the booklet-certificate for more information on how these **pharmacies** are subject to higher out-of-pocket costs.		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Preferred generic prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$10 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$10 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	$20 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$20 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$20 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$20 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
Non-preferred generic prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$60 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$60 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	$120 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$120 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$120 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$120 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$30 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$30 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	$60 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$60 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$60 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$60 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
Non-preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$60 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$60 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	$120 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$120 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$120 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$120 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$0 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$0 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	$0 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$0 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$0 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$0 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a **pharmacy**	100% per **prescription** or refill	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	100% per **prescription** or refill	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.
Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy**	$0 per **prescription** or refill No **deductible** applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**
- Maximums

that are listed in the first part of this schedule of benefits.

Deductible provisions

Eligible health services applied to the out-of-network **deductibles** will be applied to satisfy the in-network **deductibles**. **Eligible health services** applied to the in-network **deductibles** will be applied to satisfy the out-of-network **deductibles**.

The **deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/coinsurance** for **eligible health services** to which the **deductible** does not apply.

Individual
This is the amount you owe for in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

Family
This is the amount you and your covered dependents owe for in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reach this family Calendar Year **deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the Calendar Year.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

- The combined **eligible health services** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Copayments

Copayment
As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**.

Coinsurance

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

Maximum out-of-pocket limits provisions

Eligible health services that are subject to the **maximum out-of-pocket limit** include **prescription drug eligible health services** provided under the medical plan outpatient **prescription drug** plan.

Eligible health services applied to the **out-of-network maximum out-of-pocket limit** will be applied to satisfy the in-network **maximum out-of-pocket limit** and **eligible health services** applied to the in-network **maximum out-of-pocket limit** will be applied to satisfy the out-of-network **maximum out-of-pocket limit**.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/coinsurance** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual

Once the amount of the **copayments/coinsurance** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family

Once the amount of the **copayments/coinsurance** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/coinsurance** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-covered services
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the **recognized charge**

Maximum provisions

Eligible health services applied to the **out-of-network** maximum will be applied to satisfy the network maximum and **eligible health services** applied to the network maximum will be applied to satisfy the **out-of-network** maximum.

Calculations; determination of recognized charge; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the certificate.

Outpatient prescription drug maximum out-of-pocket limits provisions

Eligible health services that are subject to the **maximum out-of-pocket limit** include **eligible health services** provided under the medical plan and the outpatient **prescription drug** plan.

BENEFIT PLAN

Prepared Exclusively for
Northwestern University Postdoctoral Fellow Benefit Program

Open Choice Extraterritorial Riders

Extraterritorial Riders

Aetna Life Insurance Company

These Extraterritorial Riders are part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

aetna™

Table of Contents

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Northwestern University Postdoctoral Fellow Benefit Program

Group policy number: GP-836990

Amendment effective date: January 1, 2020

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in California. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

(GR-9N 08-020 01 CA)

YOUR BOOKLET-CERTIFICATE CONTAINS IMPORTANT INFORMATION REGARDING NETWORK AND OUT-OF-NETWORK HEALTH CARE. PLEASE READ THIS INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Obtaining Coverage for Dependents *(GR-9N 29-010 01)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; or
- Your domestic partner who meets the rules set by your employer as outlined in the *Coverage for Domestic Partners* section following; and
- Your dependent children; and
- Dependent children of your domestic partner.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Domestic Partner *(GR-9N 29-010 01)*

To be eligible for coverage, you and your domestic partner will need to:

- meet the requirements under California law for entering into a domestic partnership; and
- are "domestic partners" as determined in accordance with rules set by your Employer.

Routine Cancer Screenings *(GR-9N 11-005 01 CA)*

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 annual cervical cancer screening test, including the conventional Pap test, and any cervical cancer screening test approved by the federal Food and Drug Administration upon referral of the insured's health care provider.

Osteoporosis Services *(GR-9N 11-005 01 CA)*

Covered expenses include charges for services related to the diagnosis, treatment, and appropriate management of osteoporosis. The services include all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.

Important Reminder
Refer to the Summary of Benefits for details about deductibles, coinsurance, benefit maximums and frequency limits if applicable.

Anesthesia and Associated Hospitalization For Certain Dental Care *(GR-9N 11-181 01 CA)*

Covered expenses include charges made for general anesthesia and associated **hospital**, surgery center or other licensed facility charges in connection with dental care if any of the following applies:

- the person is a child age 6 or under;
- the person has a medical condition that requires hospitalization or general anesthesia for dental care; or
- the person is disabled.

As used in this section, "disabled" means a person, regardless of age, with a chronic disability if the chronic disability meets all of the following conditions:

- It is attributable to a mental or physical impairment or combination of mental and physical impairments.
- It is likely to continue.
- It results in substantial functional limitations in one or more of the following activities:
  - self-care;
  - receptive and expressive language;
  - learning;
  - mobility;
  - capacity for independent living; or
  - economic self-sufficiency.

Aetna may require prior authorization for covered services and associated charges in the same manner that prior authorization is required for these benefits in connection with other covered medical care.
Charges in connection with the dental procedure itself, including, but not limited to, those for the professional fees of the dentist are not covered.

Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: California Medical ET
Issue Date: November 15, 2019

Additional Information Provided by Aetna Life Insurance Company

Inquiry Procedure

The plan of benefits described in the Booklet-Certificate is underwritten by:

Aetna Life Insurance Company (Aetna)
151 Farmington Avenue
Hartford, Connecticut 06156

Telephone: (860) 273-0123

If you have questions about benefits or coverage under this plan, call Member Services at the number shown on your Identification Card. You may also call Aetna at the number shown above.

If you have a problem that you have been unable to resolve to your satisfaction after contacting Aetna, you should contact the Consumer Service Division of the Department of Insurance at:

300 South Spring Street
Los Angeles, CA 90013
https://www.insurance.ca.gov/01-consumers/101-help/index.cfm

Telephone: 1-800-927-4357 or 213-897-8921

You should contact the Bureau only after contacting Aetna at the numbers or address shown above.

Participating Providers

We want you to know more about the relationship between Aetna Life Insurance Company and its affiliates (Aetna) and the participating, independent providers in our network. Participating physicians are independent doctors who practice at their own offices and are neither employees nor agents of Aetna. Similarly, participating hospitals are neither owned nor controlled by Aetna. Likewise, other participating health care providers are neither employees nor agents of Aetna.

Participating Providers are paid on a 'Discounted Fee For Service' arrangement. Discounted fee for service means that participating providers are paid a predetermined amount for each service they provide. Both the participating provider and Aetna agree on this amount each year. This amount may be different than the amount the participating provider usually receives from other payers.

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Northwestern University Postdoctoral Fellow Benefit Program

Group policy number: GP-836990

Amendment effective date: January 1, 2020

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Colorado. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Cleft Lip or Palate Treatment *(GR-9N 11-155 02 CO)*

Treatment of Cleft Lip or Palate Cleft Lip/Palate of a Dependent Child
Covered expenses for treatment given to a dependent child for a congenital cleft lip or cleft palate are payable on the same basis as any other **illness**. This includes treatment for any other condition related to or developed as a result of the cleft lip or palate. These covered expenses include:

- Oral surgery and facial surgery. This includes pre-operative and post-operative care performed by a Physician.
- Oral prosthesis treatment (obturators and orthotic devices).
- First installation of partial or full removable dentures or of fixed bridgework, if dentures are not professionally adequate.
- Replacement of dentures or fixed bridgework when required as a result of structural changes in the mouth or jaw due to growth.
- Cleft orthodontic therapy.
- Diagnostic services of a physician to find out if and to what extent the child's ability to speak or hear has been lost or impaired.
- Habilitative speech therapy rendered by a Physician that is expected to overcome congenital or early acquired handicaps as well as to restore or improve the child's ability to speak.

An audiologist or speech therapist who is legally qualified will be deemed a **Physician** for the purposes of this section.

Limitations
Not covered under this benefit are charges for:

- Oral prosthesis, dentures or bridgework ordered before the child becomes covered, or ordered while covered but installed or delivered more than 60 days after termination of coverage.
- Services given to treat delays of speech development unless such delays are shown to be caused by cleft lip or cleft palate or any condition related to or developed as a result of cleft lip or cleft palate.
- Speech aids and training in the use of such aids.
- Augumentive (assistive) Communication Systems and training in the use of such systems.

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Cleft Lip or Palate Treatment for Dependent Children	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Child Health Supervision Services (Applicable to Dependent children under age 13) *(GR-9N 11-005-01 CO)*
Covered expenses include **physician**-delivered or **physician**-supervised services for a dependent child under 13 years of age even though they are not incurred in connection with an injury or **illness**.

The following charges will be payable when the service is delivered at the intervals and scope show in the Table below:

- A review and written record of the child's complete medical history.
- Physical examination.
- Developmental and behavioral assessment.
- Anticipatory guidance and education.
- Immunizations including diphtheria, haemophilus influenza type B, hepatitus B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunization as recommended by the American Academy of Pediatrics.
- Laboratory tests.

All of the above will be in keeping with prevailing medical standards.

Only charges of one **physician** for Child Health Supervision Services performed at birth will be payable and then at approximately each of the following ages:

2 months	15 months	5 years
4 months	18 months	6 years
6 months	2 years	8 years
9 months	3 years	10 years
12 months	4 years	12 years

Not covered are charges incurred for:

- Services which are covered to any extent under any other part of this Plan;
- Services which are covered to any extent under any other group plan sponsored by your Employer;
- Services which are for diagnosis or treatment of a suspected or identified injury or **illness**;
- Services not performed by a **physician** or under his or her direct supervision;
- Medicines, drugs, appliances, equipment, or supplies; or
- Dental exams.

