Re: Group Number 0285654

We are forwarding an electronic file containing your plan documents. Members may access benefit information by registering for and using your member website.

Your use of the documents in this medium shall signify your agreement not to alter or change their content in any way without the express consent of Aetna, and your agreement to indemnify and hold Aetna harmless for all loss, liability, damage, expense, cost, or other obligation which Aetna may incur or be required to pay as a result of any claim, demand, or lawsuit brought by any party (including yourself) arising from or in connection with any unauthorized changes.

If you have any questions, please contact your Account Manager.

We appreciate your business.

Sincerely,

aetna*

* Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Those companies include:
Aetna Health Inc., Aetna Health Insurance Company of New York and Aetna Health Insurance Company.

AETNA HEALTH INC.

Group agreement

The HMO agreement is by and between

AETNA HEALTH INC.
(**Aetna**, we, us, or our)
and
STATE OF IL (STATE HNO)
(**Contract holder**, you, or your)

Group agreement number:	0285654
Effective date:	July 01, 2022
Contract situs:	Illinois

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 agreement:	The initial term shall be the 12 consecutive month period beginning on the **effective date**. Subsequent terms shall be the 12 consecutive month period beginning with the **renewal date**.
Premium due dates:	The **effective date** and the 1st day of each succeeding calendar month.

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

This Group agreement is governed by applicable federal law and the laws of Illinois.

By: Gregory S. Martino

Gregory S. Martino
Vice President

Table of contents

The HMO agreement

The HMO agreement consists of several documents taken together. The documents listed constitute the entire contract of insurance. No change is valid unless approved by an executive officer of the company and included in this group policy. 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

STATE OF IL (STATE HNO) 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 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 apply a premium discount when multiple lines of Aetna products are sold as part of a bundle. Premium discounts are reflected in the Final Rates for the applicable product(s).

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 30 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.

We may also recover from you the costs of collecting any unpaid premium, including reasonable attorney fees and costs of suit.

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 10 days prior written notice to you of the requirement for the repayment of the waived premium.

Fees for special services and assessments

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 30 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.

Assessments
We may charge you a pro rata allocation of any assessments we receive for state high risk pools and other state programs.

Fees and assessments – when due
Fees and assessments 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 and assessments – how billed and paid
We may bill you electronically. You shall pay fees and assessments 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 and assessments – overdue amounts
You shall pay us interest on the total amount of fees and assessments that is overdue. Overdue fees and assessments 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.

We may also recover from you the costs of collecting any unpaid fees and assessments, including reasonable attorney fees and costs of suit.

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 if you request it.

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 laws. 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 and upon our request, that you have distributed them and will distribute them consistent with the 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 the 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 the ACA requirements 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 ACA. 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 end as of the last day of the grace period if you have not paid us all premiums and fees and assessments due as of the beginning 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

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.

If a **covered person** is terminated for any of the above reasons but wishes to be reinstated, reinstatement is not automatic. Reapplication is required and a reinstatement fee may be charged.

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:

- 2 weeks of your receipt of the request
- 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 not continue coverage on and after the **renewal date** and:

- You owe us any unpaid premium
- We owe you a refund if you overpaid 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, **covered persons**, 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, **covered persons**, and we also continue to be responsible for your, their, and our duties that the HMO agreement states are to occur following termination.

You, **covered persons**, 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.

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
- The **covered person** has the right to a third-party review conducted by an independent external 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 federal and state laws call 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 negligence, breach of the HMO agreement, breach of applicable federal and state laws, 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 or
- 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 laws that apply 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 if possible so it complies with applicable federal and state laws.

If the HMO agreement omits or misstates any right or duty under applicable federal and state laws, 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 writing to which we both consent.

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

We may amend the HMO agreement by notice. We must give you 90 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 federal and state laws

Payment of the applicable premium on the **effective date** of any 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.

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 make 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
- 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:
STATE OF IL (STATE HNO)
801 SOUTH 7TH ST, 6TH FL ANNEX
SPRINGFIELD, IL 62794

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 the HMO agreement 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- 800-370-4526.

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- 800-370-4526.
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- 800-370-4526.

