AETNA HEALTH INC.

Group agreement

The HMO agreement is by and between

AETNA HEALTH INC.
(**Aetna**, we, us, or our)
and
UNIVERSITY OF PENNSYLVANIA POSTDOCTORAL INSURANCE PLAN
(**Contract holder**, you, or your)

Group agreement number: 0861472
Effective date: January 01, 2023
Contract situs: New Jersey

This HMO agreement takes effect on the **effective date** if we have received your signed group application and the initial premium. It remains in force until terminated.

Term of the HMO group agreement:

- The initial term shall be the 12 consecutive months beginning on the **effective date**.
- Subsequent terms shall be the 12 consecutive months beginning with the **renewal date**.

Premium due dates: The **effective date** and the 1st day of each succeeding calendar month.

Governing Law: Federal law and the laws of New Jersey

Signed at **Aetna's** Home Office 1425 Union Meeting Road, Blue Bell, Pennsylvania 19422.

By: Gregory S. Martino

Gregory S. Martino
Vice President

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The HMO agreement

The HMO agreement consists of several documents taken together. These documents are:

- Your group application
- This group agreement
- The certificate(s) attached
- The schedule of benefits attached
- Any riders and amendments to the group agreement, the certificate, and the schedule of benefits

If you want to discuss your coverage

If you have questions about your coverage under the HMO agreement, or if you wish to discuss it, contact your agent. If you did not use an agent to purchase your coverage, or if you have additional questions, you may contact us at:

AETNA HEALTH INC.
1425 Union Meeting Road
Blue Bell, Pennsylvania 19422
1-800-445-5299

Please have your group agreement number available when you contact us. It is on the front page of this group agreement.

Glossary

You will see some words in bold type in the HMO agreement. The bold type means we have defined those words. The definitions are in this section and in the *Glossary* section of the certificate.

Contract holder

UNIVERSITY OF PENNSYLVANIA POSTDOCTORAL INSURANCE PLAN and entities associated with it for purpose of coverage under this HMO agreement.

Covered person

An employee or a dependent of an employee for whom all of the following applies:

- The person is eligible for coverage as defined in the certificate
- The person has enrolled for coverage and paid any required initial premium contribution
- The person's coverage has not ended

Dates:

Effective date

Date we first cover you under this HMO agreement.

Final rates and fees schedule effective date

Date stated on the *Final rates and fees schedule*.

Premium due date

The **effective date** and the 1st day of each succeeding calendar month

Renewal date

Date that is 12 months after the **effective date** and each 12 months after that.

Termination date

The date coverage ends according to the *Termination* section.

Premium

Premium – rates and amount due

The premium rates are in the *Final rates and fees schedule* section. You will receive a new *Final rates and fees schedule* when the premium rates change. Any new schedule will state its **effective date**.

We charge premium based on the premium rates in effect on the **premium due date**.
The premium due on any **premium due date** is the total of the premium charges for your coverage.
When we calculate premium due, we will use our records to determine who is a **covered person.**

You owe premium for a **covered person** starting with the first **premium due date** on or after the day the person's coverage starts. You stop paying premium for a **covered person** as of the first **premium due date** on or after the day the person's coverage ends.

Premium – individual proration

Premium shall be paid in full for persons who are covered for an entire month beginning with the **premium due date.**

Premiums shall be adjusted as outlined below for persons whose:

- Coverage is effective on a day other than the first day of the billing month
- Coverage terminates on a day other than the last day of the billing month

If a person's coverage starts on the first of the month, the premium for the whole month is due. If the coverage starts after the first of the month, no premium for the month is due.

If a person's coverage ends on the first of the month, no premium for the month is due. If the coverage ends after the first of the month, the premium for the whole month is due.

Premium – changes in rates

We may change the premium rates as of a **premium due date** during the initial term only if:

- There is a change in factors that materially affects the risk we assumed with this coverage. We will explain these changes in factors in our rate quote to you
- There is a change in law or regulation, or there is a judicial decision, that materially affects the cost of providing coverage

We may change the premium rates as of a **premium due date** during any following term.

We will let you know in writing of any change in premium rate 60 days before they take effect.

Premium – experience credit

We may declare an experience credit at the end of a plan year. We do not have to declare any experience credit.

If we declare an experience credit, we may return the amount of the credit to you:

- By electronic fund transfer
- By applying the amount to the premium due in the current or next plan year
- By any other manner that we and you agree to

We can require you to share an experience credit with your employees. We have to agree on the way that you intend to distribute this credit before we agree to give you the experience credit. If the total premium paid, minus the experience credit is more than the total of employee contributions, we will require you to apply at least the excess experience credit for the sole benefit of your employees.

Premium – when due

Premium is due on the **premium due date**.

You have a payment grace period of 31 days immediately following the **premium due date**. The group agreement will remain in force during the grace period. If we have not received all premiums due by the end of the grace period, it will automatically terminate at the end of the grace period. Refer to the *Termination* section of this group agreement.

Premium – how billed and paid

We may bill you electronically. You shall pay premium due by electronic fund transfer. Payment occurs when we receive good funds.

We may accept a partial payment but this does not waive our right to collect the entire amount due.

We may choose not to accept **premium** that is paid for you by someone else unless we are required to by law.

Premium – overdue amounts

If you don't pay your premium on time, we will charge you interest on the total premium amount that is overdue. Overdue premium includes amounts due but not yet paid during the grace period. The interest rate will be up to 1 1/2% per month for each month or partial month an amount due remains unpaid.

Premium – eligibility corrections

We will retroactively drop a **covered person** from coverage and credit to you premium payments if:

- We billed you based on eligibility information you provided us
- The person did not pay the required premium contribution for the period
- The eligibility information included a person who was not eligible for coverage
- You request that we retroactively drop the person from coverage

Our credit of premium is limited to 2 months' credit for a person whose loss of eligibility occurred more than 30 days before the date you notified us. If we paid benefits on behalf of such a person, we may reduce the credit by the amount of benefit paid.

If you asked us to retroactively drop coverage, we will consider that as your statement that the person did not pay the required premium contribution for the period.

We will retroactively cover eligible persons who were not included in the eligibility information you provided us. We will cover them retroactively no more than 30 days before the date you both notify us and pay all applicable past premium.

Premium – waiver

Payment of premiums

We may waive up to one month's billed premium payments during any group agreement term.

The premium waiver will not apply for those employees who were added or removed from the plan after we billed you for that month's premium. For that month of coverage, additional premium will be due or credited.

Repayment of the waived premium

We may require you to pay back the premium waived if you terminate the group agreement within 12 months of your original **effective date**. We will give 60 days prior written notice to you of the requirement for the repayment of the waived premium.

Fees for special services

Special services

You may request that we provide special services beyond the routine administration of this group agreement. We will charge you a fee for each special service we provide.

The special services are:

- Us billing you for amounts due in a non-electronic medium
- Us accepting payment of amounts due from you other than by electronic fund transfer. If you pay us by check, the check does not constitute payment until it is honored by a bank
- Us handling your check returned to us due to insufficient funds. We may return the check to you without a second attempt to cash it
- Reinstatement of the group agreement according to the *Termination* section
- Any other special service you request and we agree to provide

Special services – fees

The *Final rates and fees schedule* lists the special service fees. We may change any fee on 60 days advance notice to you. We will provide you with a new *Final rates and fees schedule* when the amount of any fee changes. The new schedule will state its **effective date**.

Payment for third party technology provider

We will pay a third party technology provider you choose to provide services related to the administration for this group agreement. The fee we pay them will be an agreed upon amount between us and you. If we stop payment to the third party technology provider, we will give you 30-60 days advance notice.

Fees – when due

Fees are due on the **premium due date** immediately following our invoicing you.

You have a payment grace period of 31 days immediately following the **premium due date**. The group agreement will remain in force during the grace period. If we have not received all fees and assessments due by the end of the grace period, this group agreement will automatically terminate at the end of the grace period.

Fees – how billed and paid

We may bill you electronically. You shall pay fees by electronic fund transfer. Payment occurs when we receive good funds.

We may accept a partial payment but this does not waive our right to collect the entire amount due.

Fees – overdue amounts

You shall pay us interest on the total amount of fees that is overdue. Overdue fees include amounts due but not paid during the grace period. The interest rate will be up to 1 1/2% per month for each month or partial month an amount due remains unpaid.

Some of our other responsibilities

We will prepare the certificate and schedule of benefits that are part of the HMO agreement, as required by applicable federal and state laws. We will provide them to you in electronic form. We will also provide them to you in paper form.

We will provide the coverage stated in the certificate and schedule of benefits that are part of the HMO agreement. We will administer the coverage as required by the HMO agreement and applicable federal and state laws.

We will protect the personal health information of **covered persons** as required by federal and state law. We will use it and share it with others as needed for their care and treatment. We will also use and share it to help us process **providers**' claims and otherwise help us administer the HMO agreement. For a copy of our Notice of Privacy Practices, call the toll-free Member Services number on your member ID card or log on to www.aetna.com.

Our duties in this section survive termination of the HMO agreement.

Some of your other requirements and responsibilities

Participation and contribution

You must comply with our participation and contribution requirements.

Distribution – certain Patient Protection and Affordable Care Act (ACA) requirements

You shall distribute two documents required by the federal ACA:

- Summary of benefits and coverage (SBC)
- Notices of material modifications

You shall distribute them to your employees and their dependents, in accordance with the federal delivery, timing, and trigger requirements.

You shall certify to us on an annual basis or upon our request, that you have distributed them and will distribute them consistent with ACA. You shall give us your certification within 30 calendar days of our request.

You shall give us information or proof upon our request, that you have distributed them and will distribute them consistent with ACA. The information or proof must be in a form we will accept. You shall give us the information or proof within 30 calendar days of our request.

Your duties and our rights in this ACA provision survive termination of the HMO agreement.

Distribution – certificate and schedule of benefits

You will distribute as required by applicable federal and state laws, the certificate and schedule of benefits that we provide you.

Information – access

You shall make payroll and other records directly related to a person's coverage under this HMO agreement available to us for inspection. This will occur:

- Upon our reasonable advance request
- At our expense
- At your office
- During regular business hours

Your duties and our rights in the Information – access provision survive termination of the HMO agreement.

Information – eligibility

You shall send us eligibility information we request to administer the HMO agreement. We will request the information monthly or as otherwise required. You will send us the information on our form, or through such other means as we require.

The eligibility information includes but is not limited to data needed to:

- Enroll your employees and their dependents
- Process terminations
- Make changes in family status

By sending the information to us you represent that it is correct. You acknowledge that we can and will rely on the information.

You shall:

- Maintain a reasonably complete record of the information you send us for at least seven years, and until the final rights and duties under the HMO agreement have been resolved
- Send us information you sent us before, upon request

We will not start covering a person under the HMO agreement until you send us the information to enroll that person. Subject to applicable federal and state laws and the HMO agreement, we will not stop covering a person until you send us the information to terminate coverage.

You shall notify us within 15 business days of the date in which:

- An employee’s employment ceases, or
- A dependent loses eligibility under the HMO agreement

You must notify us when a request for retroactive termination is a result of a **covered person**:

- Performing an act or omission that constitutes fraud
- Making an intentional misrepresentation of material fact to get coverage or to get a benefit under the HMO agreement.

Your duties and our rights in this Information – eligibility provision survive termination of the HMO agreement.

90 day waiting period limitation

Your plan can't have a waiting period of more than 90 days. That means employees and their dependents must be able to begin health coverage within 90 days. This is a requirement of the Affordable Care Act. It applies both to you and to us.

You will give us effective dates for your employees and their dependents that take into account all state and federal waiting period requirements. You acknowledge that we will rely on this information. You will inform us immediately if this information changes.

We will use this **effective date** information to enroll eligible employees and their dependents into the group plan.

Notices – termination of coverage

You shall notify **covered persons** in writing, of their rights when coverage stops.

In particular, you shall notify all eligible **covered persons** of their right to continue coverage pursuant to the *Special coverage options after your plan coverage ends* provisions in the certificate and applicable federal and state laws. Your notification will include:

- A description of plans available
- Premium rates
- Application forms

You will give the notification within 60 calendar days of a person becoming eligible for continuation coverage.

Your duties and our rights in this provision survive termination of the HMO agreement.

Workers' compensation coverage

You must comply with workers' compensation coverage laws applicable to your employees covered by the HMO agreement. Prior to the **effective date** and upon our request after the **effective date** you will provide us reasonable evidence of your satisfying applicable workers compensation coverage laws.

You will provide us with monthly reports of all workers' compensation coverage cases. The report will list for each case, the employee name, identifying number, date of loss and diagnosis.

Termination

Automatic termination

The HMO agreement and all coverage ends as of the last day of the grace period if you have not paid us all premiums due as of the end of the grace period. The *Premium* section has a description of the grace period.

Termination by you

You may end coverage under this HMO agreement if you give us 30 days advance written notice. Your termination notice may apply to all classes or any class of your employees covered under the HMO agreement. You can send us a termination notice during a period for which you have paid premium, but your **termination date** must be after that period.