Early Intervention Services *(GR-9N-11-155-05 CO)*

These are services, provided as part of an active individualized family service plan that enhances functional ability without effecting cure. They include, but are not limited to, the following:

- Speech therapy given in connection with a speech impairment resulting from a congenital abnormality, disease or injury.
- Occupational or physical therapy expected to result in significant improvement of a body function impaired by a congenital abnormality, disease, or injury.

Coverage for early intervention services for covered children supplements, and does not duplicate or replace treatment for autism spectrum disorders.

Coverage for Early Intervention services is available to an eligible child from birth up to the child's third birthday. The services are available up to the maximum annual benefit limit as set by the Division of Insurance, Department of Regulatory Agencies and the State of Colorado. The services must be performed by a qualified early intervention service provider listed in the applicable registry. Contact the Colorado Department of Human Services, Division of Community and Family Support Health Department for eligibility requirements and benefit limits.

The Early Intervention annual benefit limit shall not apply to rehabilitation or therapeutic services that are necessary as the result of an acute medical condition or post-surgical rehabilitation.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Early Intervention Services for Dependent Children from Birth to Age 3	100% per visit No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.
Maximum Benefit per Calendar Year	45 visits	45 visits	45 visits

Routine Cancer Screenings *(GR-9N 11-005-03 CO)*

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 baseline mammogram for a woman 35-40 years of age;
- 1 mammogram every calendar year for women 40 years of age or older;
- 1 cervical cancer immunization for women, up to the age limitations recommended by the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services; and
- Prostate specific antigen (PSA) test and digital rectal exam for covered males age 40 and older.

Routine Cancer Screenings *(GR-9N S 10-016 06 NG IL)*			
Mammograms	100% per visit No copay or **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	100% per visit No **deductible** applies.
Prostate specific antigen (PSA) tests/Digital rectal exams (DRE)	100% per visit No copay or deductible applies.	60% per visit No Calendar Year deductible applies.	100% per visit No deductible applies.

Colorectal Cancer Treatment

Covered expenses include charges for the treatment for the early detection of colorectal cancer and adenomatous polyps for those who are asymptomatic average risk adults who are 50 years of age or older or if you are at a high risk for colorectal cancer including those who have a family medical history of colorectal cancer, a prior occurrence of cancer or precursor neoplastic polyps, a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, ulcerative colitis or other predisposing factors as determined by a physician.

Covered expenses shall include the following tests as determined by a physician that detects adenomatous polyps or colorectal cancer modalities that are currently included in an "A Recommendation" or a "B Recommendation" by the U.S. Preventive Services task force or any successor organization sponsored by the Agency for Health Care Research and Quality, the Health Services Research Arm of the Federal Department of Health and Human Services.

For purposes of this section, an "A Recommendation" means a recommendation adopted by the task force that strongly recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the task force:

a) found good evidence that the preventive health care service improves important health outcomes; and
b) concluded that the benefits of the preventive health care service substantially outweigh its harm.

A "B Recommendation" means a recommendation adopted by the task force that recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the task force:

a) found at least fair evidence that the preventive health care service improves important health outcomes; and
b) concluded that the benefits of the preventive health care service outweigh its harm.

Covered expenses shall not be subject to the **deductible**, if applicable.

Physician Services *(GR 9N 11-20 02 CO)*

Physician Visits

Covered medical expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician**'s office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Immunizations for infectious disease, but not if solely for your employment,
- Allergy testing and allergy injections; and
- Services appropriately provided via telephone (also known as Telemedicine) if you reside in a county of 150,000 residents

Contraception Services

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a **physician** provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Autism Spectrum Disorders *(GR-9N 11-171 02 CO)*

Covered expenses include charges made by a **physician** or **behavioral health provider** for the services and supplies for the diagnosis and treatment (including behavioral therapy and Applied Behavioral Analysis) of Autism Spectrum Disorder when ordered by a **physician** as part of a Treatment Plan; and

  - The covered child is diagnosed with Autism Spectrum Disorder; and
- The **covered expenses** are incurred prior to attainment of age 19.

Applied Behavioral Analysis is an educational service that is the process of applying interventions:

- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association:

- Autistic Disorder;
- Asperger's Syndrome; and
- Atypical autism as a diagnosis with Pervasive Developmental Disorder - Not Otherwise Specified.

Treatment for Autism Spectrum Disorders shall include habilitative or rehabilitative care, including, but not limited to:

- Occupational therapy;
- Physical therapy;
- Speech therapy; or
- Any combination of these therapies.

Clinical Trials

A clinical trial is an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

Routine patient care costs are a covered expense if:

(I) your treating physician, who is providing covered health care services to you recommends participation in the clinical trial after determining that participation in the clinical trial has the potential to provide a therapeutic health benefit;

(II) the clinical trial or study is approved under the September 19, 2000 Medical National Coverage Decision Regarding Clinical Trials, as amended;

(III) your care is provided by a certified, registered or licensed health care provider practicing with the scope of their practice and the facility and personnel providing the treatment have experience and training to provide the treatment in a competent manner;

(IV) prior to participation in a clinical trial or study, you signed a statement of consent indicating that you were informed of the procedure to be undertaken, alternative methods of treatment and the general nature and extent of the risks associated with participation in the clinical trial or study, the Covered Expenses will be consistent with the coverage provided by the Group Policy and this Certificate; and

(V) you suffer from a condition that is disabling, progressive or life-threatening.

Routine care costs include:

- all items and services that a benefit under the Group Policy and this Certificate would be covered if you were not involved in either the experimental or the control arms of a clinical trial; except the investigation item or service, itself;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- items and services customarily provided by the research sponsors free of charge for any enrollee in the trial;
- routine costs in clinical trials that include items and services that are typically provided absent a clinical trial;
- items or services required solely for the provision of the investigation items or services, the clinically appropriate monitoring of the effects of the item or service or the prevention of complications; and
- items or services needed for reasonable and necessary care arising from the provision of an investigation item or service, including the diagnosis or treatment of complications.

Limitations

Not included under this clinical trial benefit are charges incurred for:

(I) any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical or medical industry;

(II) any drug or device that is paid for by the manufacturer, distributor or provider of the drug or device;

(III) extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing and other expenses that a participant or person accompanying the participant may incur;

(IV) an item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;

(V) costs for the management or research relating to the clinical trial or study; or

(VI) health care services, that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Group Policy and this Certificate.

Inherited Enzymatic Disorder. Care and treatment of inherited enzymatic disorders shall include, to the extent **medically necessary**, medical foods for home use for which a physician who is a **network provider** has issued a written, oral or electronic prescription. Inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids shall include, but not be limited to, the following diagnosed conditions: Phenylketonuria, maternal phenylketonuria, maple syrup urine disease; tyrosinemia, homocystinuria; histidinemia, urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic academia and propionic academia.

There is no age limit on benefits for the above inherited enzymatic disorders; except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is 21 years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is 35 years of age.

"Medical foods" means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by singe gene defects involved in the metabolism of amino, organic, and fatty acids for which medically standard methods of diagnosis, treatment and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered internally either via tube or oral route under the direction of a **physician** who is a **network provider**. Coverage shall only be available through a **network pharmacy**.

Hospital *(GR-9N 34-040-01 CO)*

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations; and
- Is currently licensed or certified by the Colorado Department of Health and Environment.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

Experimental or Investigational *(GR-9N-34-025-09 CO)*

Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the U.S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

It also includes the written informed consent used by the treating facility or by:

- the treating facility; or
- by another facility studying the same:
  - drug;
  - device;
  - procedure; or
  - treatment

    that states that it is **experimental or investigational**, or for research purposes.

Continuing Coverage *(GR-9N 31-015-01 CO)*

If your coverage would terminate for any reason except:

- Health Expense Coverage discontinues as to your eligible class; or
- You fail to make the required contributions;
- You become eligible for Medicare;

you may continue any health coverage (except Dental, Vision and Prescription Drug Expense Coverage) then in force for you and your dependents; but, only if you have been covered under this Plan or under this Plan and any prior plan for at least 6 months in a row.

You have to make request in writing for this continuation. It must be done within 31 days of the date your coverage would otherwise stop. Premium payments must be made.

Coverage will stop on the earlier of:

- The end of the 180 day period which starts on the date coverage would otherwise end.
- The date you are employed by any employer.
- The date you fail to make the required contributions.
- The date health coverage discontinues as to employees of your former eligible class.
- The date you became eligible for like group coverage. If you have a preexisting condition or any other condition covered under this Plan but for which coverage is not available under the like coverage, this will not apply unless and until coverage is available under the like group coverage.
- Coverage for a dependent will end earlier when the dependent ceases to be a defined dependent.

Important Note
If any coverage being continued ceases, you may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Health Insurance Policy* for more information.

Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Colorado Medical ET
Issue Date: November 15, 2019

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Northwestern University Postdoctoral Fellow Benefit Program
Group Policy No.:	GP-836990
Rider:	Washington ET Medical
Issue Date:	November 15, 2019
Effective Date:	January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Washington. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Washington, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Remember plan contributions are subject to change.

Your contributions may be reduced due to **Aetna's** failure to provide agreed upon service levels. Such service levels are guaranteed by **Aetna** and agreed to in writing by **Aetna** and your employer. See your employer for details.

You will need to enroll yourself and any eligible dependents within 30 days of your eligibility date. Otherwise, you or your eligible dependents will be considered a **late enrollee**. If you miss the enrollment period, you and your eligible dependents will not be able to participate in the plan until the next open enrollment period, unless you qualify under a Special Enrollment Period, as described below.