Para acceder a los servicios de idiomas sin costo, llame al 1- 800-370-4526. (Spanish)

如欲使用免費語言服務，請致電 1- 800-370-4526。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1- 800-370-4526. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1- 800-370-4526. (Tagalog)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó kojį' hólne' 1- 800-370-4526. (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1- 800-370-4526 an. (German)

Për shërbime përkthimi falas për ju, telefononi 1- 800-370-4526. (Albanian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1- 800-370-4526 ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1- 800-370-4526. (Arabic)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1- 800-370-4526 հեռախոսահամարով: (Armenian)

Kugira uronke serivisi z'indimi atakiguzi, hamagara 1- 800-370-4526 (Bantu)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে এই নম্বরে টেলিফোন করুন: 1- 800-370-4526। (Bengali)

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1- 800-370-4526. (Bisayan-Visayan)

သင့်အနေဖြင့် အခကြေးငွေ မပေးရဲ့ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1- 800-370-4526 သို့ ဖုန်းခေါ်ဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1- 800-370-4526. (Catalan)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1- 800-370-4526. (Chamorro)

ᏩᎩᏍᏗ ᏚᎾᏂᎯᏍᏗ ᎤᏩᏫᏯᏁᏗ Ꮭ ᎪᎢᏍᏗ ᏗGEGWᏁᏗ ᎯᎩ, ᏫᏥᎯᏏᎳᏓ 1- 800-370-4526. (Cherokee)

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1- 800-370-4526. (Choctaw)

Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1- 800-370-4526. (Cushite-Oromo)

Voor gratis toegang tot taaldiensten, bell 1- 800-370-4526. (Dutch)

Pou jwenn sèvis lang gratis, rele 1- 800-370-4526. (French Creole-Haitian)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1- 800-370-4526. (Greek)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1- 800-370-4526. (Gujarati)

No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1- 800-370-4526. Kāki 'ole 'ia kēia kōkua nei. (Hawaiian)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1- 800-370-4526 पर कॉल करें। (Hindi)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1- 800-370-4526. (Hmong)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1- 800-370-4526. (Ibo)

Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1- 800-370-4526. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1- 800-370-4526. (Indonesian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1- 800-370-4526 (Italian)

言語サービスを無料でご利用いただくには、1- 800-370-4526 までお電話ください。(Japanese)

လာတ်ကမၤနှၢ်ကျိဉ်အတ်မၤစၢၤအတ်ဖံးတ်မၤတဖျဉ်လၢတအိဉ်ဒီးအပူၤလၢကဘဉ်ဟူဉ်အီၤအဂီၢ်ဘဉ်နှဉ် ကိး: 1- 800-370-4526 တက့ၢ်. (Karen)

무료 언어 서비스를 이용하려면 1- 800-370-4526 번으로 전화해 주십시오. (Korean)

Mɨ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́uń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1- 800-370-4526. (Kru-Bassa)

بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1- 800-370-4526. (Kurdish)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ສຽຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບ 1- 800-370-4526. (Laotian)

कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1- 800-370-4526 वर फोन करा. (Marathi)

Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1- 800-370-4526. (Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1- 800-370-4526. (Micronesian-Pohnpeian)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលតតិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1- 800-370-4526។ (Mon-Khmer, Cambodian)

निःशुल्क भाषा सेवा प्राप्त गर्न 1- 800-370-4526 मा 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- 800-370-4526. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring 1- 800-370-4526. (Norwegian)

Um Schprooch Services zu griege mitaus Koscht, ruff 1- 800-370-4526. (Pennsylvania Dutch)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1- 800-370-4526 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1- 800-370-4526 (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1- 800-370-4526. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਨਿਾਂ ਕਸਿੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1- 800-370-4526 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apelați 1- 800-370-4526. (Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1- 800-370-4526. (Russian)

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1- 800-370-4526. (Samoan)

Za besplatne prevodilačke usluge pozovite 1- 800-370-4526. (Serbo-Croatian)

Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1- 800-370-4526. (Sudanic-Fulfulde)

Kupata huduma za lugha bila malipo kwako, piga 1- 800-370-4526. (Swahili)

(Syriac-Assyrian) 1- 800-370-4526

మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1- 800-370-4526 కు కాల్ చేయండి. (Telugu)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1- 800-370-4526 (Thai)

Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1- 800-370-4526. (Tongan)

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1- 800-370-4526. (Trukese)

Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1- 800-370-4526 numarayı arayın. (Turkish)

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1- 800-370-4526. (Ukrainian)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1- 800-370-4526. پر بات کریں۔ (Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1- 800-370-4526. (Vietnamese)

צו צוטריט שפּראַך באַדינונגען אין קיין פּריַז צו איר, רופן 1- 800-370-4526. (Yiddish)

Lati wọnú awọn isẹ èdè l’ọfẹ fun ọ, pe 1- 800-370-4526. (Yoruba)

Open Access Health Network Only

Health maintenance organization (HMO)
Certificate of coverage

Prepared exclusively for:
Contract holder: STATE OF IL (STATE HNO)
Contract holder number: 0285654
Group agreement effective date: July 01, 2022
Plan effective dates: July 01, 2022

Underwritten by Aetna Health Inc. in the State of Illinois

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

Your plan includes the Aetna concierge program. It provides immediate access to consultants trained in the specific details of your plan.

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 the Aetna website.

Wellness and other rewards

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

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

Coverage and exclusions

Providing covered services

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

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

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

- **Physician** care generally is covered but **physician** care for cosmetic **surgery** is never covered. This is an exclusion.
- Home health care is generally covered but it is a **covered service** only up to a set number of visits a year. This is a limitation.
- 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 acupuncture services provided by a **physician**, if the service is provided as a form of anesthesia in connection with a covered **surgical procedure**.

The following are not **covered services**:

- Acupuncture, other than for anesthesia
- Acupressure

Ambulance services

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

Emergency

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

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

Non-emergency

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

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

The following are not **covered services**:

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

Applied behavior analysis

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

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

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

Autism spectrum disorder

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

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

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

Covered services include therapeutic care, including the behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:

- Self-care and feeding
- Pragmatic, receptive and expressive language
- Cognitive functioning
- Applied behavioral analysis, intervention and modification
- Motor planning
- Sensory processing

Behavioral health

Mental health treatment

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

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

- Neuropsychological testing
- Observation
- Peer counseling support by a peer support specialist

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

Substance related disorders treatment

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

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

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

Breast cancer treatment

Covered services include medically necessary pain medication and pain therapy related to the treatment of breast cancer.

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 or investigational therapies

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

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

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

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

Diabetic services, supplies, equipment, and education

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
- Education
- Self-management training provided by a health care **provider** certified in diabetes self-management training

Dental care anesthesia

Covered services include anesthesia for dental care that your doctor has certified cannot be performed in the dentist's office due to age or condition of the covered person.

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
- Cardiopulmonary monitors when **medically necessary.**

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

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

Covered services also include:

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

The following are not **covered services**:

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

Emergency services

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

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

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

The following are not **covered services**:

- Non-emergency care in a **hospital** emergency room

Fibrocystic breast condition

Covered services include the diagnosis and medical treatment of fibrocystic breast conditions by a **provider.**

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.

Habilitation therapy services

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

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

Outpatient physical, occupational, and speech therapy

Covered services include:

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

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

The following are not **covered services**:

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

Hearing aids

Eligible health services include hearing instruments and related hearing aid services when prescribed by a hearing care professional as described below:

Hearing instrument means:

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

Hearing aid services include:

- Audiological exam
- Selection, fitting and adjustment of ear molds
- Hearing instrument repairs

Eligible health services also include bone anchored hearing aids and cochlear implants.

The following are not covered under this benefit:

- Hearing aids for adults except as described above
- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 24 month period
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any hearing aid prescribed by someone other than a hearing care professional
- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries and auxiliary equipment.
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

Home health care

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

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

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

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

The following are not **covered services**:

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

Hospice care

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

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

The following are not **covered services**:

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

Hospital care

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

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

The following are not **covered services**:

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

Infertility services

Covered services include seeing a **provider**:

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

What do you need to know about your infertility and ART services benefit?