Termination by us

We may end the HMO agreement and all coverage it provides:

- Immediately upon notice to you:
  - If you perform any act or practice that constitutes fraud or if you make any intentional misrepresentation of a material fact relevant to the coverage
  - If you no longer have any employees under the plan who live, reside, or work in the service area
  - If you are a member of an association and your membership in the association ceases

- Upon 30 days written notice to you:
  - If you breach a provision of the HMO agreement and you do not cure the breach within the notice period
  - If you cease to be a group as defined under applicable state law
  - If you fail to meet our contribution or participation requirements applicable to this HMO agreement
  - If you do not certify your compliance with our policies and procedures upon request
  - If you change your eligibility or participation requirements without our consent

- Upon 90 days written notice to you (or such longer notice period as applicable federal and state laws require,) if we cease to offer the product line provided by this HMO agreement

- Upon 180 days written notice to you (or such longer notice period as applicable federal and state laws require,) if we act as required by applicable federal and state laws for uniform termination of coverage. If we uniformly terminate all coverage, under current law we may not offer health maintenance organization coverage for five years. The five-year period begins on the termination date of the last HMO coverage that was not renewed.

We may rescind the HMO agreement and all coverage it provides for fraud or intentional misrepresentation of material fact upon 30 days advance written notice. The notice will state the **effective date** of rescission. You have the right to appeal our decision to rescind the HMO agreement and its coverage. Your appeal rights are:

- You have the right to an **Aetna** appeal as explained in the *When you disagree – claim determination procedures/complaints and appeals* section of the certificate**.**
- You have the right to a third party review conducted by an independent external review organization.

Non-renewal for failure to respond

We may request that you tell us whether you intend to renew the HMO agreement. You must reply:

- Within two weeks of your receipt of the request or
- Within 15 days prior to the **renewal date**

whichever is later.

Your reply must be in writing unless we authorize an oral reply. If you do not reply, we will continue coverage on and after the **renewal date** and you will owe premium.

Effective time of termination

The HMO agreement and its coverage end at 11:59 p.m. on the day of termination.

Effect of termination

You and we continue to be responsible following termination for the duties we each incur prior to the termination of the HMO agreement. One of your duties includes payment of premium due for coverage through any grace period up to the day of termination. You and we also continue to be responsible for your and our duties that the HMO agreement states are to occur following termination.

You and we have the rights and duties following termination of the HMO agreement, as stated specifically in the HMO agreement.

You shall notify **covered persons** of the termination of the HMO agreement. Your notice will comply with applicable federal and state laws. We have the right to notify employees of termination of the HMO agreement.

Reinstatement

You may request that we reinstate the HMO agreement and coverage after we end it. You must make the request within 30 days of the **termination date**. We will reinstate the HMO agreement as of the **termination date** upon payment of all amounts due and you giving us reasonable assurances that you can and will fulfill all of your obligations under the HMO agreement.

Intentional deception

If we learn that you or a **covered person** defrauded us or that a **covered person** intentionally misrepresented material facts, we can and may take actions that can have serious consequences for 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 or termination of benefits
- Recovery of amounts we already paid

We also may report fraud to law enforcement.

Rescission means you or a **covered person** loses coverage both going forward and going backward. If we paid claims for past coverage, we are entitled to receive the money back.

You have special rights if we rescind all coverage under the HMO agreement:

- We will give you and your employees who are **covered persons**, 30 days advance written notice of any rescission of coverage.
- You have the right to an **Aetna** appeal as explained in the *When you disagree – claim determination procedures/complaints and appeals* section of the certificate**.**
- You have the right to a third party review conducted by an independent external review organization.

A **covered person** has special rights if we rescind coverage just for that individual:

- We will give the **covered person** 30 days advance written notice of any rescission of coverage.
- The **covered person** has the right to an **Aetna** appeal as explained in the *When you disagree – claim determination procedures/complaints and appeals* section of the certificate.
- The **covered person** has the right to a third party review conducted by an independent utilization review organization.

Responsibility for conduct

Employees and agents

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

We are not responsible to you for what is done by others, such as **providers**. They are not our employees or agents. **Providers** in our **network** are what the law calls our independent contractors. That simply means we have a business relationship with them and they are not our employees or agents.

Indemnification – in general

We agree to indemnify and hold you harmless against that portion of your liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by our willful misconduct, criminal conduct or material breach of this HMO agreement.

You agree to indemnify and hold us harmless against that portion of our liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by your:

- Negligence
- Breach of the HMO agreement
- Breach of applicable federal and state laws
- Willful misconduct
- Criminal conduct
- Fraud
- Breach of a fiduciary responsibility in the case of an action under ERISA, related to or arising out of this HMO agreement or your role as employer or Plan Sponsor, as defined by ERISA.

These indemnification obligations end with the HMO agreement, except as to any matter concerning a claim that has been made in writing within 365 days after termination.

Indemnification – federal law requirements

You shall indemnify us and hold us harmless for our liability that is directly caused by your:

- Negligence
- Breach of the HMO agreement
- Breach of federal or state laws that apply
- Willful misconduct

and your act or failure to act was related to or arose out of your obligation to deliver the Summary of benefits and coverage and Notices of material modification.

Your and our rights and duties in this section survive termination of the HMO agreement.

General provisions

General provisions – content and interpretation of the HMO agreement

Applicable law

Applicable law means all federal and state law that applies to the matters covered by the HMO agreement. Federal and state law means statutes, regulations, official agency direction and guidance, and judicial decisions and orders, as they may be passed or issued, or as they may be amended, from time to time.

Compliance with law

You and we shall interpret the HMO agreement so it complies with applicable law.

If the HMO agreement omits or misstates any right or duty under applicable law, you and we shall implement the HMO agreement as though the right or duty is stated correctly in the HMO agreement.

If any provision of the HMO agreement is invalid or illegal, you and we shall implement the HMO agreement as though the provision is not in the HMO agreement.

Changes to the HMO agreement

The HMO agreement may be amended by a written form to which you and we consent.

We may change or end some or all coverage under this HMO agreement by written notice, if we act as required by applicable law for uniform modification of coverage and uniform termination of coverage.

We may amend the HMO agreement by written notice. We must give you 60 days advance written notice. Our amendment:

- Will not reduce benefits or coverage
- Will not eliminate benefits or coverage
- Will not increase benefits or coverage with a concurrent increase in premium during the current HMO agreement term, other than increased benefits or coverage required by law

Payment of the applicable premium on the **effective date** of any amendment or your signature on the amendment is your consent to any amendment requiring your consent.

Changes to the HMO agreement do not require the consent of any employee or of any other person.

Entire agreement

The HMO agreement replaces and supersedes:

- All other prior agreements of HMO coverage between us
- Any other prior written or oral understandings, negotiations, discussions or arrangements between us related to this HMO coverage

Waiver

Only an officer of **Aetna** may waive a requirement of the HMO agreement.

We may fail to implement or fail to insist upon compliance with a provision of the HMO agreement at any given time or times. Our failure to implement or to insist on compliance is not a waiver of our right to implement or insist upon compliance with that provision at any other time or times.

General provisions – administration of the HMO agreement

Aetna name, symbols, trademarks and service marks

We control the use of our name and of our symbols, trademarks and service marks presently existing or subsequently established. You shall not use any of them in advertising or promotional materials or in any other way without our prior written consent. You shall stop any and all use immediately upon our direction or upon termination of the HMO agreement.

Assignment and delegation

You shall not assign any right or delegate any duty under the HMO agreement unless we approve it in writing in advance.

We may delegate some of our functions under the HMO agreement to third parties. We may also change or end these delegations. We do not need to give you advance notice to enter into, change or end these arrangements, and we do not need your consent.

Claim determinations – ERISA claim fiduciary

We are a fiduciary for the purpose of section 503 of Title 1 of the Employee Retirement Income Security Act of 1974. We have with complete authority to review all denied claims for benefits under this HMO agreement. In exercising this fiduciary responsibility, we have discretionary authority:

- To determine whether and to what extent **covered persons** are entitled to benefits
- To construe any disputed or doubtful terms under the HMO agreement.

Our review of claims for benefits may include the use of software and other tools to take into account factors such as:

- An individual's claim history
- A provider's billing patterns
- Complexity of the service or treatment
- Amount of time and degree of skill needed
- The manner of billing

Correcting our administrative errors

A clerical error in keeping records or a delay in making an entry will not alone determine whether there is coverage. We will determine the facts and decide if coverage is in force and its amount. We will make a fair adjustment in premium if correction of the error or delay changes coverage.

We may correct, withdraw, or replace the group agreement, any certificate, any schedule of benefits and any other document issued with an error or issued in error.

Correcting your honest mistakes

If you or any employee makes an honest mistake of fact, we may make a fair change in premium. If the misstatement affects the existence or amount of coverage, we will use the true facts to determine whether coverage is or remains in effect and its amount.

Discrimination prohibited

You shall not encourage or discourage enrollment in the coverage provided by the HMO agreement based on health status or health risk.

You shall act so as not to discriminate unfairly between persons in like situations at the time of the action.

Financial sanctions exclusions

If coverage provided by this HMO agreement violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, we cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Incontestability

We will not use a statement you make to void this HMO agreement after it has been in force for 2 years from its effective date.

We will use only a statement in writing that you or a **covered person** makes, to do any of the following:

- To void coverage of the **covered person**
- To deny coverage of the **covered person**
- To deny a claim for benefits by the **covered person**

We will not use a statement by a **covered person** to deny a claim for benefit more than 2 years after the statement was made.

Notices

The HMO agreement requires or permits notice to each other. These notices shall be in writing.

Notice may be delivered:

- In person, and is effective upon delivery
- By United States mail, sent first class, postage prepaid, and is effective three U.S. Postal Service delivery days following the date of mailing
- By commercial carriers UPS and FedEx, effective upon delivery or
- By e-mail, facsimile or other electronic means, effective upon sending.

Notice sent to us by mail and commercial carrier shall be sent to:
AETNA HEALTH INC.
1425 Union Meeting Road
Blue Bell, Pennsylvania 19422
1-800-445-5299

Notice sent to you by mail and commercial carrier shall be sent to:
UNIVERSITY OF PENNSYLVANIA POSTDOCTORAL INSURANCE PLAN
18201 VON KARMAN AVE, STE 200
IRVINE, CA 92612

You and we must designate specific e-mail addresses, facsimile numbers or other electronic means in writing for purpose of notices.

Policies and procedures

We have the right to adopt reasonable policies, procedures, rules, and interpretations of this HMO agreement and the Certificate in order to promote orderly and efficient administration. You and all **covered persons** are bound by and shall comply with them. You will certify your compliance with them upon our request or as required specifically by the HMO agreement.

Third parties rights

This HMO agreement does not give any rights or impose any duties on third parties except as specifically stated.

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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 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

To access language services at no cost to you, call 1-888-982-3862.
Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862. (Spanish)
如欲使用免費語言服務，請致電 1-888-982-3862。(Chinese)
Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862. (Tagalog)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ąh ílínígóó koji' hólne' 1-888-982-3862. (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an. (German)

Për shërbime përkthimi falas për ju, telefononi 1-888-982-3862. (Albanian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862. (Arabic)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով: (Armenian)

Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-888-982-3862 (Bantu)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে এই নম্বরে টেলিফোন করুন: 1-888-982-3862। (Bengali)

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862. (Bisayan-Visayan)

သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-888-982-3862 သို့ ဖုန်းခေါ်ဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862. (Catalan)
Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862. (Chamorro)
ᏩᎩᏍᏗ ᏚᏬᏂᎯᏍᏗ ᎤᏣᎾᏓᏛᏁᏗ Ꮭ ᎠᎱᏍᏗ ᏗᏣᎬᏩᏁᏗ ᏣᎩ, ᏫᏍᏓᏏᏩᏛᏍ 1-888-982-3862. (Cherokee)
Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862. (Choctaw)
Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-982-3862. (Cushite-Oromo)
Voor gratis toegang tot taaldiensten, bell 1-888-982-3862. (Dutch)
Pou jwenn sèvis lang gratis, rele 1-888-982-3862. (French Creole-Haitian)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862. (Greek)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-888-982-3862. (Gujarati)

No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-888-982-3862. Kāki 'ole 'ia kēia kōkua nei. (Hawaiian)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-888-982-3862 पर कॉल करें। (Hindi)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862. (Hmong)
Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-888-982-3862. (Ibo)

Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-888-982-3862. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-982-3862. (Indonesian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862 (Italian)

言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。(Japanese)

လၢတၢ်ကမၤန့ၢ်ကျိာ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပှ့ၤလၢကဘၣ်ဟ့ၣ်အီၤအဂီၢ်ဘၣ်နှၣ် ကိး 1-888-982-3862 တက့ၢ်. (Karen)

무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오. (Korean)

M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́uń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1-888-982-3862. (Kru-Bassa)

بۆ دەسپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-888-982-3862. (Kurdish)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-982-3862. (Laotian)

कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा. (Marathi)

Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-888-982-3862. (Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-982-3862. (Micronesian-Pohnpeian)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862។ (Mon-Khmer, Cambodian)

निःशुल्क भाषा सेवा प्राप्त गर्न 1-888-982-3862मा टेलफिोन गर्नुहोस् । (Nepali)

Të kɔɔr yïn wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-888-982-3862. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring 1-888-982-3862. (Norwegian)

Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862. (Pennsylvania Dutch)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862 (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apelați 1-888-982-3862. (Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862. (Russian)

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-982-3862. (Samoan)

Za besplatne prevodilačke usluge pozovite 1-888-982-3862. (Serbo-Croatian)

Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-982-3862. (Sudanic-Fulfulde)

Kupata huduma za lugha bila malipo kwako, piga 1-888-982-3862. (Swahili)

[illegible]
(Syriac-Assyrian) 1-888-982-3862

మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-888-982-3862 కు కాల్ చేయండి. (Telugu)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862 (Thai)

Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-982-3862. (Tongan)

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-982-3862. (Trukese)

Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-982-3862 numarayı arayın. (Turkish)

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862. (Ukrainian)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862. پر بات کریں۔ (Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862. (Vietnamese)

צו צוטריט שפראַך באַדינונגען אין קיין פּריַז צו איר, רופן 1-888-982-3862. (Yiddish)

Lati wọnú awọn isẹ èdè l’ọfẹ fun ọ, pe 1-888-982-3862. (Yoruba)

Open Access Health Network Only

Health maintenance organization (HMO)

Certificate of coverage

Prepared for:

Contract holder: UNIVERSITY OF PENNSYLVANIA POSTDOCTORAL INSURANCE PLAN

Contract holder number: 0861472

Group agreement effective date: January 01, 2023

Plan effective dates: January 01, 2023

This Certificate is not in place of insurance for Worker's Compensation. This certificate is governed by applicable federal law and the laws of New Jersey

Underwritten by Aetna Health Inc. in the State of New Jersey

Table of contents

Welcome

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

Welcome to Aetna.