After the initial enrollment period, newborns, adopted children and children placed with you for adoption are automatically covered for 60 days after birth, adoption or placement for adoption. If the addition of your newborn or adopted child will increase your premiums, you will need to complete a change form and return it to your employer within the 60-day enrollment period to continue coverage for your child.

New Dependents
You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 30 days of acquiring the dependent through marriage.
- You elect coverage for yourself and your dependent within 60 days of acquiring a dependent through birth, adoption or placement for adoption.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

If the special enrollment will result in additional premiums, you will need to report any new dependents by completing a change form, which is available from your policyholder. The form must be completed and returned to Aetna within 31 days of the change for the addition of a spouse, and 60 days for the addition of a dependent child, by birth, adoption, or placement with you for adoption. If you do not return the form within these timeframes, you will need to make the changes during the next open enrollment period unless you qualify for another special enrollment period.

Mammograms
- 1 mammogram every 12 months for covered females age 40 and over; or as recommended by your treating **health care provider.**

Neurodevelopmental Therapy
Occupational therapy, speech therapy and physical therapy delivered to covered dependents age six and under for the maintenance of the dependent's functioning in cases where significant deterioration in his or her condition would result without the service or to restore and improve function.

Home Health Care
Covered expenses include charges made by a **home health care agency** for home health care, when you have consented to home health care as an alternative to inpatient care and the care:

- Is given under a **home health care plan**;
- Is given to you in your home while you are **homebound**; and
- Is in lieu of a stay in a **hospital** or other inpatient facility.

Home health care expenses include charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N**.;
- Part-time or intermittent home health aid services provided in conjunction with and in direct support of care by an **R.N.** or an **L.P.N.**;
- Physical, occupational, and speech therapy;
- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an **R.N.** or an **L.P.N.**; and
- Medical supplies, **durable medical equipment, prescription drugs** and lab services by or for a **home health care agency** to the extent they would have been covered under this plan if you had continued your **hospital stay**.

Benefits for home health care visits are payable up to the home health care maximum shown in the *Schedule of Benefits***.** Each visit by a nurse or therapist is one visit.

In figuring the home health care maximum visits, each visit of up to 4 hours is one (1) visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, covered medical expenses include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Coverage for home health care services does not include **custodial care**. The need for a caregiver to perform a non-skilled or **custodial care** service does not cause the service to become a **covered expense** under this plan. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled or **custodial care** needs.

Note:
Home short-term physical, speech, or occupational therapy is covered when home health care is provided in lieu of inpatient care.

Limitations
Unless expressly provided in the home health care benefit description above, the following are ***not*** **covered expenses:**

- Services or supplies that are not a part of the **home health care plan**;
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family;
- Services of a certified or licensed social worker;
- Transportation;
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present; and
- Services that are **custodial care**.

Important Reminders

- The plan does ***not*** cover **custodial care**, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.
- Home health care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.
- Refer to the *Schedule of Benefits* for details about home health care visit maximums.

Hospice Care

Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses
The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses
Covered expenses include charges made on an outpatient basis by a **hospice care agency** for:

- Part-time or intermittent nursing care by an **R.N.** or **L.P.N.**;
- Part-time or intermittent home health aide services to care for you in accordance with the approved treatment plan;
- Medical social services under the direction of a **physician** or **other health care provider**. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy;
- Consultation or case management services by a **physician** or **other health care provider**;
- Medical supplies;
- **Prescription drugs**;
- Dietary counseling; and
- Psychological counseling; and
- Respite care that is continuous in the most appropriate setting for a maximum of 5 days per 3 month period of **Hospice Care**.

Covered expenses also include charges made by the providers below if they are not an employee of a **hospice care agency** and such agency retains responsibility for your care:

- A **physician** or other **health care provider** for a consultation or case management;
- A physical or occupational therapist; and
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care as set forth in the approved treatment plan;
  - Medical supplies;
  - **Prescription drugs**;
  - **Durable medical equipment (DME)** which would have been provided in an inpatient setting;
  - Psychological counseling; and
  - Dietary counseling.

Limitations

Unless specified above, charges for the following are not **covered expenses**:

- Daily **room and board** charges over the **semi-private room rate**;
- Bereavement counseling;
- Funeral arrangements;
- Pastoral counseling;
- Financial or legal counseling (this includes estate planning and the drafting of a will); and
- Homemaker or caretaker services; these are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members, transportation, and maintenance of the house.

Important Reminders

- Refer to the *Schedule of Benefits* for details about **hospice care** maximums.

Inpatient **hospice care** and home health care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**

Acupuncture
The plan covers charges made for acupuncture services provided by a **health care provider**, within the scope of his or her license, if the service is performed:

- As a form of anesthesia in connection with covered surgery; or
- To treat an **illness**, **injury** or alleviate chronic pain.

Physician
A duly licensed member of a medical profession who:

- Has a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction within which he or she practices;
- Provides medical services which are within the scope of his or her license or certificate, and
- Is not any person who resides in your home; or who is a member of your family, or a member of your spouse's family or your domestic partner.

Continuation of Coverage During a Labor Dispute

If your coverage under this plan would cease because you cease work due to a strike, lockout or other labor dispute, you can arrange to continue your coverage during your absence from work. You may make the premium payments to your employer. Your employer will transmit the payments to **Aetna**. Call the Member Services toll free number on you ID card for information on the premium payment process. Coverage may continue for up to 6 months. At the end of 6 months you will be eligible for Conversion Coverage.

Continuation will cease when the first of these events occurs:

- You fail to make the required contributions;
- You go to work full time for another employer;
- The labor dispute ends; or
- The 6 month continuation period ends.

The monthly premium required by **Aetna** for each person's coverage will be the applicable effective rate in effect on the date you cease work. If the premium paid by your employer changes during the time you are continuing coverage under this provision, your premiums will change correspondingly.

Coordination of Benefits

Benefits Subject To This Provision: This coordination of benefits (COB) provision applies to **this plan** when you or your covered dependent has medical, dental, vision, or hearing coverage under more than one **plan.** "**Plan**" and "**this plan**" are defined herein. The order of benefit determination rules below determines which **plan** will pay as the **primary plan**. The **primary plan** pays first without regard to the possibility that another **plan** may cover some expenses. A **secondary plan** pays after the **primary plan** and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total **allowable expense**.

Definitions. When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means any health care expense for any **medically necessary** health care service or supply, including, coinsurance and **copayments** and without reduction of any applicable **deductible**, that is covered at least in part by any of the **plans** covering the person. When a **plan** provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an **allowable expense** and a benefit paid. **This plan** limits coordination of health care services or expenses with those services or expenses that are covered under similar types of **plans,** (for example, Medical coverage is coordinated with another Medical **plan**). An expense or service that is not covered by any of the **plans** is not an **allowable expense**. This plan does not coordinate benefits for **prescription drugs**. The following are examples of expenses and services that are not **allowable expense**s:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an **allowable expense**. This does not apply if one of the **plans** provides coverage for a private room.
2. If a person is covered by 2 or more **plans** that compute their benefit payments on the basis of **UCR charges** or relative value schedule reimbursement or other similar reimbursement method, any amount in excess of the highest of the reimbursement amount for a specified benefit is not an **allowable expense**.
3. If a person is covered by 2 or more **plans** that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest negotiated charges is not an **allowable expense**.
4. If all plans covering a person are high deductible plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible plan's deductible is not an **allowable expense**, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

When a **plan** provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an **allowable expense** and a benefit paid.

Claim Determination Period. A Calendar Year.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation. In cases where a court decree awards more than half of the Calendar Year's residential time to one parent without the use of "custodial" terminology, the parent to whom the greater resident time is awarded is considered the **custodial parent**.

Plan. Any **plan** providing benefits or services by reason of medical, dental, vision or hearing care or treatment, which benefits or services are provided by one of the following:

- Group, individual or blanket disability insurance contracts, and group or individual contracts;
- Closed panel plans or other forms of group or individual coverage;
- The medical care components of long term care contracts, such as skilled nursing care; and
- Medicare or other governmental benefits as permitted by law.

Plan does not include:

- Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;
- Accident only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage, as defined in WAC 284-50-370;
- School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from school" basis;
- Benefits provided in long-term care insurance policies for non medical services;
- Medicare Supplement policies;

- A state plan under Medicaid;
- A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan'
- Benefits provided as part of a direct agreement with a direct patient-provider primary care practice' and
- Automobile insurance policies required by statute to provide medical benefits.

If the **plan** includes medical, dental, vision and hearing coverage, those coverages will be considered separate **plans**. For example, medical coverage will be coordinated with other medical **plans**, and dental coverage will be coordinated with other dental **plans**. This **plan** does not coordinate coverage for **prescription drugs**.

This plan is any part of the policy that provides benefits for health care expenses.

Primary plan/secondary plan. The order of benefit determination rules state whether **this plan** is a **primary plan** or **secondary plan** as to another **plan** covering the person.

- When **this plan** is a **primary plan**, its benefits are determined before those of the other **plan** and without considering the other **plan's** benefits. A **plan** is considered the **primary plan** if it either has no order of benefit determination rules, or if its rules differ from those permitted by Washington State regulations.
- When **this plan** is a **secondary plan**, its benefits are determined after those of the other **plan** and may be reduced because of the other **plan's** benefits. When coordinating benefits, any **secondary plans** must pay an amount which, together with the payment made by the primary plan, totals the higher of the **allowable expenses**. In no event will a **secondary plan** be required to pay an amount in excess of its maximum benefit plus accrued savings.
- When there are more than two **plans** covering the person, **this plan** may be a **primary plan** as to one or more other **plans**, and may be a **secondary plan** as to a different **plan** or **plans**.