Read this section carefully so that you know:

- How to find a network **infertility** and ART **specialist** and facility
- How your plan works
- **Covered services** under your plan

How to find a network infertility and ART specialist and facility

You can find a network infertility and ART specialist and facility in several ways:

- Online: By logging onto https://www.aetna.com
- From our National infertility unit (NIU): Our NIU can provide you with information about our Institutes of Excellence infertility facilities. You can reach our dedicated NIU at 1-800-575-5999

How your plan works

The first step to using your comprehensive infertility or ART health care services is enrolling with our NIU. To enroll you can reach our dedicated NIU at 1-800-575-5999.

What are ART services?

ART services are more advanced medical procedures or treatments performed to help a woman achieve pregnancy.

ART services include:

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

Who is eligible for infertility or ART services?

You are eligible for coverage if:

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

How can we help?

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

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

Eligible comprehensive infertility health services under your plan

So what **infertility** services does the plan cover? Any **infertility** service that meets these requirements:

- They are listed as covered in the *Coverage and Exclusions* section
- They are not beyond any limits in the schedule of benefits

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

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

Who is eligible for ART services?

- You have exhausted the comprehensive **infertility** services benefits or have clinical need to move on to ART procedures based on our clinical policy bulletin

Who is eligible for fertility preservation benefits?

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 only when you:

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

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

- You, your partner or dependent child has 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 reasonably likely to result in a successful pregnancy by meeting the criteria below:

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

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

Eligible ART health services under your plan

So what ART services does the plan cover? Any ART service that meets these requirements:

- They are listed as covered in the *Coverage and Exclusions* section
- They are not beyond any limits in the schedule of benefits

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

- Any combination of the following ART services subject to cycle and dollar maximums shown on the schedule of benefits below:
  - In vitro fertilization (IVF)*
  - Uterine embryo lavage
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Low tubal ovum transfer (LTOT)
  - Cryopreserved embryo transfers (Frozen Embryo Transfer (FET))
  - **Prescription drug** therapy used during an oocyte retrieval cycle
- 4 complete oocyte retrieval cycles, unless a live birth follows a completed oocyte retrieval cycle, in which case 2 more oocyte retrieval cycles will be covered
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. The embryo transfer itself is not covered
- Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you
- Medical costs of oocytes or sperm donors for ART procedures used to retrieve oocytes or sperm and includes the cost of the procedure used to transfer oocytes or sperm to the covered recipient. We will also cover associated donor medical expenses, established by us, as a prerequisite to donation
- The procedures are done while not confined in a **hospital** or any other facility as an inpatient

A “cycle” is an attempt at a particular type of **infertility** treatment (e.g. GIFT, ZIFT, cryopreserved embryo transfers). 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 a pregnancy, a cycle is considered completed 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) of eggs, embryos, or sperm. However, subsequent non-experimental or investigational procedures that use the cryopreserved eggs, embryos or sperm are covered.
- Travel costs within 100 miles of your home or travel cost not required by Aetna.
- Treatment for covered dependents under age 18
- Non-medical costs of an egg or sperm donor
- Selected termination of an embryo, unless the life of the mother would be in danger if all embryos were carried to full term

- **Experimental** or **investigational** treatment as determined by the American Society for Reproductive Medicine
- Services to the surrogate. If you choose to use a surrogate, this does not apply to the cost for procedures to obtain the eggs, sperm or embryo from a covered individual.

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

Covered services also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

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

Nutritional support

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

Covered services include:

- Amino acid-based formula products ordered by a **physician** for the treatment of eosinophilic disorders or short bowel syndrome, regardless of the delivery method
- 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
- 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
  - Medical foods
  - Other nutritional items

  even if it is the sole source of nutrition.

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**

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

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

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

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

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

Physician surgical services

Covered services include the services of:

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

The following are not **covered services**:

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

Preventive care

Preventive **covered services** are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing,

you may pay more as these services aren't preventive. If a **covered service** isn't listed here under preventive care, it still may be covered under other **covered services** in this section. For more information, see your schedule of benefits.

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

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

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

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

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

Breast-feeding support and counseling services

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

Breast pump, accessories and supplies

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

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

Counseling services

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

- Alcohol or drug misuse
  - Preventive counseling and risk factor reduction intervention
  - Structured assessment
- Genetic risk for breast and ovarian cancer
- Obesity and healthy diet
  - Preventive counseling and risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- Sexually transmitted infection
- Tobacco cessation
  - Preventive education and counseling to help stop using tobacco products
  - Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked
  - Treatment visits
  - Class visits

Family planning services – female contraceptives

Covered services include family planning services as follows:

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

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

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

Immunizations

Covered services include preventive immunizations for infectious diseases.