Introduction

This is your certificate of coverage or "certificate." It describes your **covered services** – what they are and how to get them. The schedule of benefits tells you how we share expenses for **covered services** and explains any limits. Along with the group agreement, they describe your Aetna plan. Each may have riders or amendments attached to them. These change or add to the document. This certificate takes the place of any others sent to you before.

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

How we use words

When we use:

- "You" and "your" we mean you and any covered dependents (if your plan allows dependent coverage)
- "Us," "we," and "our" we mean Aetna
- Words that are in bold, we define them in the *Glossary* section

Contact us

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

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

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

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

Your ID card

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

Coverage and exclusions

Providing covered services

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

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

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

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

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

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

Acupuncture

Covered services include manual or electro acupuncture.

Acupressure is not a **covered service**.

Ambulance services

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

Emergency

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

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

Non-emergency

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

- From a **hospital** to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a **hospital** if an ambulance is the only safe way to transport you; limited to 100 miles
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment

The following are not **covered services**:

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

Applied behavior analysis

Covered services include certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is the process of applying interventions based on principles of learning that:

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

Important note:
Applied behavior analysis may require **precertification** by us. See the *How your plan works – Medical necessity and precertification* section.

Clinical trials

Routine patient costs

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

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

The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free

- The experimental intervention itself (except Category B investigational devices and promising **experimental** and **investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

Experimental and investigational therapies

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

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

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

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

Dental care anesthesia

Covered services include anesthesia and facility costs for dental care. Your **physician** must certify that the dental care cannot be performed in the dentist's office due either to age or medical condition.

The following are not **covered services**:

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

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

Covered services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Injection devices including syringes, needles and pens
  - Test strips - blood glucose, ketone and urine
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Prescribed self-care programs with a health care **provider** certified in diabetes self care training

Durable medical equipment (DME)

DME and the accessories needed to operate it are:

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

Your plan only covers the same type of DME that Medicare covers. But there are some DME items Medicare covers that your plan does not. You or your **provider** can contact us to find out if a DME item is a **covered service** under your plan

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

Covered services also include:

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

The following are not **covered services**:

- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

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

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

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

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

Foot orthotic devices

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

Gender affirming treatment

Covered services include certain services and supplies for gender affirming (sometimes called sex change) treatment.

Important note:
Visit https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html for detailed information about this benefit, including eligibility and **medical necessity** requirements. You can also call the toll-free number on your ID card.

Habilitation therapy services

Habilitation therapy services help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age). The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a:

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

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

Covered services include:

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

The following are not **covered services**:

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

Hearing aids

Hearing aid means:

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

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

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

The following are not **covered services**:

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

Hearing exams

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

The following are not **covered services**:

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

Home health care

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

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

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

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

The following are not **covered services**:

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

Home hemophilia treatment

Covered services include home treatment of bleeding disorders associated with hemophilia. The home treatment must be provided by a "designated" health care **provider**. A designated health care **provider** means a **provider** approved by the New Jersey Department of Banking and Insurance to contract with carriers for the purpose of rendering services for the home treatment of bleeding episodes associated with hemophilia.

Loss of Designated Status

When a designated health care **provider** loses their designation, we shall not continue to refer you to that health **provider.** If you have been using such a **provider,** we will continue to provide services at network level until:

- A new designated health care **provider** arrangement is made or
- Four months following the date of the loss of designation, whichever comes first

We shall not be required to continue to provide services at a network level when the **provider's** loss of designation is the result of:

- Revocation or surrender of a license, permit or registration
- Suspension of a license, permit or registration that cannot be corrected by reinstatement within 45 days following the date of the suspension, except as may be necessary for us and the **provider** to transition care to another designated health care **provider**

Termination of Agreement

In the event that we or a designated health care **provider** terminates their agreement, we shall continue to provide services at a network level until:

- A new designated health care **provider** arrangement is made or
- Four months following the date of the; loss of designation, whichever comes first

The requirements above shall not apply when the agreement terminates on the basis of:

- Breach
- Fraud

Hospice care

Covered services include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

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

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

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

The following are not **covered services**:

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

Hospital care

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

- Semi-private **room and board**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition or when only private rooms are available.
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge.
- Services of **physicians** employed by the **hospital**.
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.

The following are not **covered services**:

- All services and supplies provided in:
  - Rest homes

- Any place considered a person's main residence or providing mainly custodial or rest care
- Health resorts
- Spas
- Schools or camps

Infertility services

Covered services include visiting a **provider**:

- To diagnose and evaluate the underlying medical cause of **infertility** including up to 12 intrauterine insemination (IUI) procedures for members without a partner as limited under the definition of infertility. **Covered services** are dependent on age and prior care received.
- To do **surgery** to treat **infertility**. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.
- For ovulation induction cycle(s) while on oral synthetic ovulation stimulants and menotropin injectable medications to stimulate the ovaries
- For artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.

Once diagnosed as **infertile** we will cover expenses, including but not limited to the following:

- Assisted reproductive technology (ART), including medications.
- Surgery needed to treat the underlying medical cause of **infertility** including microsurgical sperm aspiration.
- Private room rates will be covered when the hospital has only private rooms.

For help using the comprehensive **infertility** health care services you may enroll with our National **infertility** unit (NIU). To enroll you can reach our dedicated (NIU) at 1-800-575-5999.

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

- You are covered under this plan. For the purposes of this provision, when we will refer to your partner we mean spouse, domestic partner or civil union partner.
- There exists a condition that:
  - Is demonstrated to cause the disease of **infertility**.
  - Has been recognized by your or your partner's **physician** or **infertility specialist** and documented in your or your partner's medical records.
  - You or your partner are unable to carry a pregnancy to live birth.
- You or your partner have not had a voluntary sterilization with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Or any procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or as defined by the New Jersey Department of Health.

- You or your partner do not have **infertility** that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- Medical necessity for ART procedures has been established.
    - The infertile member is 45 years of age or younger and has not reached the limit of 4 completed egg retrievals where the covered person's cost is covered by insurance plans or programs offered or administered by the **contract holder** through **Aetna** or an affiliated company. An infertile member over 45 years of age is not eligible for egg retrievals.
- ART services include, but are not limited to:
    - In vitro fertilization (IVF)
    - Zygote intrafallopian transfer (ZIFT)
    - Gamete intrafallopian transfer (GIFT)
    - Cryopreserved embryo transfers (Frozen Embryo Transfers)
    - Intracytoplasmic sperm injection (ICSI) or ovum microsurgery
    - Assisted hatching (AH)
    - 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.
    - Charges associated with obtaining the spouse's sperm for ART services, when the spouse is also covered under this plan.
- You and your partner have met the requirement for the number of months trying to conceive:
    - You are a member under 35 years of age with a partner who has had 12 months or more of unprotected sexual intercourse.
    - You are a member under 35 years of age without a partner who has had 12 failed attempts of intrauterine insemination under medical supervision. The number of months of unprotected sexual intercourse does not apply.
    - You are a member 35 years of age or older with a partner who has had unprotected sexual intercourse 6 months or more.
    - You are a member 35 years of age or older without a partner who has had 6 failed attempts of intrauterine insemination under medical supervision.
- If you have been diagnosed with premature ovarian insufficiency (POI), you are eligible for ART services through age 45 regardless of FSH level.

Fertility preservation

Fertility preservation involves 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 if you are covered under this plan and:

- Are believed to be fertile
- Have planned services that may cause **infertility** such as:
    - Chemotherapy
    - Pelvic radiotherapy
    - Other gonadotoxic therapies
    - Ovarian or testicular removal

- You are covered under this plan and have a diagnosis of latrogenic infertility caused by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.
- Or any procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or as defined by the New Jersey Department of Health.
- You are covered under this plan and have a diagnosis of cancer and you are planning cancer treatment that is demonstrated to result in **infertility.** Planned cancer 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 to result in a successful pregnancy by meeting the criteria below:
  - You are a member under 35 years of age that has had an unmedicated day 3 FSH test done within the past 12 months. The results of your unmedicated day 3 FSH test must be less than 19mIU/mL in your most recent lab test to use your own eggs.
  - You are a member 35 years of age or older that has had an unmedicated day 3 FSH test done within the past 6 months. The results of your unmedicated day 3 FSH test must be less than 19mIU/mL in your most recent lab test to use your own eggs if you are less than age 40. If you are age 40 and older, the results of your unmedicated day 3 FSH test must be less than 19mIU/mL in all prior tests to use your own eggs.

Our National Infertility Unit (NIU) is here to help. 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 with **precertification** of **covered services**.
- Coordinate **precertification** for ART services and fertility preservation services when these services are **covered services**. Your **provider** should obtain **precertification** for fertility preservation through the NIU either directly or through a reproductive endocrinologist.
- Evaluate medical records to determine whether ART services and fertility preservation services are reasonably likely to result in success.

A cycle is an attempt at ovulation induction or intrauterine insemination. The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered complete at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

The following are not **covered services**:

- Cryopreservation (freezing), storage of eggs, embryos, sperm or reproductive tissue, unless due to iatrogenic **infertility**.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate where the surrogate is not covered under this plan. A surrogate is a member carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.

- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor oocytes or donor sperm.
- Reversal of voluntary sterilizations, including follow-up care.
- More than four completed egg retrievals while you are covered under this plan or any other plan with this contract holder.
- Egg retrievals if you are over 45 years of age.

Maternity and related newborn care

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

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

We provide such coverage subject to the following:

- The attending **physician** or **specialist** prescribes inpatient care
- The mother must request the inpatient care

Covered services also include services and supplies needed for circumcision by a **provider** and those not directly related to the delivery and newborn care but that are related to the pregnancy.

The following are not **covered services**:

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

Mental health conditions

Mental health conditions treatment

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

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), or (when only private rooms are available) 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** and/or **telehealth** consultation)
  - Individual, group, and family therapies for the treatment of **mental health conditions**
  - Other outpatient **mental health conditions** treatment such as:
    - Partial hospitalization treatment provided in a facility or program for **mental health conditions** treatment provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for **mental health conditions** treatment provided under the direction of a **physician**

- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
  - Your **physician** orders them
  - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
  - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- Observation
- Peer counseling support by a peer support specialist

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

Autism spectrum disorder or other developmental disabilities

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.

A developmental disability is a severe, chronic disability which:

- Is attributable to a mental or physical impairment or a combination of them
- Is likely to continue indefinitely
- Limits function in at least three of the following:
  - Self-care
  - Language
  - Learning
  - Mobility
  - Self-direction
  - Independent living
  - Economic self-sufficiency
- Reflects the need for special care, treatment or other services which are lifelong or of extended duration.

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

- The diagnosis and treatment of autism spectrum disorder or other developmental disability
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder or other developmental disability
- Applied Behavior Analysis (ABA)

Substance use disorders treatment

Covered 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** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), or when only private rooms are available) 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
  - 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 psychologist, social worker, or licensed professional counselor (includes **telemedicine** and/or **telehealth** consultation)
  - Individual, group, and family therapies for the treatment of **substance use disorders**
  - Other outpatient **substance use disorders** treatment such as:
    - 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 or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Peer counseling support by a peer support specialist

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

Nutritional support

For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein. Also, for the purposes of this benefit, "medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under direction of a **physician**.

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids. **Covered services** also include donated breast milk which may include milk fortifiers for infants.

The following are not **covered services**:

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

Outpatient surgery

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

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

The following are not **covered services**:

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

Physician services

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

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

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

All in-person office visits covered with a **behavioral health provider** are also covered if you use **telemedicine** and/or **telehealth** instead.

Telemedicine and/or **telehealth** 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

Covered services include the services of:

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

The following are not **covered services**:

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

Preventive care

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

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

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

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

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

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

Breast-feeding support and counseling services

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

Breast pump, accessories and supplies

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

Coverage for the purchase of breast pump equipment is limited to two breast pump kits per birth. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Counseling services

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

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

Family planning services – contraceptives

Covered services include family planning services as follows:

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

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

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

Immunizations

Covered services include preventive immunizations for infectious diseases.