Order of Benefit Determination
When two or more **plans** pay benefits, the rules for determining the order of payment are as follows:

- The **primary plan** pays or provides its benefits as if the **secondary plan** or **plans** did not exist.
- A **plan** that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the **plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a **closed panel plan** to provide out-of-network benefits.
- A **plan** may consider the benefits paid or provided by another **plan** in determining its benefits only when it is secondary to that other **plan**.
- The first of the following rules that describes which **plan** pays its benefits before another **plan** is the rule to use:
  1. Non-Dependent or Dependent. The **plan** that covers the person other than as a dependent, for example as an employee, covered person, subscriber or retiree is primary and the **plan** that covers the person as a dependent is **secondary**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **plan** covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **plans** is reversed so that the **plan** covering the person as an employee, covered person, subscriber or retiree is secondary and the other **plan** is primary.

2. Child Covered Under More Than One **Plan**. The order of benefits when a child is covered by more than one **plan** is:
   A The **primary plan** is the **plan** of the parent whose birthday occurs earlier in each Calendar Year if:
      - The parents are married or living together whether or not married;
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the **plan** that covered either of the parents longer is primary.

   B If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the **plan** of that parent has actual knowledge of those terms, that **plan** is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the **primary plan**.
      - If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
         - The **plan** of the **custodial parent**;
         - The **plan** of the spouse of the **custodial parent**;
         - The **plan** of the non-**custodial parent**; and then
         - The **plan** of the spouse of the non-**custodial parent**.

   For a dependent child covered under more than one **plan** of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.
3. Active Employee or Retired or Laid off Employee. The **plan** that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the **primary plan**. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the **secondary plan**. If the other **plan** does not have this rule, and if, as a result, the **plans** do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another **plan**, the **plan** covering the person as an employee, covered person, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other **plan** does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
5. Longer or Shorter Length of Coverage. The **plan** that covered the person as an employee, covered person, or subscriber longer is primary. To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended. The start of a new plan does not include a change in the amount or scope of a plan's benefits; a change in the entity that pays, provides, or administers the plan's benefits; or a change from one type of plan to another, such as from a single employer plan to a multiple employer plan.
6. If the preceding rules do not determine the **primary plan**, the **allowable expense**s shall be shared equally between the **plans** meeting the definition of **plan** under this provision. In addition, **this plan** will not pay more than it would have paid had it been **primary** plus any accrued savings.

Effect on Benefits of This Plan

In determining the amount to be paid when this plan is secondary on a claim, the **secondary plan** will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any **allowable expense** under this plan that was unpaid by the **primary plan**. The amount will be reduced so that when combined with the amount paid by the **primary plan**, the total benefits paid or provided by all plans for the claim do not exceed 100% of the total **allowable expense**.

In addition, a **secondary plan** will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of **this plan**, the amount normally reimbursed for covered benefits or expenses under **this plan** is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under **this plan** for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of **this plan** and another plan both agree that **this plan** determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more **closed panel plan**s COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans

When a **plan** is the **secondary plan**, it may reduce its benefits so that the total benefits paid or provided by all **plans** during a **claim determination period** do not exceed one hundred percent of the total **allowable expenses**. The **secondary plan** must calculate its savings by subtracting the amount that it paid as a **secondary plan** from the amount it would have paid had it been **primary**. These savings are recorded as a benefit reserve for the covered person and must be used by the **secondary plan** to pay any **allowable expenses** not otherwise paid, that are incurred by the covered person during the **claim determination period**. As each claim is submitted, the issuer of the **secondary plan** must:

- Determine its obligation under its **plan**;
- Determine whether a benefit reserve has been recorded for the covered person; and
- Determine whether there are any unpaid allowable expenses during that **claims determination period**.
- Use any amount that has accrued in the covered person's recorded benefit reserve to make payment so that one hundred percent of the total allowable expenses incurred are paid during the claim determination period.

Multiple Coverage Under Aetna Plans
If a person is covered under **this plan** and another **Aetna** plan both as an employee and a dependent or as a dependent of 2 employees, the following will also apply:

- The person's coverage in each capacity under **this plan** and the other **Aetna** plan will be set up as a separate "**plan**".
- The order in which various **plans** will pay benefits will apply to the "**plans**" set up above and to all other **plans**.
- This provision will not apply more than once to figure the total benefits payable to the person for each claim under this **plan.**

Right to Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this **plan** and other **plans**. **Aetna** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment
Any payment made under another **plan** may include an amount which should have been paid under **this plan**. If so, **Aetna** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under **this plan**. **Aetna** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by **Aetna** is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or 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 any benefits provided in the form of services.

Claims, Appeals, Grievances, Independent Medical Review

Appeals Procedure

Definitions

Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit. Written notice of Adverse Benefit Determinations, including the reasons for the determination, will be provided to you and your provider according to the time frames given below. The notice will include information which will assist you in making an appeal if you wish to do so.

In Washington State, an **adverse benefit determination** is either:

- An "**adverse determination and noncertification**" which means a decision to deny, modify, reduce, or terminate payment for, coverage of, authorization of or provision of health care services or benefits including the admission to or continued stay in a facility"; or
- A decision that a service or benefit is not covered for other reasons including, but not limited to, member not eligible for coverage at time service is provided, benefit maximums under the plan have been reached, or the service or supply is not covered under the plan.

Such **adverse benefit determination** may be based on, among other things:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

Appeal: An oral or written request to **Aetna** to reconsider an **adverse benefit determination**.

Complaint: Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a previously approved course of treatment.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received. Refer to the *How the Plan Works, "Understanding Precertification"* section for additional information about when you or your **health care provider** must make **pre-service claims**.

Post-Service Claim: Any claim that is not a "**Pre-Service Claim**", "**Urgent Care Claim**" or a "**Concurrent Care Claim**".

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- Jeopardize your life;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

You or **"the claimant"**. For purposes of this amendment "you" also means "you ***or*** your attending **health care provider** or the facility making the claim on your behalf".

Claim Determinations – Group Health Coverage

Urgent Care Claims

Aetna will make notification of an **urgent care** claim determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, **Aetna** will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **health care provider** to provide **Aetna** with the information.

If the claimant fails to follow plan procedures for filing a claim, **Aetna** will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

If no additional information is required **Aetna** will make a claim determination as soon as possible but not later than 2 business days after the claim is made. **Aetna** will provide notification 2 calendar days after the **pre-service claim** determination is made. **Aetna** may determine that an extension is needed because **Aetna** needs additional information to make a claim determination**. Aetna** will notify you within 15 calendar days from receipt of a **pre-service claim** if additional information is needed. The notice of the extension shall specifically describe the required information. You will have 30 calendar days, from the date of the notice, to provide **Aetna** with the required information. **Aetna** will make the claim determination within 2 business days of receipt of all necessary information and will provide notification to the member and the attending **health care provider** or ordering provider or facility within 2 calendar days of the determination.

Post-service Claims

If all information necessary to evaluate a claim is provided when the **post service claim** is received, **Aetna** will make notification of a claim determination as soon as possible but not later than 30 calendar days after the **post-service claim** is made. **Aetna** may determine that we need additional information in order to make a claim determination, in which case we may request an extension. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. The notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information. **Aetna** will not retrospectively deny coverage for **precertified** care including **precertified prescription drugs**, if covered.

Concurrent Care Claim Extension

Following a request for **a concurrent care claim extension**, **Aetna** will make notification of a claim determination for **emergency** or **urgent care** as soon as possible but not later than 24 hours, with respect to **emergency** or **urgent care** provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. With respect to all other care, **Aetna** will make a determination within 14 days following a request for a concurrent care claim extension and will provide notification within one day of the determination.

Concurrent Care Claim Reduction or Termination

Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**, but in no event will the timeframe for the notification be longer than one day. If you choose to appeal **Aetna**'s determination, **Aetna** will continue to provide the previously approved course of treatment until the **appeal** is resolved, including Independent Medical Review if requested. If **Aetna**'s decision is affirmed then you will be responsible for the cost of the services provided after the termination date provided in the notification.

Notification of Adverse Determination and Noncertification
Notifications of claim determinations which include an **adverse determination and noncertification** will include the actual reasons for the determination, instructions for obtaining an appeal of the decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination. Notifications of an **adverse determination and noncertification** are provided to you and the treating **health care provider** or facility making the claim.

Complaints
If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must call or write Aetna Customer Service within 180 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a notification of receipt of your **complaint** within 5 days, and a written response within 14 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. If additional information is necessary to respond to your **complaint**, **Aetna** will notify you within the initial 14 day period and may extend the response time to 30 days from the date of receipt of the **complaint**. **Aetna** will not take longer than 30 days to respond to your **complaint** without your written permission. The notice of the decision will tell you what you need to do to request an External Review.

Appeals of Adverse Benefit Determinations
You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one level of **appeal**. It will also provide an option to request an external review of the **adverse benefit determination**.

You have 180 calendar days with respect to Group Health claims following the receipt of notice of an **adverse benefit determination** to request your **appeal**. Your **appeal** may be submitted orally or in writing and should include:

- Your name;
- Your policyholder's name;
- A copy of **Aetna**'s notice of an **adverse benefit determination**;
- Your reasons for making the **appeal**; and
- Any other information you would like to have considered.

Send in your **appeal** to Customer Service at the address shown on your ID card, or call in your **appeal** to Customer Service using the toll-free telephone number shown on your ID card.

Alternatively, you may send your **appeal** to the address shown on the notice of **adverse benefit determination**, or you may call in your **appeal** using the toll-free telephone number listed on such notice.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf by providing written consent to **Aetna**.