Doses, recommended ages and recommended population vary.

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

- Inactive poliovirus
- Rotavirus

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
- Expanded tobacco intervention and counseling for pregnant tobacco users

Routine cancer screenings

Covered services include the following routine cancer screenings:

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

- Lung cancer screenings: adults age 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 **years**
- 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 for everyone ages 15-65 and other ages at increased risk
  - High risk human papillomavirus (HPV) DNA testing for women
  - Screening for diabetes (type 2) for adults with high blood pressure
  - Bone density screenings for osteoporosis
  - Aspirin use to prevent cardiovascular disease for men and women of certain ages
  - Blood pressure screening
  - Cholesterol screening for adults of certain ages of at higher risk
  - Depression screening
  - Hepatitis C screening for:
    - Adults at increased risk
    - 1 time for everyone born 1945-1965
  - Hepatitis B screening for adults and adolescents ages 11-17 at high risk. This includes:
    - People from countries with 2% or more hepatitis B prevalence
    - U.S. born people not vaccinated as infants and with at least 1 parent born in a region with 8% or more hepatitis B prevalence
  - Fall prevention
  - Latent tuberculosis infection screening for populations at increased risk
  - Skin cancer behavioral counseling

Covered services include:

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

Well child preventive visits

Covered services include routine:

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

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 annual Pap smears including surveillance tests for ovarian cancer for women at risk for ovarian cancer.
- Preventive care breast cancer (BRCA) gene blood testing
- Clinical breast exams as follows:
  - For women over 20 **years** of age but less than 40, at least every 3 **years**
  - For women 40 **years** of age and older, annually
- Breast cancer chemoprevention counseling
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk
- HIV screening and counseling for sexually active women
- Osteoporosis screening for women over age 60 depending on risk factors
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

Covered services for pregnant women or women who may become pregnant include:

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

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

The following are not **covered services**:

- Services covered under any other benefit
- 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 or implant removal
- Prostheses
- A physician office visit or in-home nurse visit within 48 hours after discharge

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

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation services

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

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

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

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

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

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

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

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

The following are not **covered services**:

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

Skilled nursing facility

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

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

Tests, images and labs – outpatient

Diagnostic complex imaging services

Covered services include:

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

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

Diagnostic x-ray and other radiological services

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

Therapies – chemotherapy, 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**.

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.

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

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.

You must get transplant services from the IOE facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the network **copayment**, **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, they will not be **covered services**.

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

The following are not **covered services**:

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

Urgent care services

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

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

Walk-in clinic

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

- Scheduled and unscheduled visits for illnesses and injuries that are not **emergency medical conditions**
- Preventive care immunizations administered within the scope of the clinic's license
- Individual screening and counseling services that will help you:
  - With obesity or healthy diet
  - To stop using tobacco products

General plan exclusions

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

Behavioral health treatment

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

- **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions, Preventive care* section
- Pathological gambling, kleptomania, and pyromania
- Specific developmental disorders of scholastic skills (Learning Disorders/Learning Disabilities)
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language
- Other disorders of psychological development

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

Examples of these are:

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

Cosmetic services and plastic surgery

Any treatment, **surgery** (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons, except where described in *Coverage and exclusions* under the *Reconstructive breast surgery and supplies* and *Reconstructive surgery and supplies* sections

Court-ordered services and supplies

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

Custodial care

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

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

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

Educational services

Examples of these are:

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

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Foot care

Non-diabetic services and supplies for the following:

- The treatment of calluses, bunions, toenails, hammertoes or fallen arches
- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
- Supplies (including orthopedic shoes), ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies

Growth/height care

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

Hearing exams

Hearing exams performed for the evaluation and treatment of illness, injury or hearing loss.