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

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

Prenatal care

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

- Anemia screening

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

Routine cancer screenings

Covered services include the following routine cancer screenings:

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

Routine physical exams

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

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
    - Screening and counseling services on topics such as:
        - Interpersonal and domestic violence
        - Sexually transmitted diseases
        - Human immune deficiency virus (HIV) infections
    - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

- Office visit to a **physician**
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns
    - An initial **hospital** checkup
    - Hearing loss screenings include periodic monitoring for delayed onset hearing loss

Well woman preventive visits

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

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

Prosthetic device

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

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

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

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

The following are not **covered services**:

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

Reconstructive breast surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prostheses
- The following coverage is provided following a mastectomy
  - A minimum of 72 hours of inpatient care following a modified radical mastectomy
  - A minimum of 48 hours of inpatient care following a simple mastectomy
  - A shorter length of **stay**, if you in consultation with the physician determine a shorter length of **stay** is medically necessary

Reconstructive surgery and supplies

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

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

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

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

These dental related services are limited to:

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

Routine cancer screenings

Covered services include the following routine cancer screenings such as:

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

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation services

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

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

Covered services includes:

- Spinal manipulation to correct a muscular or skeletal problem. Your **provider** must establish or approve a treatment plan that details the treatment and specifies frequency and duration.

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

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

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

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

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

The following are not **covered services**:

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

Sickle cell anemia

Covered services include the medical expenses and **prescription** drugs for treatment of sickle cell anemia.

Skilled nursing facility

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

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

Telemedicine and/or **telehealth**

Covered services include **telemedicine** and/or **telehealth** consultations when provided by a **physician**, **specialist, behavioral health provider** or other **telemedicine** and/or **telehealth provider** acting within the scope of their license.

Covered services for **telemedicine** and/or **telehealth** consultations are available from a number of different kinds of **providers** under your plan. Log in to your member website at https://www.aetna.com/ to review our **telemedicine** and/or **telehealth provider** listing and contact us to get more information about your options, including specific cost sharing amounts.

The following are not **covered services**:

- Telephone calls
- **Telemedicine** kiosks
- Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

Tests, images and labs – outpatient

Diagnostic complex imaging services

Covered services include:

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

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

Diagnostic x-ray and other radiological services

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

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

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

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

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

Key Terms

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

Gene

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

Molecular

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

Therapeutic

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

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. We call these "GCIT services."

GCIT **covered services** include:

- Cellular immunotherapies.
- Genetically modified viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for treatment of certain conditions.
- All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)

  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza (Nusinersen).
  - siRNA.
  - mRNA.
  - microRNA therapies.

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

Important note:
You must get GCIT **covered services** from a GCIT-designated facility/**provider**. If there are no GCIT-designated facilities/**providers** assigned in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your GCIT services at the facility/**provider** we designate, they will not be **covered services**.

Infusion therapy

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

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

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

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

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

Radiation therapy

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

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

Transplant services

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

This includes the following transplant types:

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

Network of transplant facilities

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

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

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

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

The following are not **covered services**:

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

Urgent care services

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

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

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

- **Urgent condition** within the service area
  - If you need care for an **urgent condition**, you should first seek care through your **physician**, **PCP**. If your **physician** is not reasonably available, you may access urgent care from an urgent care center within the service area.
- **Urgent condition** outside the service area
  - You are covered for urgent care obtained from a facility outside of the service area if you are temporarily absent from the service area and getting the health care service cannot be delayed until you return to the service area.

The following are not **covered services**:

- Non-urgent care in an urgent care center

Vision care

Adult vision care

Covered services include:

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

The following are not **covered services**:

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

Pediatric vision care

Covered services include:

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

The following are not **covered services**:

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

Walk-in clinic

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

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

- **Telemedicine** and/or t**elehealth** consultation
- Individual screening and counseling services that will help you:
  - With obesity or healthy diet
  - To stop using tobacco products

Weight management surgery

Covered services include one weight management **surgical procedure**. However, the **covered services** also include a multi-stage procedure when planned and approved by us. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

Weight management or weight loss **surgery** is a type of procedure performed on people who are **morbidly obese** for the purposes of losing weight.

Obesity is typically diagnosed based on **body mass index (BMI).** To determine whether you qualify for obesity **surgery**, your physician will consider your **BMI** and any other condition or conditions you may have. In general, obesity **surgery** will not be approved for any member with a **BMI** less than 35.

General plan exclusions

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

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

Examples of these are:

- The provision of blood to the **hospital**, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The service of blood donors, including yourself, apheresis or plasmapheresis
- The blood you donate for your own use, excluding administration and processing expenses and except where described in the *Coverage and exclusions, Transplant services* section

Important note:
This exception does not apply to services provided in the *Home hemophilia treatment* section.

Cosmetic services and plastic surgery

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

Court-ordered services and supplies

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

Custodial care

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

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

Dental services

The following are not **covered services**:

- Services normally covered under a dental plan. Call the number on your ID card if you have any questions.
- Dental implants

Educational services

Examples of these are:

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

Examinations

Any health or dental examinations needed:

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

Experimental and investigational

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

Foot care

Routine services and supplies for the following:

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

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

The following are not **covered services** unless you receive prior written approval from us:

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**.

- All associated services when GCIT services are not covered. Examples include:
  - Infusion
  - Lab
  - Radiology
  - Anesthesia
  - Nursing services

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

Growth/height care

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

Jaw joint disorder treatment

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

Maintenance care

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

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Mental health conditions and substance use disorders conditions treatment

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

- **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates **mental health conditions** treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Missed appointments
Any cost resulting from a canceled or missed appointment

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

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

Other non-covered services

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

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

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

Private duty nursing

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

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

Sexual dysfunction and enhancement due to a physical condition
Any treatment, **prescription** drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire due to relationship distress or other stressors, the effects of substance or medication, or the effects of another medication condition, including:

- **Surgery**, **prescription** drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape of a sex organ

- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

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

Therapies and tests

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

Treatment in a federal, state, or governmental entity

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

Weight management treatment

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

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

Wilderness treatment programs

See *Educational services* in this section

Work related illness or injuries

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

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

How your plan works

How your plan works while you are covered

Your HMO plan:

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

Providers

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

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

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

Service area

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

Who provides the care

Network providers

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

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

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

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

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

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

How you choose your PCP
You can choose a **PCP** from the list of **PCP**s in our directory.

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

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

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

Keeping a provider you go to now (continuity of care)
You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the network
- You are already an Aetna member and your **provider** stops being in our network

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

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

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

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

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

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

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

Precertification

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

Your network **physician** or **PCP** is responsible for obtaining any necessary **precertification** before you get the care. **Network providers** cannot bill you if they fail to ask us for **precertification**. If your **provider** or **PCP** request **precertification** and we don't approve coverage, we will tell you why and explain how you or your **provider** may request review of our decision. See the *Complaints, claim decisions and appeal procedures* section.

Timeframes for **precertification** are listed below. For **emergency services**, **precertification** is not required, but you should notify us as shown. **Precertification** is not required for **substance use disorder** treatment for the first 180 days of treatment.

To obtain **precertification**, contact us. Your **physician** or the facility must call us within these timelines:

Type of care	Timeframe
Non-emergency admission	Call at least 14 days before the date you are scheduled to be admitted.
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted.
Urgent admission	Call before you are scheduled to be admitted.
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment or procedure is scheduled.

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

We will tell you and your **physician** in writing of the **precertification** decision. An approval is valid for 180 days as long as you remain enrolled in the plan.

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

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

Types of services that require precertification

Precertification is required for inpatient stays and certain outpatient services and supplies.

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

Requesting a medical exception

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

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

Certain **prescription** drugs are covered under the medical plan when they are given to you by your physician or health care facility. The following **precertification** 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**.

Contact us or go online to get the most up-to-date **precertification** requirements.

Requesting a medical exception

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

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

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

What the plan pays and what you pay

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

The general rule

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

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

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

Negotiated charge

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

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

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

Some of these arrangements are called:

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

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

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

Paying for covered services – the general requirements

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

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

You pay the entire expense when:

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

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

Where your schedule of benefits fits in

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

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

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

Coordination of benefits

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

Key Terms

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

Allowable expense means:

- The charge for any health care service, supply or other expense for which you are responsible when the health care service, supply or other expense is covered at least in part by any of the plans involved, except where a law requires another definition, or as stated below.

  When this plan is coordinating benefits with a plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, allowable expense is limited to items covered under the other plan.

  We will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an allowable expense unless the stay in a private room is medically necessary and appropriate.

  When this plan is coordinating benefits with a plan that limits coordination of benefits to a specific coverage, we will only consider corresponding services, supplies or other expense which the other plan considers an allowable expense.

Claim determination period means:

- A calendar year, or any part of a calendar year, during which you and/or your dependents are covered by this plan and at least one other plan and incurs allowable expense(s) under these plans.

Plan means:

- Coverage with which coordination of benefits is allowed. Plan includes:
  - Group insurance and group subscriber contracts, including insurance continued according to a federal or state continuation law
  - Self-funded arrangements of group or group-type coverage, including insurance continued according to a federal or state continuation law

- Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued according to a federal or state continuation law
- Group hospital indemnity benefit amounts that exceed $150.00 per day
- Medicare or other governmental benefits, except when, according to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan

- Plan does not include:
  - Individual or family insurance contracts or subscriber contracts
  - Individual or family coverage through a health maintenance organization (HMO) or under any other prepayment, group practice and individual practice plans
  - Group or group-type coverage where the cost of coverage is paid solely by the covered person Coverage being continued according to a federal or state continuation law will be considered a plan
  - Group hospital indemnity benefit amounts of $150.00 per day or less
  - School accident-type coverage
  - A state plan under Medicaid

Primary plan means:

- A plan whose benefits for your health care coverage must be determined without taking into consideration the existence of any other plan. There may be more than one primary plan. A plan will be the primary plan if either of the below exist:
  - The plan has no order of benefit determination rules, or it has rules that differ from those contained in this coordination of benefits section, or
  - All plans which cover you use order of benefit determination rules consistent with those contained in the coordination of benefits section and under those rules, the plan determines its benefits first.

Reasonable and customary means:

- An amount that is not more than the usual or customary charge for the service or supply as determined by us, based on a standard which most often charged for a given service by a **provider** within the same geographic area

Secondary plan means:

- A plan which is not a primary plan. If you are covered by more than one secondary plan, the order of benefit determination rules of this coordination of benefits section will be used to determine the order in which the benefits payable under the multiple secondary plans are paid.

  The benefits of each secondary plan may consider:
  - The benefits of the primary plan(s) and
  - The benefits of any other plan which, under this coordination f benefits section, has its benefits determined before those of that secondary plan

How COB works

We consider each plan separately when coordinating payments. The primary plan pays or provides services or supplies first, as though the secondary plan does not exist. If a plan has no COB provision, or if the order of benefit determination rules differ from those in this section, it is the primary plan. A secondary plan takes into consideration the benefits provided by a primary plan when, according to the rules below, the plan is the secondary plan. If there is more than one secondary plan, the order of benefit determination rules determine the order among the secondary plans. During each claim determination period the secondary plan(s) will pay up to the remaining unpaid allowable expenses, but no secondary plan will pay more than it would have paid if it had been the primary plan. The method the secondary plan uses to determine the amount to pay is outlined below in the *Determining who pays under a health plan* section.

The secondary plan will not reduce allowable expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Determining who pays under a health plan

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

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

COB rule	Primary Plan	Secondary plan
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together	• Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent's plan if there is no court order	• Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent's plan
Child – covered by individuals who are not parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)

COB rule	Primary Plan	Secondary plan
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

How are benefits paid?

In order to determine which procedure to follow, it is necessary to consider:

- How the primary plan and the secondary plan pay benefits
- Whether the **provider** who provides or arranges the services and supplies is in the network of either the primary plan or the secondary plan.

Benefits may be based on the reasonable and customary charge (R & C), or some similar term. This means that the **provider** bills a charge and you may be responsible for the full amount of the billed charge. In this section, a plan that bases benefits on a reasonable and customary charge is called an R & C plan.

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a **provider**, called a **network provider**, bills a charge, you may be responsible only for an amount up to the negotiated fee. In this section, a plan that bases benefits on a negotiated fee schedule is called a fee schedule plan. If you use the services of a non-network **provider**, the plan will be treated as an R & C plan even though the plan under which you are covered calls for a fee schedule.

Payment to the **provider** may be based on a capitation. This means that the HMO or other plan pays the **provider** a fixed amount per covered person. You are responsible only for the applicable **deductible, coinsurance** or **copayment**. If you use the services of a non-network **provider**, the HMO or other plan will only pay benefits in the event of **emergency services** or urgent care. In this section, a plan that pays **providers** based upon capitation is called a capitation plan. In the rules below, **provider** refers to the **provider** who provides or arranges the services or supplies and HMO refers to a health maintenance organization plan.

A plan determined to be a secondary plan may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. Where a benefit is payable by both the primary and secondary plans on the basis of usual, customary and reasonable fees (UCR), the secondary plan will pay the difference between billed charges for allowable expenses and the amount paid by the primary plan as long as the amount is no greater than the amount the secondary plan would have paid if primary. The amount by which the secondary plan's benefits have been reduced will be used by the secondary plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by you. As each claims is submitted the secondary plan will determine its obligation to pay for allowable expenses based on all claims which were submitted up to that time during the claim determination period.

The benefits of the secondary plan will be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of this COB provision, and the benefits that would be payable for the allowable expenses under other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds those allowable expenses in a claim determination period. In this case, the benefits of the secondary plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of this plan are reduced as described above, each benefit will be reduced in proportion, and the amount paid will then be charged against any applicable benefit limit of this plan.