An **appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel not involved in making the **adverse benefit determination**. You may request assistance making your **appeal** by calling the toll free customer service number listed on your ID card. **Aetna** will send you notification that your **appeal** has been received.

Appeal Response Times
Urgent care claims (may include concurrent care claim reduction or termination)

Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**.

Pre-service claims (may include concurrent care claim reduction or termination)
Aetna shall issue a decision within 14 calendar days of receipt of the request for an **appeal** unless additional information is necessary to complete review of the **appeal**. You will be notified within the initial 14 day period if additional information is necessary. **Aetna** will make a decision on the claim within 30 days of the receipt of the claim, unless we have your written consent to extend the **appeal** period. For **appeals** of claims decisions based on the determination that the requested treatment, service or supply is **experimental or investigational**, **Aetna** will issue a decision within 20 working days.

Post-Service Claims
Aetna shall issue a decision within 14 calendar days of receipt of the request for an **appeal** unless additional information is necessary to complete review of the **appeal**. You will be notified within the initial 14 day period if additional information is necessary. **Aetna** will make a decision on the claim within 30 days of the receipt of the claim, unless we have your written consent to extend the **appeal** period.

Exhaustion of Process

You are encouraged to exhaust the applicable process of the Appeal Procedure before you:

- contact the Office of the Insurance Commissioner to request an investigation of a **complaint** or **appeal**; or
- file a **complaint** or **appeal** with the Office of the Insurance Commissioner; or
- initiate any:
  - Litigation;
  - Arbitration; or
  - Administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

External Review Group Health Claims
If you do not agree with **Aetna's** decision of your **appeal**, or if **Aetna** takes longer than 30 days from the date of receipt of your **appeal** to reach a decision without your written consent, you or your provider may request an independent external review. An external review is a review by an External Review Organization, who assigns a reviewer with expertise in the problem or question involved to review your request and reach an independent decision.

The **appeal** denial letter you receive from **Aetna** will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to **Aetna** within 180 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization, according to the requirements of Washington Law, which will conduct the review of your claim and not later than the third business day after the date we receive your request for external review, will forward the required documents, including the material you sent to us to the External Review Organization. You may request a copy of the material we send, and we may request a copy of any additional material your or your treating provider send to the External Review Organization.

The External Review Organization will select an independent **physician** or contract specialist with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow **Aetna**'s contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of **Aetna**'s receipt of your request form and all necessary information. A quicker review is possible if your **health care provider** certifies (by telephone or on a separate Request for External

Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after **Aetna** receives the request.

Aetna will abide by the decision of the External Review Organization.

Aetna is responsible for the cost of sending the information that was used to make the initial determination and the claim determination, and any information from you or your provider to the External Review Organization and for the cost of the external review. You are responsible for the cost of compiling and sending documentation other than medical records that you wish to be reviewed by the External Review Organization to **Aetna**.

Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Northwestern University Postdoctoral Fellow Benefit Program

Group policy number: GP-836990

Amendment effective date: January 1, 2020

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Wisconsin. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Benefits payable under this *Booklet-Certificate* are primarily based on recognized charges or scheduled benefits which may be less than the actual charge.

For benefit information questions, please contact:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna's** toll free customer service number found on your ID card or visit **Aetna's** website at www.Aetna.com.

Coverage for Dependent Children

To be eligible for coverage, a dependent child must be under 27 years of age.

Special Enrollment Periods *GR-9N-29-015-02 WI)*

If You Adopt a Child

Your plan will cover a child who is placed for adoption. ("Placed for adoption" means any of the following: 1) the department, a county department or a child welfare agency licensed under the Wisconsin Code places a child in the insured's home for adoption and enters into an agreement under the Code with the insured; 2) a court under the Wisconsin Code orders a child placed in the insured's home for adoption; 3) a sending agency as defined in the Wisconsin Code places a child in the insured's home for adoption, and the insured takes physical custody of the child at any location within the United States; 4) the person bringing the child into this state has complied with the Wisconsin code, and the insured takes physical custody of the child at any location within the United States; or 5) a court of a foreign jurisdiction appoints the insured as guardian of a child who is a citizen of that jurisdiction, and the child arrives in the insured's home for the purpose of adoption by the insured under the Wisconsin Code.)

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 60 days of the placement.

- Proof of placement will need to be presented to **Aetna** prior to the dependent enrollment.
- Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Covered expenses for children from birth to age 6 also include:

- Diphtheria;
- Haemophilus influenza type B;
- Hepatitis A;
- Hepatitis B;
- Measles;
- Mumps;
- Pertussis;
- Polio;
- Rubella;
- Tetanus; and
- Varicella.

May not be subject to any deductibles, copayments, or coinsurance.

Routine Cancer Screenings

Covered expenses include charges incurred for routine cancer screening as follows:

- Routine Mammogram:
  (1) A baseline mammogram for women between the ages of 35 to 40; and
  (2) A mammogram every two years; or more frequently based on the recommendation of the women's physician for women ages 40 to 50;
  (3) A mammogram on an annual basis for women 50 years of age and older.

Autism Spectrum Disorders *(GR-9N 11-171 04 WI)*

Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Covered expenses include charges made by a **physician** for the services and supplies for the diagnosis and treatment, (including behavioral therapy and Applied Behavioral Analysis), of Autism Spectrum Disorder when ordered by a **physician** for Intensive-Level Services and Non-Intensive Level Services as described below.

Coverage also includes early intensive behavioral interventions such as Applied Behavioral Analysis(ABA). Applied Behavioral Analysis is an educational service that is the process of applying interventions that:

- Systematically change behavior; and
- Are responsible for the observable improvement in behavior.

"Intensive-Level Services**"** means evidence-based behavioral therapy that is designed to help a person with Autism Spectrum Disorder overcome the cognitive, social and behavioral deficits associated with that disorder.

Non-Intensive Level Services

For each covered person who has a primary diagnosis of Autism Spectrum Disorder, expenses for the treatment of Non-Intensive Level Services will be covered up to the maximum benefit amount, if any, as shown on the *Schedule of Benefits*.

"Non-Intensive Level Services" means evidence-based therapy that occurs after the completion of treatment with Intensive-Level Services that is designed to sustain and maximize gains made during treatment with Intensive-Level Services. For a person who has not and will not receive Intensive-Level Services, this means evidence-based therapy that will improve the person's condition.

Limitations:
Unless specified above, not covered under this benefit are charges for:

- Educational services for behavioral disorders that are listed as not covered in the Medical Plan Exclusions and Limitations section of the Policy.

Outpatient Equipment, Supplies and Diabetic Self-Management Education Program Expenses *(GR-9N-11-135-02 WI)*

Covered expenses include charges for the following expenses incurred in connection with the treatment of diabetes (including insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes):

- Equipment;
- Supplies;
- Outpatient self-management training and education;
- Medications.

Charges for a diabetic self-management education program are covered; but only if:

- the person is a diabetic who is covered under this Policy; and not confined in a hospital or skilled nursing facility as a full-time inpatient; or
- the person is covered under this Policy; and cares for; or helps care for a diabetic who is covered under this Policy and not confined in a hospital or skilled nursing facility as a full-time inpatient.

Charges include tuition and fees.

A "diabetic self-management education program" is a scheduled program on a regular basis which is designed to instruct a person in the self-management of diabetes. It is a day care program of educational services and self-care training. All the following requirements must be met.

- A physician must direct and supervise the program.
- The program's services and training must be rendered by health care professionals who are familiar with diabetes and its treatment. This includes physicians; R.N.'s registered pharmacists; registered dieticians; and licensed social workers.
- The program must include:
  - An assessment of the diabetic's needs and skills. This must be done:
    - by the health care professionals who render the service; and
    - before the program starts and after it ends.
  - An education plan designed for the diabetic's condition and skills.
  - At least a total of 10 hours of one on one or group instructions.
  - At least one dietary counseling session for the diabetic and the persons who help in his or her care.
  - A discussion of:
    - the history of diabetes;
    - psycho-social factors which affect the diabetic and his or her family;
    - complications and related symptoms;
    - special general health care concerns. (These include hygiene and pregnancy care if appropriate.)
  - Training in:
    - dietary and nutritional planning;
    - procedures for testing and monitoring of blood sugars; and
    - adjusting medications or diet to correspond to activities and exercises done.
    - Provision for at least one follow-up evaluation. This is done after the person completes the program.

Not included as covered medical expense are program expenses incurred for a diabetic education program whose only purpose is weight control or a diabetic education program that is available to the public at no cost

Kidney Disease Treatment			
Kidney Disease Treatment Maximum	$30,000 per Calendar Year	$30,000 per Calendar Year	$30,000 per Calendar Year

Mail Order Pharmacy Benefits

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

Jaw Joint Disorder Treatment *(GR 9N 11-150 01 WI)*

This plan pays for charges made by a **physician** for the medically necessary surgical or non-surgical treatment (including intraoral splint therapy devices) for correction of temporomandibular joint disorders. Such treatment will be considered medically necessary if:

- caused by congenital, development or acquired deformity, disease or injury;
- the procedure or device is to control or eliminate infection, pain, disease or dysfunction; and
- under accepted standards of the profession of the medical provider rendering the service the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.

Benefits are payable up to the jaw joint disorder maximum shown in the *Schedule of Benefits*.

No benefits are payable for:

- Cosmetic or elective orthodontic care, periodontic care or general dental care.

Hospital or ambulatory surgery center charges incurred, and anesthetics provided in conjunction with dental care that is provided to a covered individual in a hospital or ambulatory surgery center, if any of the following applies:

- The individual is a child under the age of 5.
- The individual has a chronic disability as defined in the Wisconsin Code.
- The individual has a medical condition that requires hospitalization or general anesthesia for dental care.