Primary plan is R & C plan and secondary plan is R & C plan
The secondary plan will pay the lessor of:

- The difference between the amount of the billed charges and the amount paid by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

When the benefits of the secondary plan are reduces as a result of this calculation, each benefit will be reduced in proportion, and the amount paid will be charged against any applicable benefit limit of the plan.

Primary plan is fee schedule plan and secondary plan is fee schedule plan
If the **provider** is a **network provider** in both the primary plan and the secondary plan, the allowable expense will be the fee schedule of the primary plan. The secondary plan will pay the lessor or

- The amount of any **deductible, coinsurance** or **copayment** required by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

The total amount the **provider r**eceives from the primary plan, the secondary plan and you will not exceed the fee schedule of the primary plan. In no event will you be responsible for any payment in excess of the **copayment, coinsurance** or **deductible** of the secondary plan.

Primary plan is R & C plan and secondary plan is fee schedule plan
If the **provider** is a **network provider** in the secondary plan, the secondary plan will pay the lesser of:

- The difference between the amount of the billed charges for the allowable expenses and the amount paid by the primary plan' or
- The amount the secondary plan would have paid if it had been the primary plan.

You will only be responsible for the **copayment, deductible** or **coinsurance** under the secondary plan if you have no responsibility for **copayment, deductible** or **coinsurance** under the primary plan and the total payments by both the primary and secondary plans are less than the **provider's** billed charges. In no event will you be responsible for any payment in excess of the **copayment, coinsurance** or **deductible** of the secondary plan.

Primary plan is fee schedule plan and secondary plan is R & C plan
If the **provider** is a **network provider** in the primary plan, the allowable expense considered by the secondary plan will be the fee schedule of the primary plan. The secondary plan will pay the lesser of:

- The amount of any **deductible, coinsurance** or **copayment** required by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

Primary plan is fee schedule plan and secondary plan is R & C plan or fee schedule plan
If the primary plan is an HMO plan that does not allow for the use of non-network **providers** except in the event of urgent care or **emergency services** and the service or supply you receive from a non-network **provider** is not considered as urgent care or **emergency services**, the secondary plan will pay benefits as if it were the primary plan.

Primary plan is capitation plan or fee schedule plan or R & C plan and secondary plan is capitation plan
If you receive services or supplies from a **provider** who is in the network of the secondary plan, the secondary plan will be responsible to pay the capitation to the **provider** and will not be responsible to pay the **deductible, coinsurance** or **copayment** imposed by the primary plan. You will not be responsible to pay any **deductible, coinsurance** or **copayments** of either the primary plan or the secondary plan.

Primary plan is an HMO and secondary plan is an HMO
If the primary plan is an HMO plan that does not allow for the use of non-network **providers** except in the event of urgent care or **emergency services** and the service or supply you receive from a non-network **provider** is not considered as urgent care or **emergency services**, but the **provider** is in the network of the secondary plan, the secondary plan will pay benefits as if it were the secondary plan, except that the primary plan will pay out-of-network services, if any, authorized by the primary plan.

How COB works with Medicare

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

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. If you are eligible but not covered, and Medicare would be your primary payer, we may still pay as if you are covered by Medicare and coordinate with the benefits Medicare would have paid. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered.

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

How this plan works with automobile plans for automobile related injuries

This section explains how the benefits under this plan interact with benefits available when expenses are incurred as a result of an automobile related injury.

Key terms
Automobile related **injury** means:

- Bodily **injury** sustained by a person as a result of an accident:
  - while occupying, entering, leaving or using an automobile; or
  - as a pedestrian

  caused by an automobile or an object propelled by or from an automobile.

Allowable expense means:

- A **medically necessary**, reasonable and customary item of expense covered at least in part as an eligible expense by:
  - The policy
  - PIP, or
  - OSAIC

Eligible expense means:
That portion of medical expense incurred for treatment of an **injury** which is covered under this plan without application of cash **deductibles** and **copayments**, if any or **coinsurance**.

Out-of-State Automobile Insurance Coverage (OSAIC) means:

- Any coverage for medical expenses under an automobile insurance policy other than PIP.

OSAIC includes automobile insurance policies issued in another state or jurisdiction.

PIP means:

- Personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determining who pays when there is an automobile plan for automobile related injuries
This plan provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for you under this plan. This election is made by the named insurance under a PIP policy. Such election affects that person's family members who are not themselves named insured's under another automobile policy. This plan may be primary for one covered person, but not for another if the person has separate automobile policies and has made different selections regarding primacy of health coverage.

This plan is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to this plan. In that case this plan will be primary.

If there is a dispute as to which plan is primary, this plan will pay benefits as if it were primary.

If this plan is primary to PIP or OSAIC, it will pay benefits for **covered services** in accordance with its terms.

The rules of the coordination of benefits section of this plan will apply if:

- You are insured under more than one insurance plan, and
- Such insurance plans are primary to automobile insurance coverage.

If this plan is secondary to PIP or OSAIC, the actual benefits payable will be the lesser of:

- The allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying cash **deductibles** and **copayments,** or
- The benefits that would have been paid if this plan had been primary.

If this plan supplements coverage under Medicare, it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

Other health coverage updates – contact information

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

Our rights

We have the right to:

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

Benefit payments and claims

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

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

Claim type and timeframes

Urgent care claim

An urgent claim is one for which the **physician** treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 72 hours.

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

Pre-service claim

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

Post-service claim

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

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

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

During this continuation period, you are still responsible for your share of the costs, such as **copayments**, **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.

Filing a claim

When you see a **network provider**, that office will usually send us a detailed bill for your services. You should always keep your own record of the date, **providers** and cost of your services.

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

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back. You can refer to the *General provisions - other things you should know* section for more information on rescissions.

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

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

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

Appeal

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

Claim decisions and appeal procedures

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

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

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will answer urgent utilization review clam appeals within 36 hours for level one and two appeals and within 72 hours for an initial determination. We will answer utilization review pre-service claims within 15 calendar days. We will answer utilization review pre-service claim appeals within in 10 calendar days for level one appeals and within 15 calendar days for level two appeals. There are no extensions for urgent care utilization review claims. Extensions for pre-service claim utilization are 15 days. The additional information request timeframe for urgent care utilization review claims is 72 hours. The additional information request timeframe for pre-service claim utilization review is 15 days. Responses to additional information requests are required within 48 hours for urgent care utilization claims and within 45 days for pre-service utilization claims.

A concurrent claim appeal will be addressed according to what type of service and claim it involves. We will answer urgent concurrent care claims within 24 hours if received at least 24 hours before the previously approved health care services end. Non-urgent concurrent care utilization claim review timeframes are 15 calendar days.

Any other claim appeal

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

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

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

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

Extensions for non-utilization review post service claims are 15 calendar days. The additional information request and response timeframes for non-utilization review post service claims are 30 calendar days.

Benefit determination for level one and level two appeals depends on the response time from receipt of appeals. The timeframe for non-utilization claim review for rescission of coverage is 30 calendar days for both level one and level two appeals. Post service non-utilization claim timeframes for both level one and level two appeals are 30 calendar days.

If coverage is rescinded:

- We will provide you with a 30 day advance written notice prior to the date of the rescission
- We will refund any premiums paid for any period after the termination date, minus the cost of covered benefits provided during this period

The date of the rescission will be the date coverage would have otherwise terminated if a complaint had not been filed.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 180 calendar days from the date you receive the notice of the first appeal decision.

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

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

Appeals of inpatient substance use disorder claims

Aetna will notify you, an authorized representative and your physician of an inpatient substance use disorders treatment claim decision within 24 hours. This notice will include your rights with regard to filing an expedited internal appeal of an adverse determination. Aetna will communicate the determination regarding your appeal of the adverse determination within 24 hours to you, an authorized representative and your physician.

If the determination is to uphold the denial, you an authorized representative or your physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program through the Department of Banking and Insurance. An independent utilization review organization shall make a determination within 24 hours.

If the independent utilization review organization upholds the determination and it is determined continued inpatient care is not medically necessary, Aetna shall remain responsible to provide benefits for the inpatient care through the day following the date the determination is made and you shall only be responsible for any applicable copayment, deductible and coinsurance for the stay through that date as applicable under the contract. For any costs incurred after the day following the date of determination until the day of discharge, you shall only be responsible for any applicable cost sharing, and any additional charges shall be paid by the facility or **provider**.

Exhaustion of appeal process

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

- Contact the New Jersey Department of Banking and Insurance to request an investigation of a claim, complaint or appeal:
  Department of Banking and Insurance
  Consumer Protection Services
  Office of Managed Care
  PO Box 329
  Trenton, New Jersey 08625-0329
  (888) 393-1062

- File a complaint or appeal with the New Jersey Department of Banking and Insurance
- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding

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

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
- We did not follow all of the claim determination and appeal requirements of the New Jersey Department of Banking and Insurance. 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 Independent Utilization Review Organization (IURO). An IURO is assigned by the State Insurance Commissioner and is made up of physicians or other appropriate **providers**. The IURO must have expertise in the problem or question involved.

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

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

There are times when you do not have to complete the level one and level two appeals processes. You may pursue an appeal directly through the Independent Health Care Appeals program if:

- A determination on any appeal regarding urgent or emergency care is not given to you within 72 hours of receipt by us
- A determination on an initial appeal, is not given to you within 10 calendar days of the date we received the notice
- A determination of a subsequent level of appeals is not given to you within 20 business days of the date we received notice

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:

Department of Banking and Insurance Consumer Protection Services
Office of Managed Care
BO Box 329
Trenton, New Jersey 08625-0329
(888) 393-1062

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

You will pay for any information that you send and want reviewed by the IURO. The filing fee is $25.00 and will not exceed $75.00 annually per covered person. We will pay for information we send to the IURO plus the cost of the review.

The New Jersey Department of Banking and Insurance will contact the IURO that will conduct the review of your claim.

The IURO will:

- Perform a preliminary review and immediately notify the covered person and/or **provider** in writing as to whether the appeal is accepted for processing
- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

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

How long will it take to get an IURO decision?

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

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

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

For initial adverse benefit determinations

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

For final adverse determinations
Your **provider** tells us a delay in receiving health care services would:

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

If your situation qualifies for this faster review, you will receive a decision within 48 hours of us getting your request.

Recordkeeping

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

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal except those described in the *External review* provision.

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

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

When you can join the plan

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

You can enroll:

- At the end of any waiting period the contract holder requires
- Once each year during the annual enrollment period
- At other special times during the year (see the *Special times you can join the plan* section below)

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

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Your civil union partner who meets any contract holder rules and requirements under state law
- Your domestic partner who meets contract holder rules and requirements under state law
- Dependent children – yours or your spouse's or partner's
    - Dependent children must be:
        - Under 26 years of age
    - Dependent children include:
        - Natural children
        - Stepchildren
        - Adopted children including those placed with you for adoption
        - Foster children
        - Children you are responsible for under a qualified medical support order or court order

A newborn child

Your newborn child is covered on your health plan for the first 60 days after birth and the following criteria are required:

- To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth
- You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent
- If you miss the deadline, your newborn will not have health benefits after the first 60 days

Adding new dependents

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

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

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 31 days after the event date.

Special times you can join the plan

You can enroll in these situations:

- You didn't enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended
- You are now eligible for state premium assistance under Medicaid or S-Chip which will pay your premium under this plan
- A court orders that you cover a dependent on your health plan

We must receive the completed enrollment information within 31 days of the date when coverage ends and within 60 days of becoming eligible under Medicaid or S-Chip.

Notification of change in status

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

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

Starting coverage

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

Stopping coverage

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

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

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The contract holder asks to end coverage

- You are no longer eligible for coverage, including when you move out of the service area
- Your work ends
- You stop making required contributions, if any apply
- We end your coverage
- You start coverage under another medical plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage
- You stop making premium contributions, if any apply
- Your coverage ends for any of the reasons listed above except:
  - Exhaustion of your overall lifetime maximum benefit.
  - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.
- The date this plan no longer allows coverage for domestic partners
- The date the domestic partnership
  - You will need to complete a Declaration of Termination of Domestic Partnership

What happens to your dependents if you die?

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

Why would we end your coverage?

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

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

Special coverage options after your coverage ends

When coverage may continue under the plan

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

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

Consolidated Omnibus Budget Reconciliation Act (COBRA)

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

- Your active employment ends for reasons other than gross misconduct

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

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

Continuation of coverage for other reasons

To request an extension of coverage, just contact us.

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

Your coverage may be extended if you are totally disabled when coverage ends and you have been continuously insured for the 3 months prior to coverage ending.

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

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

You may extend coverage until the earliest of:

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

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

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

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

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

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

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

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

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

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

- When you are discharged
- When you no longer need inpatient care
- 36 months of coverage

The extension of benefits shall not extend the time period during which you may:

- Enroll for continuation coverage under any New Jersey Continuation law of COBRA
- Expand the benefits for such coverage nor
- Waive the requirements concerning the payment of premium contribution for any continuation for any continuation plan selected

Continuation of coverage during temporary lay-off or approved leave of absence

If your coverage would terminate due to a temporary lay-off or an approved absence, coverage may be continued for up to 60 days, or as otherwise agreed upon by the contract holder and Aetna, if the contract holder:

- Pays the premium for such continued coverage and
- Provides continued coverage from us or its other sponsored health benefit plans to all eligible enrollees in the same class as yours whose coverage would otherwise terminate because of a temporary lay-off or approved leave of absence.

How your dependent can extend coverage after you die

Your dependents can continue coverage after your death if:

- You were covered at the time of your death
- The request is made within 31 days after your death, and
- Payment is made for coverage

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

- The end of the 12 month period after your death
- They no longer meet the definition of dependent
- Dependent coverage stops under your plan
- The dependent becomes covered by another health benefits plan
- The date your spouse remarries

To request extension of coverage, the dependent, or their representative, can contact us.

Important note:
Coverage that is continued under this provision will reduce continuation coverage under COBRA.

Over-age dependent continuation

Who is an over-age dependent child?

Your child by blood or law who:

- Has reached the limiting age as described in the *Who can be a dependent on this plan* section, but is less than 31 years of age
- Is not married or is not a domestic partner or in a civil union

- Has no dependents of their own
- Is either a resident of New Jersey or is enrolled as a full-time student at an accredited school
- Is not covered under any other:
  - Group or individual health benefits plan
  - Group health plan
  - Church plan or health benefits plan
- Is not entitled to Medicare on the date continuation coverage begins

How can you continue coverage for over-age dependents?
A child who meets these conditions may elect to be covered until their 31 birthday, subject to all of the following:

- The over-age dependent must provide evidence of prior creditable coverage or receipt of benefits under:
  - A group or individual health benefits plan
  - A group health plan
  - Church plan or health benefits plan or
  - Medicare
- The prior coverage must have been effective at some time prior to making an election for this over-age dependent coverage
- A parent of an over-age dependent must be enrolled as having elected dependent coverage at the time the over-age dependent elects continued coverage

The policyholder will validate dependent coverage for an over-age dependent's parent.

What is the effective date of over-age dependent continuation once elected?
The effective date of the of the continued coverage will be the later of:

- The date the over-age dependent gives written notice to us. The enrollee must complete the *HINT Supplemental Enrollment Information Form.*
- The date the over-age dependent pays the first premium
- The date the dependent would otherwise lose coverage due to attainment of the limiting age
  - The election must be made within 30 days prior to attainment of the limiting age to avoid lapse in coverage

If the dependent was not covered on the date of reaching the limiting age, the written election may be made at any time.

If the dependent did not qualify as an over-age dependent, but who subsequently meets all of the requirements, the written election may be made at any time after meeting all of the requirements.

Continued coverage
The continued coverage will be identical to the coverage provided to the over-age dependent's parent covered under the plan, however:

- If coverage is modified for dependents under the limiting age, the coverage for over-age dependents shall also be modified in the same manner.
- All cost sharing requirements will apply and will not combine with the parent's plan. Covered benefits incurred by the over-age dependent will not contribute towards the family deductible and out-of-pocket maximums.

- Family incurred expenses will not contribute towards the over-age dependent's deductibles or out-of-pocket maximums.
- The *When will your coverage end* and *When dependent coverage ends* provisions do not apply

The first month's premium will be determined by the effective date of the over-age dependent's election. Subsequent monthly premiums must be paid in advance, at the times and in the manner specified by Aetna. The grace period for the first premium payment is 31 days after the billing due date. We will bill the covered over-age dependent directly and the over-age dependent will remit the premium directly to us. Subsequent premium payment must be made within 31 day of the date the premium is due.

When does continuation end?
An over-age dependent's continued group health benefits end on the first of the following dates the over-age dependent:

- Attains age 31
- Marries, becomes a domestic partner, or enters into a civil union
- Acquires a dependent, including any newborn children
- Is no longer either a resident of New Jersey or enrolled as a full-time student at an accredited school
- Becomes covered under any other:
  - Group or individual health benefits plan
  - Group health plan
  - Church plan or health benefits plan
  - Becomes entitled to Medicare
- The end of the period for which premium has been paid for the over-age dependent subject to the grace period
- The date the plan ceases to provide coverage to the over-age dependent's parent who is covered under the plan
- The date the plan under which the over-age dependent elect to continue coverage is amended to eliminate coverage for dependents.
- The date the over-age dependent's parent who is covered under the plan waives dependent coverage. Except, if you have no other dependents, the over-age dependent's coverage will not end as a result of your waiving dependent coverage.

Over-age dependents who have made an election for continuation under this provision and whose coverage is later terminated are not eligible for continuation provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or New Jersey Continuation under the group plan.

Discontinuance and replacement provisions

This section determines a carrier's responsibility when one carrier's policy or contract replaces another carrier's plan providing similar types of coverage.

How is the responsibility between the prior carrier and new carrier determined?
Your prior carrier's responsibility:

- Claims incurred on the day prior to the new carrier's effective date
- You are totally disabled on the date prior carrier's plan ended

- Extension of benefits will remain the same if the group policyholder, contract holder or other entity:
  - Obtains replacement coverage from a new carrier
  - Decides to self-fund or
  - Decides to stop providing coverage

Your new carrier's responsibility:

- You are eligible for coverage with the new carrier on the effective date of the new carrier's plan
- You were covered under the prior plan on the date that plan ended and you are in an eligible class of covered employees on the effective date of the new carrier's plan

The minimum amount of benefits to be provided by the new carrier are the prior carrier's plan minus any benefits payable or services or supplies provided by the prior plan.

Coverage shall be provided by the prior carrier until at least the earliest of the following:

- The date the individual becomes eligible under the new carrier's plan
- For each type of coverage, the date the individual's coverage would terminate in accordance with the new carrier's termination provision (for example, at termination of employment or ceasing to be an eligible dependent , as the case may be)
- In the case of an individual who was totally disabled, and in the case of a type of coverage for which New Jersey law requires an extension of accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by New Jersey law

What happens to the time you have already satisfied for any benefit waiting periods?
The new carrier will give you credit for this time. Your employer will confirm the time already satisfied with the prior carrier.

What happens to any amount of your deductible satisfied with the prior plan?
Credit is given for expenses occurring and claimed under the prior carrier's plan during the 90 days before the effective date of the new carrier's plan. Keep in mind, the new carrier must have a similar **deductible** provision for these expenses to match.

In any situation where determination of the prior carrier's benefit is required by the new carrier, at the new carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information sufficient to permit verification of the benefit or the determination itself by the new carrier.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this certificate

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

How we administer this plan

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

Who's responsible to you

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

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

Coverage and services

Your coverage can change

Your coverage is defined by the group agreement. This document may have amendments and riders too. Under certain circumstances, we, the contract holder 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 we may waive a requirement of your plan. No other person, including the contract holder or **provider**, can do this.

Legal action

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

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

Physical examination and evaluations

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

Records of expenses

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

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

Honest mistakes and intentional deception

Honest mistakes

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

Intentional deception

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

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

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

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 advance written notice of any rescission of coverage
- You have the right to an Aetna appeal

Some other money issues

Assignment of benefits

When you see a **network provider**, they will usually bill us directly.

When you assign your rights to receive reimbursement for covered services to an out of network provider, we are required to pay benefits in line with the assignment of benefits. We will directly pay the health care provider in the form of a check payable:

- To the health care provider or
- To the health care provider and you as a joint payee with signature lines for each.

Any payment made solely to you rather than the health care provider under these circumstances shall be considered unpaid, and unless remitted to the health care provider within the time frames established by New Jersey Law, shall be considered overdue and subject to an interest charge as provided in the act.

Financial sanctions exclusions

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

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

Recovery of overpayments

We sometimes pay too much for **covered services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid, you or your **provider**, to return what we paid. However, we have to request reimbursement no more than 18 months following the date the first payment on the particular claim was made. We can only request one reimbursement per particular claim. We have the right to reduce any future benefit payments by the amount we paid by mistake.
We will work directly with your **provider** throughout the reimbursement process.

Your health information

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

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

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

Glossary

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

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

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

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

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

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

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

Detoxification
The process of getting a substance out of an addicted person's system and getting them physically stable.

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

Emergency medical condition
A severe medical condition that:

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

- Loss of function to a body part or organ
- Danger to the health of an unborn baby

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

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

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

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental and 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 and investigational**.

Formulary exclusions list
A list of prescription drugs excluded from preferred cost-sharing. This list is subject to change.

Generic prescription drug
An FDA-approved drug with the same intended use as the brand-name product, that is considered to be as effective as the brand-name product. It offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance

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

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

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

Infertile, infertility

A disease defined by one of the following:
The failure to become pregnant:

- A male is unable to impregnate a female;
- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart
- For an individual or their partner who has been clinically diagnosed with gender identity disorder
- For an individual or their partner who has been clinically diagnosed with gender identity disorder
- Partners unable to conceive as a result of involuntary medical sterility;
- A person is unable to carry a pregnancy to live birth; or
- A previous determination of infertility pursuant to this section

Jaw joint disorder

This is:

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

Mail order pharmacy

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

Maximum out-of-pocket limit

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

Medically necessary, medical necessity

Health care services that a **provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that 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
- With respect to **substance use disorder**, in accordance with an evidence - based and peer reviewed clinical review tool as designated in regulation by the Commissioner of Human Services.

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
- With respect to **substance use disorder**, your provider will determine medical necessity for the first 180 days if treatment

Mental health condition

A mental health condition as defined to be consistent with the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and any subsequent editions published by the American Psychiatric Association.

Negotiated charge

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

Network provider

A **provider** listed in the directory for your plan. A National Advantage program (NAP **provider**) listed in the NAP directory is not a **network provider**. A **network provider** can also be referred to as an in-network **provider**.

Out-of-network provider

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

Physician

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

Precertification, precertify

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

Preferred drug

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

Prescription

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

Primary care physician (PCP)

A **physician** who:

- The directory lists as a **PCP**
- Is selected by a covered person from the list of **PCP**s in the directory
- Supervises, coordinates and provides initial care and basic medical services to a covered person
- Initiates **referrals** for **specialist** care, if required by the plan, and maintains continuity of patient care
- Shows in our records as your **PCP**

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

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

Provider

A **physician**, **health professional**, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare. With respect to the treatment of autism, the treatment must be administered directly by or under the direct supervision of an individual who is credentialed by the national Behavior Analyst Certification Board as either:

- a Board Certified Behavior Analyst – Doctoral (BCBA-D)
- a Board Certified Behavior Analyst – (BCBA)

Psychiatric hospital

An institution licensed or certified as a **psychiatric hospital** by applicable laws to provide a program for the diagnosis, evaluation, and treatment of **substance use disorders** or **mental health conditions**.

Referral

This is a written or electronic authorization made by your **PCP** to direct you to a **network provider** for **medically necessary** services and supplies.

Residential treatment facility

An institution specifically licensed as a **residential treatment facility** by applicable laws to provide for **mental health conditions** or **substance use disorder** residential treatment programs. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

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

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

For substance **use disorder** residential treatment programs:

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

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

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

Retail pharmacy

An independent pharmacy, a supermarket pharmacy, a chain pharmacy or a mass merchandiser pharmacy having a state license to dispense medications to the general public at retail prices as a pharmacy. Retail community pharmacy does not include a pharmacy that dispenses prescription medications to patients primarily through mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or pharmacy benefit managers.

Room and board

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

Same terms and conditions

With respect to the treatment of **mental health conditions** and **substance use disorders**, we will not apply more restrictive non-quantitative limitations or more restrictive quantitative limitations to **mental health conditions** and **substance use disorders**, than we apply to substantially all other medical or surgical benefits.

Semi-private room rate

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

Skilled nursing facility

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

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

Skilled nursing facility does not include institutions that provide only:

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

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

Skilled nursing services

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

Specialist

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

Specialty prescription drug

An FDA-approved **prescription** drug that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:

- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

Specialty pharmacy

A pharmacy that fills **prescriptions** for specialty drugs.

Stay

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

Substance use disorder

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent including withdrawal. These are defined to be consistent with the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM), and any subsequent editions published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a **mental health condition** that are focus of attention or treatment.

Surgery, surgical procedure

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

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

Telehealth

The use of information and communication technologies, such as:

- Telephones
- Remote patient monitoring devices
- Other electronic means
- to support Clinical health care
- **Provider** consultation

- Patient and professional health-related education
- Public health
- Health administration
- Other services

in accordance with New Jersey state law.

Telemedicine

The delivery of **eligible health services** using:

- Electronic communications
- Information technology
- Other electronic or technological means

To bridge the gap between a **provider** and you, either with or without the assistance of another **provider** in accordance with New Jersey state law.

Telemedicine does not include the use, in isolation, of:

- Audio-only telephone conversation
- Electronic mail
- Instant messaging
- Phone text
- Facsimile transmission

Terminal illness

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

Urgent condition

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

Value prescription drugs

A group of medications determined by us that may be available at a reduced **copayment** or **coinsurance** and are noted on the **drug guide**.

Walk-in clinic

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

- Drug store
- Pharmacy
- Retail store
- Supermarket

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

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

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.

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Disclosures to covered persons regarding out-of-network treatment

This summary only provides an overview of how a covered person's health benefits plan covers out-of-network treatment. It is only guidance to help a covered person understand their out-of-network benefits. This summary does not alter your coverage in any way.

The covered person should refer to their Group Policy, Certificate or Evidence of Coverage (if employer group plan), or Summary of Benefits and Coverages for more information about your out-of-network benefits and about coverages and costs for in-network treatment.

For additional information – including whether a health care professional or facility is in-network or out-of-network, examples of out-of-network costs and estimates for specific services - please contact us at: the toll-free telephone number on your member identification card. The hours of operation are 24 hours per day.

Or

Visit our website at: **aetna.com**
And select legal notices, state specific and scroll to New Jersey out-of-network claims.