Treatment of Mental Disorders *(GR-9N 11-172-04 WI)*

Covered expenses include charges made by a **hospital**, **psychiatric hospital**, **residential treatment facility** or **behavioral health providers** for the treatment of **mental disorders** as follows**:**

- Inpatient **room and board** at the **semi-private room rate,** and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**.

- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:

  - **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a **physician**. The facility or program does not make a **room and board** charge for the treatment.

  - Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment) provided in a facility or program under the direction of a **physician.**

  - Office Visits to a **physician (**such as a **psychiatrist)**, psychologist, social worker, or licensed professional counselor, as well as other health professionals.

- **Transitional treatment arrangements**. Benefits will be payable, after any applicable **deductible**, at the covered percentage up to the maximum days or maximum benefit for such expenses incurred in any calendar year. The applicable **deductibles**, covered percentages, maximum days, and maximum benefits are shown on the *Schedule of Benefits.*

Important Notes:

Please refer to the ***E-visits*** section for information about **covered expenses** for **e-visits**.

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See the *Exclusions* section for more information.

Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Please refer to the *Schedule of Benefits* for any **copayments**/**deductibles**, maximums, **coinsurance limits** that may apply to your **mental disorders** benefits.

Treatment of Substance Abuse *(GR-9N 11-172-04 WI)*

Covered expenses include charges made by a **hospital**, **psychiatric hospital**, **residential treatment facility** or **behavioral health provider** for the treatment of **substance abuse** as follows:

- Inpatient **room and board** at the **semi-private room rate** and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility**. Treatment of **substance abuse** in a general medical **hospital** is only covered only when you are admitted to the **hospital's** separate **substance abuse** section (or unit) for treatment of medical complications of **substance abuse**.

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

- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:

  - **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a **physician**. The facility or program does not make a **room and board** charge for the treatment.

  - Intensive Outpatient Program (at least 2 hours per day and at least six hours per week of clinical treatment) provided in a facility or program under the direction of a **physician.**

  - Ambulatory detoxification –Outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications.

  - Office visits to a **physician (**such as a **psychiatrist)**, psychologist, social worker, or licensed professional counselor, as well as other health care professionals.

  - **Transitional treatment arrangements**. Benefits will be payable, after any applicable **deductible**, at the covered percentage up to the maximum days or maximum benefit for such expenses incurred in any calendar year. The applicable **deductibles**, covered percentages, maximum days, and maximum benefits are shown on the *Schedule of Benefits.*

Important Notes:

Please refer to the ***E-visits*** section for information about **covered expenses** for **e-visits**.

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See the ***Exclusions*** section for more information.

Inpatient treatment and certain outpatient treatments must be **precertified** by **Aetna**. Refer to the *How the Plan Works* section for details.

Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums and **coinsurance limits** that may apply to your **substance abuse** benefits.

Skilled Nursing Inpatient Facility			
Maximum Days per period of confinement	60 days	60 days	60 days

Continuing Coverage for Dependents After Your Death

If you should die while enrolled in this plan, your dependent's health care coverage, if applicable will continue as long as:

- You were covered at the time of your death,
- Your coverage, at the time of your death, is not being continued after your employment has ended;
- A request is made for continued coverage within 30 days after your death; and
- Payment is made for the coverage.

Your dependent's coverage will end when the first of the following occurs:

- The end of the 18 month period following your death;
- He or she no longer meets the plan's definition of "dependent;"
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop; and
- For your spouse, the date he or she remarries.

If your dependent's coverage is being continued for your dependents, a child born after your death will also be covered.

Important Note
Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Medical Insurance Policy* for more information.

Continuing Coverage Full-time Student on Medical Leave *(GR-9N-31-015-03 WI)*

You may continue health care benefits for a full-time student dependent child, if coverage ends due to a medically necessary leave of absence.

A full-time student is only entitled to continue coverage if he or she submits to Aetna documentation and certification of the medical necessity of the leave of absence from the full-time student's attending **physician**. The date on which the full-time student ceases to be a full-time student due to the medically necessary leave of absence shall be the date on which the coverage continuation begins.

Your full-time student dependent child's coverage will end when the first of the following occurs:

- Does not intend to return to school full-time.
- Becomes employed full-time.
- Becomes eligible for comparable benefits under this or any other group plan.
- Marries and is eligible for coverage under his or her spouse's health care coverage.
- Ceases to be defined as a full-time student.
- Full-time student coverage ceases under this Plan.
- One year has elapsed since the full-time student's coverage continuation began and the full-time student has not returned to school full-time.

Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Wisconsin Medical ET
Issue Date: November 15, 2019

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial booklet-certificate amendment

Policyholder: Northwestern University Postdoctoral Fellow Benefit Program

Group policy number: GP-836900

Amendment effective date: January 1, 2020

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Limitations:

If the benefits for **covered benefits** in this amendment are greater than the benefits for the same **covered benefits** in your booklet-certificate, the benefits under this amendment will apply.

The following has been added to or replaced in the *Preventive care and wellness* section of your booklet-certificate:

Preventive care immunizations

Eligible health services include immunizations provided by your **physician** or **PCP** for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Preventive care immunizations		
Performed in a facility or at a **physician's** office Routine immunizations for a child from birth to age 5 are not subject to any **deductible**, **coinsurance**, **copayment** or benefit maximums.	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.

The following has been added to or replaced in the *Preventive care and wellness* section of your booklet-certificate:

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms (age 35 and older or as recommended by a **physician** due to a family history of breast cancer)
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure
- Lung cancer screenings

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

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

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

Routine cancer screenings (applies whether performed at a physician's, specialist office or facility)		
Routine cancer screenings	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit
Maximums	Subject to any age, family history and frequency guidelines as set forth in the most current: • 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; and • The comprehensive guidelines supported by the Health Resources and Services Administration; or • As required by state law where stricter. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Subject to any age, family history and frequency guidelines as set forth in the most current: • 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; and • The comprehensive guidelines supported by the Health Resources and Services Administration; or • As required by state law where stricter. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.
Mammogram Maximum	Age 35 and older, subject to any family history, and frequency guidelines as set forth in the most current: • 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; and • The comprehensive guidelines supported by the Health Resources and Services Administration; or • State law (where stricter). For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Age 35 and older, subject to any family history, and frequency guidelines as set forth in the most current: • 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; and • The comprehensive guidelines supported by the Health Resources and Services Administration; or • State law (where stricter). For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months	1 screening every 12 months
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		

The following has been added to or replaced in the *Physicians and other health professionals* section of your booklet-certificate:

Alternatives to physician office visits

E-Visits and Telemedicine consultations

Eligible health services include routine, non-emergency medical consultation with your **physician** or **provider**.

Important note:
You may have to register with an authorized internet service vendor in order to make an **E-visit** appointment or participate in a **telemedicine** consultation with your **provider**. DocFind® tells you who those are. **E-visits** and **telemedicine** are not the same as office visits and may have different cost sharing.

Walk-in clinic

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

- Unscheduled, non-medical emergency **illnesses** and **injuries**
- The administration of immunizations administered within the scope of the clinic's license
- Individual screening and counseling services to aid you:
  - In weight reduction due to obesity and/or healthy diet
  - To stop the use of tobacco products

E-Visits and Telemedicine		
Telemedicine consultation by a **physician**	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit
Telemedicine consultation by a **specialist**	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit
Important Note: The cost-share for a **telemedicine** consultation will be no greater than the cost share for a visit to the **provider's** office.		

The following has been added to or replaced in the *Hospital and other facility care* section of your booklet-certificate:

Anesthesia and hospital charges for dental care

Eligible health services include the administration of general anesthesia and hospital charges provided in a hospital, surgery center, or physician's office for dental care provided to the following covered persons:

- A child under 5 years of age
- A person who is severely disabled
- A person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental services are provided.

Anesthesia and hospital charges for dental care		
	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

The following has been added to or replaced in the *Specific conditions* section of your booklet-certificate:

Autism spectrum disorder

Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association as a neurobiological disorder, an **illness** of the nervous system that includes:

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

Eligible health services include the services and supplies provided by a **physician**, autism service provider, line therapist or **behavioral health provider** for the diagnosis and treatment of Autism Spectrum Disorder, including:

- Psychiatric and psychological services
- Habilitative and rehabilitative care, including applied behavioral analysis, speech, occupational and physical therapy
- Medications (covered under your pharmacy benefit)
- Equipment related to care

We will only cover this treatment if a **physician**, autism service provider, line therapist or **behavioral health provider** prescribes or orders it as part of a treatment plan.

We will cover early intensive behavioral interventions such as Applied Behavior Analysis. Applied Behavior Analysis is the design, implementation and evaluation of environmental changes, using behavior incentives and penalties to create socially meaningful progress in human behavior. This includes the use of:

- Direct observation
- Measurement; and
- Functional analysis of the relationships between environment and behavior

Autism spectrum disorder		
Autism spectrum disorder treatment Autism spectrum disorder is not subject to any age or benefit maximums	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Autism spectrum disorder diagnosis and testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Applied Behavior Analysis for the treatment of Autism Spectrum Disorders	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

The following has been added to or replaced in the *Specific therapies and tests, Outpatient Therapies* section of your booklet-certificate:

You pay no more for orally administered cancer medications than for the same covered intravenously or injected cancer medication.

Outpatient physical therapy, occupational therapy, and speech therapy are covered according to the type of benefit and the place where the service is received. The cost share will be no greater than the cost share of a **physician** or **PCP**.