Your policy covers:	What this means:	How am I protected by NJ law?
Medically necessary treatment on an emergency or urgent basis by out-of-network health care professionals/facilities	Emergency - You are covered for out-of- network treatment for a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain; psychiatric disturbances and/or symptoms of Substance Use Disorder such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual or unborn child in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. This includes any further medical examination and such treatment as may be required to stabilize the medical condition. This also includes if there is inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery or such transfer may pose a threat to the health or safety of the woman or unborn child. Urgent – You are covered for out-of-network treatment of a non-life-threatening condition that requires care by a health care professional within 24 hours.	Except as discussed below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost- sharing") applicable to the same services when received in-network. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: **www.state.nj.us/dobi/consumer.htm.**
		Your carrier and the out-of-network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the emergent/urgent medical services. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of- pocket cost-sharing liability may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the final Explanation of Benefits if settled.
		If an agreement cannot be reached, your carrier or the out-of-network health care professional/facility may seek to enter into binding arbitration to determine the amount to be paid for the medical services. The amount awarded by the arbitrator may exceed what the carrier has already paid to the out-of-network health professional/facility; however, any additional amount paid by the carrier pursuant to the arbitration award <u>will not</u> increase your cost-sharing

Your policy covers:	What this means:	How am I protected by NJ law?
		liability above the amount indicated as your responsibility on the second Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total allowed charge/amount for the service(s).

Your policy covers:	What this means:	How am I protected by NJ law?
Inadvertent out-of- network services	You are covered for treatment by an out-of- network health care professional for covered services when you use an in-network health care facility (e.g. hospital, ambulatory surgery center, etc.) and, for any reason, in- network health care services are unavailable or provided by an out-of-network health care professional in that in-network facility. This includes laboratory testing ordered by an in- network health care professional and performed by an out-of-network bio- analytical laboratory (e.g., imaging, x-rays, blood tests, and anesthesia).	Except as provided below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost- sharing") applicable to the same services when received in-network. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: **https://www.state.nj.us/dobi/consumer.htm**
		Your carrier and the out-of-network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the inadvertent out-of-network services. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of-pocket cost-sharing liability may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the final Explanation of Benefits if settled.
		If an agreement cannot be reached, your carrier or the out-of-network health care professional/facility may seek to

Your policy covers:	What this means:	How am I protected by NJ law?
		enter into binding arbitration to determine the amount to be paid for the inadvertent out-of-network services. The amount awarded by the arbitrator may exceed what the carrier has already paid to an out-of-network health care professional/facility; however, any additional amount paid by the carrier pursuant to the arbitration award will not increase your cost-sharing liability above the amount indicated as your responsibility on the second Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total allowed charge/amount for the service(s).
Your policy covers:	**What this means:**	**How am I protected by NJ law?**
Treatment from out-of-network health care professionals/ facilities if in-network health care professionals/facilities are unavailable.	Plans are required to have adequate networks to provide you with access to professionals/facilities within certain time/distance requirements so you can obtain medically necessary treatment of all illnesses or injuries covered by your plan.	You can request treatment from an out-of- network health care professional/facility when an in-network health care professional/facility is unavailable through an appeal, often called a request for an "in-plan exception." Please see the Department of Banking and Insurance's guide at: **https://nj.gov/dobi/appeal/.**
Your policy DOES NOT cover:	**What this means:**	**How am I protected by NJ law?**
Voluntary out-of-network services	You are not covered for treatment by an out-of-network health care professional/ facility when you knowingly, voluntarily and specifically select an out- of-network professional/facility for treatment when you have the opportunity to be serviced by an in-network healthcare professional/facility.	As discussed above, you can request treatment from an out-of-network health care professional/facility when an in-network health care professional/facility is unavailable through an appeal, called a request for "in-plan exception."

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY: 711,
Fax: 859-425-3379, 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).**

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42.28.301.1-NJV3 (01/19)

Important information about organ and tissue donation

Each year, we're required to send you informational materials about organ and tissue donation and registration. This is required* as your health benefits plan is written in New Jersey.

For information on how to make an anatomical gift, including information on the registration of a gift in the Donate Life New Jersey registry, please use the following contact information, depending on where you live:

If you live in northern or central New Jersey, contact:

New Jersey Sharing Network
691 Central Avenue, New Providence, NJ 07974
Phone: **(800) 742-7365**
Email: info@NJSharingNetwork.org
Web address: **www.NJSharingNetwork.org**

If you live in southern New Jersey, contact:

Gift of Life Donor Program
401 N. 3rd Street, Philadelphia, PA 19123
Phone: **(800) DONORS-1 (800) 366-6771**
Email: info@donors1.org
Web address: **www.donors1.org**

If you live in another state, please find the organization for your state online at:
https://organdonor.gov/awareness/organizations/local-opo.html

If you have any questions, please call our customer service department at the phone number on the back of your ID card. Thank you.

***This notice is sent in compliance with Chapter 220 of the New Jersey Laws of 2017.**
Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc., Aetna Health Insurance Company of New York and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

47.03.345.1-NJ (03/18)

Aetna Health Inc. Rider

Prescription drug plan

Rider effective date: January 01, 2023

This **prescription** drug plan rider is added to your certificate. It describes your **prescription** drug benefits. This rider is subject to all other requirements described in your certificate, including general exclusions and defined terms.

What you need to know about the prescription drug plan

Read this rider carefully so you will know:

- How to access your benefit
- How to access network pharmacies
- How to get an emergency **prescription** filled
- Coverage and exclusions
- Where your schedule of benefits fits in
- **Precertification** requirements that apply
- Utilization review
- Requesting a medical exception
- General provisions – other things you should know
- How to read your schedule of benefits

How to access your benefit

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

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

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

We base your **prescription** drug plan on the drugs in the **drug guide**. Your cost may be higher if you're prescribed a **prescription** drug that is not listed in the **drug guide**. You can find out if a **prescription** drug is covered, see the *Contact us* section for how.

How to access network pharmacies

How to find a network pharmacy

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

You may go to any of our network pharmacies. If you don't get your **prescription** at a network pharmacy, it will not be a **covered service** under the plan.

Network pharmacies include a:

- **Retail pharmacy**
- **Mail order pharmacy**
- **Specialty pharmacy**

When the pharmacy you use leaves the network

Sometimes a pharmacy might leave the network. If this happens, you will have to get your **prescriptions** filled at another network pharmacy. You can use your **provider** directory or call us to find another network pharmacy in your area.

How to get an emergency prescription filled

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

Type of pharmacy	Your cost share will be
A network pharmacy	The plan cost share
Out-of-network pharmacy	The full cost of the **prescription**

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

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

Coverage and exclusions

Providing covered services

Your **prescription** drug plan provides **covered services**. Your **provider** can give you a **prescription** in different ways including:

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

For covered pharmacy services:

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

Prescription drug synchronization

If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, your network pharmacy can coordinate that for you. This is called synchronization. We will apply a prorated daily cost share rate, to a partial fill of a maintenance drug, if needed, to synchronize your **prescription** drugs.

Covered services

Anti-cancer drugs taken by mouth, including chemotherapy drugs

Covered services include any drug prescribed for the treatment of cancer if it is recognized in a standard reference publication or recommended in the medical literature for this use. This applies even if the drug is not approved by the U.S. Food and Drug Administration (FDA) for the same use.

Contraceptives (birth control)

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

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

Preventive contraceptives important note:
You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review.
If the exception is approved, the **brand-name prescription drug** contraceptive will be covered at 100%.

Diabetic supplies

Covered services include items such as:

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

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

Immunizations

Covered services include preventive immunizations as required by the Affordable Care Act, (ACA), guidelines when administered at a network pharmacy. Call the number on your ID card to find a participating network pharmacy. Call the pharmacy for vaccine availability, as not all pharmacies will stock all available vaccines.

Infertility drugs

Covered services include oral and injectable **prescription** drugs used primarily for the purpose of treating the underlying medical cause of **infertility**.

Over-the-counter drugs

Covered services include certain OTC medications, as determined by the plan. Coverage of these medications requires a **prescription**. You can access a list of these OTC medications. See the *Contact us* section for how.

Preventive care drugs and supplements

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

Risk reducing breast cancer prescription drugs

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

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

Tobacco cessation prescription and OTC drugs

Covered services include FDA approved **prescription** and OTC drugs to help stop the use of tobacco products. You must receive a **prescription** from your **provider** and submit the **prescription** to the pharmacy for processing**.**

Exclusions

The following are not **covered services**:

- Abortion drugs
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a **covered service**
- Drugs or medications
    - Not approved by the FDA or not proven safe or effective
    - Provided under your medical plan while inpatient at a healthcare facility
    - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
    - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a **covered service**
    - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
    - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies
- Duplicative drug therapy, for example, two antihistamines for the same condition
- Genetic care including:

  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes.
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule or the certificate
- Injectables including:
  - Any charges for the administration or injection of **prescription** drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription** drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or **prescription** drugs for the treatment to a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance or otherwise improper and drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- Tobacco cessation drugs unless recommended by the USPSTF

Pharmacy types

Retail pharmacy

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

Mail order pharmacy

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

Specialty pharmacy

We cover **specialty prescription drugs** when filled through a network **retail** or **specialty pharmacy**. Each **prescription** is limited to a maximum 30 day supply. You can view the list of **specialty prescription drugs**. See the *Contact us* section for how.

Where your schedule of benefits fits in

You are responsible for paying your part of the cost share for **prescription** drugs covered under the plan. This schedule of benefits lists the **deductibles**, limits and **copayments** or **coinsurance**, if any, that apply to the **covered services** you receive under the **prescription** drug plan.

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

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

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

Precertification requirements that apply

For certain drugs, your **provider** 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 certain drugs and makes sure they are **medically necessary**.

See the *Contact us* section for how to get the most up-to-date **precertification** requirements.

Utilization review

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

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

Requesting a medical exception

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

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

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

General provisions – other things you should know

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

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

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

How to read your schedule of benefits

How your cost share works

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

How your cost share works

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

How your prescription drug maximum out-of-pocket limit works

This schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of the year.

Plan features

Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand name prescription drug** for that method will be paid at 100%.

The **prescription** drug **deductible** and cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug deductible and the per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

Maximum out-of-pocket limit

Maximum out-of-pocket type	In-network
Individual	$1,500 per calendar year
Family	$3,000 per calendar year

General coverage provisions

This section explains the **maximum out-of-pocket limits** in this schedule.

Prescription drug maximum out-of-pocket limits provisions

Covered services that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **coinsurance** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

Individual prescription drug maximum out-of-pocket limit

Once the amount of the cost share and **deductible** you and your covered dependents pay for **covered services** during the year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charges for **covered services** that apply toward the limit for the rest of the year for that person.

Family prescription drug maximum out-of-pocket limit

After the amount of the cost share and **deductible** you and your covered dependents pay for **covered services** during the year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charges for **covered services** that apply toward the limit for the rest of the year for all covered family members.

This plan has an individual and family **prescription** drug **maximum out-of-pocket limit**.

To satisfy this family **maximum out-of-pocket limit** for the rest of the 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 **prescription** drug **maximum out-of-pocket limit** is met by a combination of family members with no single person in the family contributing more than the individual **maximum out-of-pocket limit** in a year

When this happens, the individual **maximum out-of-pocket limit** is met for the rest of the year.

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

- All costs for non-**covered services**

Covered services

Generic prescription drugs

Description	In-network
For each fill up to a 30 day supply filled at a **retail pharmacy**	$10
For more than a 60 day supply but less than a 91 day supply filled at a **retail pharmacy**	$20
For each fill up to a 30 day supply filled at a **mail order pharmacy**	$20
For more than a 60 day supply but less than a 91 day supply at **mail order pharmacy**	$20

Preferred prescription drugs

Description	In-network
For each fill up to a 30 day supply filled at a **retail pharmacy**	$15
For more than a 60 day supply but less than a 91 day supply at **retail pharmacy**	$30
For each fill up to a 30 day supply filled at a **mail order pharmacy**	$30
For more than a 60 day supply but less than 91 day supply at a **mail order pharmacy**	$30

Non-preferred prescription drugs

Description	In-network
For each fill up to a 30 day supply filled at **retail pharmacy**	$30
For more than a 60 day supply but less than 91 day supply at **retail pharmacy**	$60
For each fill up to a 30 day supply filled at a **mail order pharmacy**	$60
For more than a 60 day supply but less than 91 day supply at a **mail order pharmacy**	$60

Anti-cancer prescription drugs taken by mouth

Description	In-network

For each fill up to a 30 day supply filled at **retail pharmacy**	Payable in accordance with the type of drug prescribed

For more than a 60 day supply but less than 91 day supply at **retail pharmacy**	Payable in accordance with the type of drug prescribed

For each fill up to a 30 day supply filled at a **mail order pharmacy**	Payable in accordance with the type of drug prescribed

For more than a 60 day supply but less than 91 day supply at **mail order pharmacy**	Payable in accordance with the type of drug prescribed

Contraceptives (birth control)

Description	In-network
90 day supply or 6 month supply of generic and OTC drugs and devices	$0
90 day supply or 6 month supply of **brand name prescription drugs** and devices	$0

Diabetic supplies, drugs and insulin

Description	In-network

30 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits, above

More than 60 day supply but less than 91 day supply at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits, above

30 day supply at **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits, above

More than 60 day supply but less than 90 day supply at a **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits, above

Preventive care drugs and supplements

Description	In-network
Preventive care drugs and supplements	$0
Limit	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered drugs and supplements or more information see the *Contact us* section.