The following has been added to or replaced in the *Specific therapies and tests* section of your booklet-certificate:

Early intervention for infants and toddlers (First Steps)

Eligible health services include:

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

Coverage is only for a dependent child who:

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

Early intervention services office visits for children from birth to age 3 is covered according to the type of benefit and the place where the service is received. The copayment or coinsurance for any physical therapy services under this benefit will be no greater than a physician's office visit copay or coinsurance. At no time will any dollar limit be less than Missouri law.

The following has been added to or replaced in the *Other services* section of your booklet-certificate:

Clinical trial therapies (experimental or investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an "approved clinical trial" only when you have cancer or terminal illnesses and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- We determine based on published, peer-reviewed scientific evidence that you may benefit from the treatment.

An "approved clinical trial" is a clinical trial that meets all of these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

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

As it applies to in-network coverage, coverage is limited to benefits for routine patient services provided within the network.

Cancer clinical trials (Routine Patient Costs)

Eligible health services include "routine patient care costs" for drugs or devices incurred to you by a **provider** in connection with participation in a phase II, III or IV clinical trial. The purpose of the clinical trial is the prevention, early detection and treatment of cancer.

Routine care for phase II clinical trials must be:

- Sanctioned by the NIH or National Cancer Institute;
- Conducted at an academic or National Cancer Institute Center; and
- You are actually enrolled in the clinical trial and not merely following the protocol of a phase II clinical trial.

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

- The study or investigation is approved or funded by one or more of the following:
  - The National Institutes of Health (NIH)
  - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
  - The Food and Drug Administration (FDA) in the form of an investigational new drug application
  - The Department of Veterans Affairs
  - The Department of Defense
  - An institutional review board in Missouri that has an appropriate assurance approved by the

Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or
- A qualified research entity that meets the criteria for NIH Center support grant eligibility.

- The treating facility and **provider** must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.
- The clinical trial **providers** obtained your informed consent to participate in the clinical trial and they did so by following legal and ethical standards.

Clinical trial therapies (experimental or investigational)		
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Clinical trials (routine patient costs)		
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

The following has been added to or replaced in the *Other services* section of your booklet-certificate:

Osteoporosis

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

Osteoporosis		
Physician's office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

The following has been added to or replaced in the *When you disagree - claim decisions and grievance procedures* section of your booklet-certificate.

When you disagree - claim decisions and grievance procedures

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

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

Claim procedures

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

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from your employer. If we do not provide you with a claim form within 15 days, you will have complied with any requirements to submit proof of loss. • The claim form will provide instructions on how to complete and where to send the form(s).	• Within 20 working days of your request. • If the claim form is not sent on time, we will accept a written description that is the basis of the claim as proof of loss. It must detail the nature and extent of loss within 90 days of your loss. We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.
Proof of loss (claim)	• A completed claim form and any additional information required by us.	• No later than 90 days after you have incurred expenses for **covered benefits.** • We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible. • Proof of loss may not be given later than 2 years after the time proof is otherwise required, except if you are legally unable to notify us.
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid within 30 processing days after receipt of a filed claim, or as soon as the necessary proof to support the claim is received. • Processing days are the number of days that the claim is in our possession. This does not include days while we are waiting for additional information

		from the **provider**.

Types of claims and communicating our claim decisions

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

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim/Emergency care claim

An urgent claim is one for which delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. Or it could be a situation in which you need care to avoid severe pain. However, the condition is not so severe as to require **emergency services. Precertification** is not required for **emergency medical conditions**.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby, but **emergency services** are not required.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we precertify them.

Post-service claim

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

Concurrent care claim review

During a concurrent care claim review, we may extend the length of your coverage. This occurs when you ask us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**.

If we deny your request for a concurrent care claim extension, we will notify you of such a determination. You will have enough time to file a grievance of an **adverse benefit determination**. Your coverage for the service or supply will continue until you receive a final grievance decision from us or an external review organization, if the situation is eligible for external review.

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

Note that if we have **precertified eligible health services** under this plan, we will not change our decision, except if you have intentionally misrepresented your health condition or if your coverage ends before the **eligible health services** are provided.

Timely Access to Review

A toll-free telephone number is listed on the back of your of your member ID card, if you or your **provider** need to contact Aetna's review staff.

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. Where state regulations are stricter than federal regulations, we will abide by state

regulations.

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

Type of notice	**Urgent care claim/Emergency care claim**	**Pre-service claim**	**Post-service claim**	**Concurrent care claim**
Initial determination (us) Verbal or electronic notice to the **provider**	72 hours for prospective urgent/emergent request 60 minutes for **precertification** for immediate post-evaluation or post-stabilization services. The **precertification** will be deemed approved if a decision is not made within 30 minutes	36 hours, which shall include one working day, of obtaining all necessary information	30 calendar days	24 hours for urgent request* or an adverse decision 1 working day for non-urgent request or approval
Extensions	None	15 calendar days	15 calendar days	Not applicable
Additional information request (us)	72 hours	15 calendar days	30 calendar days	Not applicable
Response to additional information request (you)	48 hours	45 calendar days	45 calendar days	Not applicable
Written or electronic confirmation to you and your **provider**	1 working day for an adverse decision 2 working days for approval	1 working day for an adverse decision 2 working days for approval	10 working days	1 working day

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

Timeframes and requirements listed are based on state and federal regulations. Where state regulations are stricter than federal regulations, we will abide by state regulations.

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** with a **network provider** and the **recognized amount** with an **out-of-network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an "adverse benefit determination" or "adverse decision". It is also an "adverse benefit determination" if:

- We rescind your coverage entirely
- We deny your request for
    - a concurrent claim extension

- an admission, or
- a service or supply

because we determined it was not **medically necessary** or the service or supply was not an **eligible health service**.

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

The difference between a complaint and a grievance

A Complaint

You may be dissatisfied about a **provider** or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. Member Services will review all the facts of your complaint as quickly and as courteously as possible. Complaints are resolved on an informal basis.

A Grievance

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

- Getting an appointment with a **provider**
- The quality of the service you received
- An adverse benefit determination or adverse decision
- Getting a claim paid or reimbursement for a payment you made
- Operational issues between you and the plan

You can write to Member Services if you are dissatisfied about:

- Getting an appointment with a **provider**
- The quality of the service you received, or
- Operational issues between you and the plan

Your grievance should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know in writing within 10 working days that we received your grievance. We will then review your grievance and provide you with a written response within 20 working days of receiving the grievance**.** We will let you know if we need more information to make a decision and will complete our investigation within 30 working days after we receive all the information we need.

Grievances of adverse benefit determinations

First-Level Grievance

You or your authorized representative can ask in writing us to re-review an adverse benefit determination. This is a grievance of an adverse benefit determination. We will assign your grievance to someone who was not involved in making the original decision and who is not the subordinate of the person who made the initial decision. You must file your grievance no later than 180 calendar days from the time you receive the notice of an adverse benefit determination.

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

You or your authorized representative can send your written grievance to the address on the notice of adverse benefit determination. Or you can call Member Services at the number on your ID card. You need to include:

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

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

If your adverse benefit determination was based on a medical judgment, we will consult with a **health professional** who is knowledgeable about your medical condition and who was not involved in making the original decision. The **health professional** will be a clinical peer of the same or similar specialty in the field of medicine involved in the medical judgment. This individual will be someone who was not involved in the initial decision and who is not the subordinate of the person who made the initial decision.

We will make a determination on your grievance within the timeframes listed in the chart below. We will tell you in writing about our decision and explain this decision in terms that are clear and specific. In addition, we will inform you of your right to submit a second grievance.

Second-Level Grievance

You or your authorized representative can submit a second grievance of an adverse determination under this plan. You must present your second grievance no later than 180 calendar days from the date you receive the notice of the first grievance decision.

A grievance committee will review your second-level grievance. The grievance committee will consist of other plan members and some of Aetna's employees who were not involved with your first grievance. If your adverse benefit determination was based on a medical judgment, a majority of the committee will be **health professionals** possessing the same or similar expertise in treating the medical condition that is under review. They also would not have been involved in your first-level grievance.

The review of your second-level grievance will follow the time frames listed in the chart below. We will tell you in writing of the grievance committee's final decision in terms that are clear and specific. You may request access to and copies of documents, records and information relevant to the grievance. This includes the actual benefit provision, guideline, protocol, or other similar criterion on which the grievance decision was based. We will provide you with that information free of charge.

If you are unhappy with our decision, you may at any time contact the Missouri Department of Insurance, at:

Missouri Department of Insurance,
Financial Institutions and Professional Registration
Consumer Services Section
P. O. Box 690
Jefferson City, Missouri 65102-0690
Consumer Hotline: 800-726-7390
TDD: (573) 526-4536

Urgent care/Emergency care claim or pre-service claim grievances

If your claim is an urgent/emergency care claim or a pre-service claim, your **provider** may send us a grievance on your behalf.

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

Timeframes for deciding grievances

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

Type of notice	**Urgent care/Emergency care claim**	**Pre-service claim**	**Post-service claim**	**Concurrent care claim**
First-level grievance determinations (us)	36 hours We will confirm our decision in writing within 3 working days of the initial decision.	15 calendar days or 5 days after our investigation is complete (whichever is earlier).	20 working days* or 5 days after our investigation is complete (whichever is earlier).	As appropriate to type of claim
Second-level grievance determinations (us)	36 hours We will confirm our decision in writing within 3 working days of the initial decision	15 calendar days or 5 days after our investigation is complete (whichever is earlier).	20 working days* or 5 days after our investigation is complete (whichever is earlier).	
Extensions	None	None	30 calendar days	

***** If we cannot make a decision within the timeframe listed, we will send you a letter telling you why. We will however make a decision within 30 calendar days thereafter.

External review

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

You or your authorized representative may request an external review if:

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

You do not have to exhaust the Plan's internal grievance process before you can request an external review**.** If you wish to pursue an external review, you may write to:

The Missouri Department of Insurance,
Financial Institutions and Professional Registration
Consumer Services Section
P. O. Box 690
Jefferson City, Missouri 65102-0690

And include any information or documentation to support your request. If you have any questions or concerns during the external review process, you can call the Missouri Department of Insurance, Financial Institutions and Professional Registration Consumer Hotline at 800-726-7390.

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

The Missouri Department of Insurance ("Department") will first review your grievance as any other consumer complaint; however, if the grievance remains unresolved after exhausting the Department's consumer complaint process, then the Department will contact a state-qualified External Review Organization (ERO) that will conduct the review of your claim.

The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.
- Consider appropriate credible information that you sent.
- Follow our contractual documents and your plan of benefits.
- Notify the Department of its opinion with 20 calendar days.

The ERO may request additional time for its investigation, but not exceeding 5 calendar days.

The Department will tell you in writing of its decision within 25 calendar days of receiving the IRO's opinion. At no time will the external review decision be longer than 45 calendar days of the date the ERO received your request for an external review and all the necessary information. We will stand by the decision that the Department makes.

How long will it take to get an ERO decision?

The Missouri Department of Insurance ("Department") will tell you of the ERO's decision not more than 45 calendar days after the ERO received your request for an external review and all the necessary information.

But sometimes you can get a faster external review decision. Your **provider** must call or send the Missouri Department of Insurance a request for an expedited external review. The Department will choose an ERO that will conduct the expedited external review and inform the Department of its opinion within 72 hours.

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

For initial adverse determinations

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

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

For final adverse determinations
Your **provider** tells us 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 (in the case of **experimental or investigational** treatment), or
- The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received **emergency services**, but have not been discharged from a facility

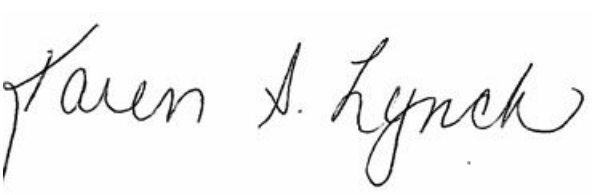
If your situation qualifies for this faster review, you will receive a verbal decision within 72 hours of the Department getting your request. The Department will send you written confirmation of its decision by mail or electronic media within 48 hours after a verbal notification.

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

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

The following has been added to or replaced in the *Glossary* section of your booklet-certificate:

Advanced practice registered nurse (APRN)
A nurse who has education beyond the basic nursing education and is certified by a nationally recognized professional organization as a certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or a certified clinical nurse specialist.



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Missouri Medical ET
Issue Date: November 15, 2019

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-982-3862.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Language Assistance

TTY: 711

For language assistance in English call 1-888-982-3862 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862 . (Spanish)

欲取得繁體中文語言協助，請撥打1-888-982-3862 ， 無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad. (Tagalog)

T'áá shí shizaad k'ehjí bee shíká a'doowoł nínízingo Diné k'ehjí kojį' t'áá jíík'e hólne' 1-888-982-3862 (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an. (German)

Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862 . (Albanian)

በ አማርኛ የቋንቋ እገዛ ለማግኘት በ 1-888-982-3862 በነጻ ይደውሉ (Amharic)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862. (Arabic)

Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով: (Armenian)

Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa. (Bantu-Kirundi)

Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad. (Bisayan-Visayan)

বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862 -তে কল করুন। (Bengali- Bangala)

ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။ (Burmese)

Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862 . (Catalan)

Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu. (Chamorro)

ᏱᏩᎾᎦᏔᎵᏍᏗᏱ ᎠᏂᏧᏣᏛᏁᎸᎢ ᎾᏍᎩᏯ ᎾᏍᎩᏃᎮᏓᎾ ᎤᏪᏥ (GW) ᏫᏚᏬᏔᎲ 1-888-982-3862 ᎤᏪᏥ ᏣᎠᏍᏆᏂᎪᏙᎲᏍᎦ ᎠᎴ ᎤᏂᎬᎫᏅᏒᎾ ᏄᏍᏛ ᎢᏳᏃᎷᏤᎵᏍᏗᏍᎩᏂ (Cherokee)

(Chahta) anumpa ya apela a chi ! paya hinla **1**-888-982-3862 . (Choctaw)

Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa. (Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862 . (Dutch)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση. (Greek)

(Gujarati) ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ કરો.

No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-982-3862 . Kāki ʻole ʻia kēia kōkua nei. (Hawaiian)

(Hindi) **हिन्दी में भाषा सहायता के लिए,** 1-888-982-3862 **पर मुफ्त कॉल करें।**

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862 . (Hmong)

Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla (Ibo)

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo. (Ilocano)

Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya. (Bahasa Indonesia)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862 . (Italian)

日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。(Japanese)

လာတၢ်မၤဘၤတၢ်ကတိၤကျိုဉ်အဂီၤ် ကျိုဉ် ကိး 1-888-982-3862 လာတအိဉ်ဒီးတၢ်လၢာ်ဘျည်လၢာ်စုတာ်ဉ် (Karen)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인1-888-982-3862 번으로 전화해 주십시오. (Korean)

Bɛ̀ m̀ ké gbo-kpá-kpá dyé pídyi ɖé Bǎsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 1-888-982-3862 (Kru-Bassa)

(Kurdish) .بۆ وەرگرتنی ڕێنوێنی پێوەندیدار بە زمان بە زمان بە ژمارەی 1-888-982-3862 بە خۆڕایی پەیوەندی بکەن

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ. (Laotian)

तील भाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावर कोणत्याही खर्चाशिवाय कॉल करा. (Marathi)

Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān. (Marshallese)

Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais. (Micronesian-Pohnpeian).

សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។ (Mon-Khmer, Cambodian)

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस्। (Nepali)

Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aɣöc. (Nilotic-Dinka)

For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt. (Norwegian)

Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix. (Pennsylvanian Dutch)

(Persian) برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862 . (Polish)

Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente. (Portuguese)

(Punjabi) ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-888-982-3862 (Romanian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862 . (Russian)

Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi. (Samoan)

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862 . (Serbo-Croatian)

Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862 . Njodi woo fawaaki on. (Sudanic-Fulfulde)

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862bila malipo. (Swahili)

ܟܬܒ ܠܗ ܒܥܘܬܐ ܒܠܫܢܐ ܕܥܡ ܐܝܢ ܠܫܢܐ ܠܛܠܦܘܢ ܠ 1-888-982-3862 ܒܠܐ ܡܚܐܠ. (Assyrian-Syriac)

భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862కాల్ చేయండి. (తెలుగు) (Telugu)

สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทย โทร 1-888-982-3862ฟรีไม่มีค่าใช้จ่าย (Thai)

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā tōtōngi. (Tongan)

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862nge esapw kamé ngonuk. (Trukese-Chuukese)

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862. (Turkish)

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862. (Ukrainian)

اُردو میں لسانی معاونت کے لیے 1-888-982-3862پر مفت کال کریں۔ (Urdu)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862. (Vietnamese)

פאר שפראך הילף אין אידיש רופט 1-888-982-3862פריי פון אפצאל. (Yiddish)

Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862lái san owó kankan rárá. (Yoruba)

Important Information about the Affordable Care Act (ACA)

Non-discrimination Rule

The Office of Civil Rights recently issued a Non-discrimination Rule in response to Section 1557 of the Affordable Care Act (ACA). Section 1557 prohibits discrimination because of race, color, national origin, sex, age or disability in health-related insurance or other health-related coverage. This applies to Aetna. Changes to health insurance plans are effective on the first day of the policy or plan year beginning on or after January 1, 2017.

Some language changes may not be in the enclosed certificate of coverage or policy. This may be because the language is still under official review for approval. See the *Important note* below for how this affects your policy or plan.

Important note:
We will comply with the requirements of the Rule for all new and renewing policies or plans with an effective date on or after January 1, 2017.

Below is a summary of some of the recent Non-discrimination Rule changes.

An insurer covered by the Rule that provides or administers health-related insurance or other health-related coverage:

- Shall not:
  - Cancel, limit or refuse to issue or renew a policy or plan
  - Deny or limit coverage of a claim
  - Apply additional cost sharing

  to a person because of race, color, national origin, sex, age, or disability.

- Shall not:
  - Deny or limit coverage
  - Deny or limit coverage of a claim
  - Apply additional cost sharing

  to a transgender person, if it results in discrimination against that person.

- Shall not exclude or limit health services related to gender transition.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates. Aetna companies that receive funds from the federal Department of Health and Human Services are subject to the Rule.

Important Information About Your Plan

Coverage of Applied Behavior Analysis
For the Treatment of Autism Spectrum Disorder

Your Plan includes coverage for the diagnosis and treatment of autism spectrum disorder. Eligible health services include the services and supplies provided by a physician or behavioral health provider for the diagnosis and treatment of autism spectrum disorder.

As part of this coverage, we will cover 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, and
- That are responsible for observable improvements in behavior.

Applied behavioral analysis will be subject to the same cost sharing requirements as other, outpatient services provided by a behavioral health provider for the treatment of autism spectrum disorder.

Important notes:

For plans that did not include such coverage previously, applied behavior analysis for the treatment of autism spectrum disorder will be an eligible health service for all new and renewing policies or plans with an effective date on or after January 1, 2017.

Applied behavior analysis requires precertification by Aetna.