Risk reducing breast cancer prescription drugs

Description	In-network
Risk reducing breast cancer **prescription** drugs	$0
Limit	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered risk reducing breast cancer drugs or more information, see the *Contact us* section.

Tobacco cessation drugs

Description	In-network
Tobacco cessation **prescription** and OTC drugs	$0
Limit	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.

Schedule of benefits

Prepared for:
Contract holder: UNIVERSITY OF PENNSYLVANIA POSTDOCTORAL INSURANCE PLAN
Contract holder number: 0861472
Plan name: Open Access Health Network Only
HMO group agreement effective date: January 01, 2023
Plan effective date: January 01, 2023

Schedule of benefits

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

How your cost share works

- The **deductibles**, **copayments** and **coinsurance**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- You are responsible to pay any **deductibles**, **copayments** and **coinsurance** if they apply and before the plan will pay for any **covered services**.
- When a **covered service** shows "no charge", this means you have no responsibility for **deductibles, copayments,** or **coinsurance**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits.
  See the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.
- Sometimes we don't show a specific cost share for a benefit. Instead we say, "Covered based on type of service and where it is received." That means your cost share will depend on the exact care you get and who provides it. For example, if you receive services for diabetes from a **specialist** in their office, you will pay the cost share listed in **Specialist** office visits. If you receive services for diabetes during a **hospital stay**, you will pay the cost share listed in **Hospital** care.

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

How your PCP or physician office visit cost share works

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

How your maximum out-of-pocket works

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

Contact us

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

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

Plan features

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

Maximum out-of-pocket limit

Maximum out-of-pocket type	In-network
Individual	$1,500 per calendar year
Family	$3,000 per calendar year

General coverage provisions

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

Deductible credit

If you paid part or all of your **deductible** under other coverage for the year that this plan went into effect, we will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If we ask, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

Copayment

This is a flat fee you pay for certain visits or **covered services.**

Coinsurance

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

Maximum out-of-pocket limit provisions

Maximum out-of-pocket limit

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

Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

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

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

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

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-covered services which are identified in the certificate and the schedule

Your financial responsibility and decisions regarding benefits

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

Covered services

Acupuncture

Description	In-network
Acupuncture	$20 per visit
	no **deductible** applies
Visit limit per year	20

Ambulance services

Description	In-network
Emergency services	$0 per trip
	no **deductible** applies
Non-emergency services	Not covered

Applied behavior analysis

Description	In-network
Applied behavior analysis	$0 per visit
	no **deductible** applies

Clinical trials

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

Dental care anesthesia

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

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

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

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

Durable medical equipment (DME)

Description	In-network
DME	$0 per item
	no **deductible** applies

Emergency services

Description	In-network	Out-of-Network
Emergency room	$75 per visit	Paid same as in-network
	no **deductible** applies	

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

Foot orthotic devices

Description	In-network
Orthotic devices	$20 per item
	no **deductible** applies

Habilitation therapy services

Physical (PT), occupational (OT) therapies

Description	In-network
PT, OT therapies	$0 per visit
	no **deductible** applies

Speech therapy

Description	In-network
ST	$0 per visit
	no **deductible** applies

Hearing aids

Description	In-network
Hearing aids	$20 per hearing aid
	no **deductible** applies
Age limit	Covered persons through age 16
Frequency limit	One per ear every 24 consecutive months
Benefit limit per year	$1,000

Hearing exams

Description	In-network
Hearing exams	$0 per visit
	no **deductible** applies

Home health care

A visit is a period of 4 hours or less

Description	In-network
Home health care	$30 per visit no **deductible** applies
Visit limit per day	3 intermittent visits
Limit per year	unlimited

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

Home hemophilia treatment

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

Hospice care

Description	In-network
Inpatient services - **room and board**	$250 per admission
	no **deductible** applies
Other inpatient services	No charge

Outpatient services	$0 per visit
	no **deductible** applies

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

Hospital care

Description	In-network
Inpatient services – **room and board**	$250 per admission
	no **deductible** applies
Other inpatient services	No charge

Infertility services

Description	In-network
Treatment of **infertility**	Covered based on type of service and where it is received
Inpatient **hospital room and board**	$250 per admission
	no **deductible** applies
Other inpatient **hospital** care services and supplies (other than **room and board**)	No charge
Outpatient **infertility** services performed in an **infertility specialist's** office	$30 per visit
	no **deductible** applies
Outpatient **infertility** services performed in a **hospital** outpatient facility	$100 per visit
	no **deductible** applies
Outpatient **infertility** services performed in a facility other than a **hospital** outpatient facility	$100 per visit
	no **deductible** applies

Advanced reproductive technology (ART)

Description	In-network
Treatment of **infertility**	Covered based on type of service and where it is received
Inpatient **hospital room and board**	$250 per admission
	no **deductible** applies
Other inpatient **hospital** care services and supplies (other than **room and board**)	No charge
Outpatient **infertility** services performed in an **infertility specialist's** office	$30 per visit
	no **deductible** applies
Outpatient **infertility** services performed in a **hospital** outpatient facility	$100 per visit
	no **deductible** applies

Maternity and related newborn care

Includes complications

Description	In-network
Inpatient services – **room and board**	$250 per admission
	no **deductible** applies
Other inpatient services	No charge
Services performed in **physician** office	$30 per visit
	no **deductible** applies
Services performed in **specialist** office or a facility	$30 per visit
	no **deductible** applies

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

Mental health conditions

Mental health treatment

Coverage provided under the **same terms and conditions** as for any other condition

Description	In-network
Inpatient services-**room and board** including **residential treatment facility**	$250 per admission
	no **deductible** applies
Other inpatient services and supplies Other **residential treatment facility** services and supplies	No charge
Outpatient office visit to a **physician** or **behavioral health provider**	$30 per visit
	no **deductible** applies
Outpatient mental health **telemedicine** and/or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider**	$0 per visit no **deductible** applies
Physician or **behavioral health provider telemedicine** visit	$30 per visit
	no **deductible** applies
Other outpatient services including: • 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	$0 per visit
	no **deductible** applies
Telemedicine and/or **telehealth provider mental health disorders** consultation	Covered based on type of service and where it is received.

Autism spectrum disorder and other developmental disabilities

Description	In-network
Diagnosis and testing	$30 per visit
	no **deductible** applies

Treatment	$30 per visit
	no **deductible** applies
Outpatient Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	$0 per visit
	no **deductible** applies

Substance use disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**
Coverage provided is the **same terms and conditions** as for any other condition

Description	In-network
Inpatient services – **room and board** during a **hospital stay**	$250 per admission
	no **deductible** applies
Other inpatient services and supplies during a **hospital stay**	No charge
Outpatient office visit to a **physician** or **behavioral health provider**	$30 per visit
	no **deductible** applies
Outpatient **telemedicine** and/or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider**	$0 per visit no **deductible** applies
Physician or **behavioral health provider telemedicine** and/or **telehealth** consultation	$30 per visit
	no **deductible** applies
Other outpatient services including: • 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	$0 per visit
	no **deductible** applies

Telemedicine and/or **telehealth provider substance related disorders** consultation	Covered based on type of service and where it is received.

Nutritional support

Description	In-network
Nutritional support	$0 per item
	no **deductible** applies

Outpatient surgery

Description	In-network
At **hospital** outpatient department	$100 per visit no **deductible** applies
At facility that is not a **hospital**	$100 per visit no **deductible** applies
At the **physician** office	Covered based on type of service and where it is received

Physician and specialist services

Including surgical services

Description	In-network
Physician office hours (not surgical, not preventive)	$20 per visit
	no **deductible** applies
Immunizations that are not considered preventive care	Covered based on type of service and where it is received.
Physician visit during inpatient **stay**	$20 per visit
	no **deductible** applies
Physician home visit (not preventive)	$20 per visit
	no **deductible** applies
Physician surgical services	$20 per visit
	no **deductible** applies
Physician telemedicine and/or **telehealth** consultation	$20 per visit
	no **deductible** applies

Telemedicine and/or **telehealth provider** consultation Basic medical services	Covered based on type of service and where it is received.

Physician Services-Specialist

Description	In-network
Specialist office hours (not surgical, not preventive)	$30 per visit
	no **deductible** applies
Specialist home visit (not preventive)	$30 per visit
	no **deductible** applies
Specialist surgical services	$30 per visit
	no **deductible** applies
Specialist telemedicine and/or **telehealth** consultation	$30 per visit
	no **deductible** applies
Telemedicine and/or **telehealth provider** consultation **Specialist** services	Covered based on type of service and where it is received.

Preventive care

Description	In-network
Preventive care services	$0 no **deductible** applies
Breast feeding counseling and support limit	unlimited visits in a group or individual setting **Telemedicine** and/or **telehealth** visits do not apply toward your visit limit All other visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	**Important note:** You are limited to 2 breast pump kits per birth • The purchase of an electric or manual breast pump, including supplies and accessories • The purchase or rental of a multi-user breast pump, including supplies and accessories

Description	In-network
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump
Counseling for **substance use disorder** visit limit per day	1
Counseling for **substance use disorder** visit limit	5 visits/12 months
Counseling for obesity, healthy diet visit limit per day	1
Counseling for obesity, healthy diet visit limit	Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Family planning services (female contraception and counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	$0
Immunizations limit	Covered persons age 0-99 Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section of your certificate
Routine lung cancer screening limit	1 screening every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing

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

Prosthetic devices

Includes medical wigs

Description	In-network
Prosthetic devices	$20 per item
	no **deductible** applies

Reconstructive surgery and supplies

Including breast **surgery**

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

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

Description	In-network
Cardiac rehabilitation	$30 per visit no **deductible** applies

Pulmonary rehabilitation

Description	In-network
Pulmonary	$30 per visit no **deductible** applies

Short-term rehabilitation services

The limitations shown do not apply to mental health conditions treatment.

Spinal manipulation

Description	In-network
At the **physician** office	$25 per visit no **deductible** applies
At facility that is not a **hospital**	$25 per visit no **deductible** applies
At **hospital** outpatient department	$25 per visit no **deductible** applies

Visit limit per day	1
Visit limit per year	20

Physical, occupational and speech therapies

Description	In-network
At the **physician** office	$20 per visit no **deductible** applies
At facility that is not a **hospital**	$20 per visit no **deductible** applies
At **hospital** outpatient department	$20 per visit no **deductible** applies

Visit limit per day	1
Visit limit per year	60

Cognitive rehabilitation

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

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

Sickle cell anemia

Description	In-network
Medical expenses and **prescription** drugs for treatment	Covered based on type of service and where it is received

Skilled nursing facility

Description	In-network
Inpatient services – **room and board**	$250 per admission

	no **deductible** applies

Day limit per year (Does not apply to **mental health conditions**)	unlimited

Other inpatient services and supplies	No charge

Tests, images and labs - outpatient

Diagnostic complex imaging services

Description	In-network
At facility that is not a **hospital**	$30 per visit no **deductible** applies
At **hospital** outpatient department	$30 per visit no **deductible** applies

Diagnostic lab work

Description	In-network
At facility that is not a **hospital**	$0 per visit no **deductible** applies
At **hospital** outpatient department	$0 per visit no **deductible** applies

Diagnostic x-ray and other radiological services

Description	In-network
At facility that is not a **hospital**	$0 per visit no **deductible** applies
At **hospital** outpatient department	$0 per visit no **deductible** applies

Therapies

Chemotherapy

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

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

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

Infusion therapy

Outpatient services

Description	In-network
In **physician** office	$30 per visit
	no **deductible** applies

At an infusion location	$100 per visit
	no **deductible** applies
In the home	$30 per visit
	no **deductible** applies
At **hospital** outpatient department	$100 per visit
	no **deductible** applies
At facility that is not a **hospital**	$100 per visit
	no **deductible** applies

Radiation therapy

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

Transplant services

Description	Network (IOE facility)
Inpatient services and supplies	$250 per admission
	no **deductible** applies

Urgent care services

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

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

Description	In-network
Urgent care facility	$30 per visit
	no **deductible** applies
Complex imaging and radiology services	No charge
Lab services	No charge
Non-urgent use of an urgent care facility or **provider**	Not covered

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Adult vision care

Description	In-network
Adult vision exam	$30 per visit

	no **deductible** applies

Limit	Limited to covered persons age 19 and older

Visit limit	1 every 24 months

Pediatric vision care

Description	In-network
Pediatric vision exam	$30 per visit

	no **deductible** applies

Limit	Limited to covered persons through the end of the month in which the person turns 19

Visit limit	1 every 24 months

Walk-in clinic

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

Description	In-network
Non-emergency services	$20 per visit

	no **deductible** applies

Preventive immunizations	$0 per visit no **deductible** applies
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician**
Screening and counseling services	$0 per visit no **deductible** applies
Screening and counseling limits	See the *Preventive care services* section of the SOB

Weight management surgery

Description	In-network
Inpatient **hospital** (includes surgical procedure and acute **hospital** services)	$250 per admission

	no **deductible** applies

Outpatient weight management services performed at a **specialist** office	$30 per visit

	no **deductible** applies

Outpatient weight management services performed in a **hospital** outpatient facility	$0 per visit
	no **deductible** applies
Outpatient weight management services performed in a facility other than a **hospital** outpatient facility	$0 per visit
	no **deductible** applies