Jaw joint disorder treatment

Surgical and non-surgical medical and dental services, and 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

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, step-child, brother, sister, in-law, or any household member

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

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

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

This exclusion does not include **surgery** and prosthetic devices for erectile dysfunction resulting from:

- Natural causes
- Trauma
- Infection
- Congenital disease or defects

Strength and performance

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

Telemedicine

- Services given when you are not present at the same time as the **provider**
- Telephone calls
- **Telemedicine** kiosks

- Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

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

Treatment in a federal, state, or governmental entity

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

Voluntary sterilization

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

Wilderness treatment programs

See *Educational services* in this section

Work related illness or injuries

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

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

How your plan works

How your plan works while you are covered

Your 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. You can find **network providers** and see important information about them most easily on our online **provider** directory. Just log in to the Aetna website.

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 transplant services. See the *Who provide 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 the 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

If a **provider** stops participation with Aetna and provides us with notice, we will provide you with 60 day advance notice. If the **provider** notifies us in less than 60 days, we will immediately notify you of the termination.

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.

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

Precertification

You need pre-approval from us for some **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**. 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.

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

To obtain **precertification**, contact us. You, 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, where required by state law. An approval is valid for 180 days as long as you remain enrolled in the plan.

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

If you or your **provider** request **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. Visit our website at https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html or contact us to get a list of the services that require **precertification**. The list may change.

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**.

Certain **prescription** drugs are covered under the medical plan when they are given to you by your doctor 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**.

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

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

Sometimes you or your **provider** may ask for a medical exception to request coverage for a **prescription drug** that is:

- Not covered
- Discontinued (for reasons other than safety or drug manufacturer withdrawal)
- Ineffective in the treatment of your disease or medical condition
- Likely to be ineffective or adversely affect the drug's effectiveness or patient compliance based on:
    - Your known relevant physical and mental characteristics
    - The known characteristics of the drug regimen from a step therapy requirement or dosage limitation

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

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

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

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 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**.
- 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

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

You pay the entire expense when:
- You get services or supplies that are not **medically necessary**.
- Your plan requires **precertification**, your **physician** requests it, we deny it and you get the services without **precertification**.
- You get care 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** and **copayments**.

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

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

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

How COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
    - We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
    - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
    - Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
        - The amount that the secondary plan saved due to COB
        - Used to cover any unpaid allowable expenses
        - Erased at the end of the year

Determining who pays

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

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

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

How COB works with Medicare

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

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

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

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

Our rights
We have the right to:

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

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

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

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

If benefits are not paid within 30 days after proof of loss is received, the network provider is entitled to 9% interest. Interest will be calculated from the 30th day until the date the benefits are paid. However, interest less than $1 may not be paid.

Filing a claim

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

The benefit payment determination is made based on many things, such as your **deductible** or **copayment**, 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.

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

You may contact the Department of Insurance at any time. However, you are encouraged to contact us before filing a complaint with the Illinois Office of Consumer Health Insurance. Complaints to the Office of Consumer Health Insurance may be submitted in the following ways:

- Online at https://mc.insurance.illinois.gov/messagecenter.nsf
- By email at consumer_complaints@ins.state.il.us
- By fax to (217) 558-2083
- Office of Consumer Health Insurance hotline telephone number: (866) 445-5364
- By mail to:
  Office of Consumer Health Insurance
  320 W. Washington Street
  Springfield, IL 62767

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 give you an answer within 36 hours for an urgent appeal and within 15 days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

Any other claim appeal

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

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

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by 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

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

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

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

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

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

Exhaustion of appeal process

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

- Contact the Illinois Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Illinois Department of Insurance
- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding
- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
- You filed an appeal under the internal appeal process and we did not provide a written decision within:
    - 30 days from the date you filed an appeal of a concurrent or pre-service claim
    - 60 days from the date you filed an appeal of a post-service claim except to the extent you agreed to a delay
- You filed a request for an expedited internal review and we did not provide a decision within 48 hours, except to the extent you requested or agreed to a delay
- Your provider certifies in writing that the recommended health care service or treatment is experimental or investigational and would be significantly less effective if delayed
- We did not follow all of the claim determination and appeal requirements of the state. But you will not be able to proceed directly to external review if:
    - The rule violation was minor and not likely to influence a decision or harm you
    - The violation was for a good cause or beyond our control
    - The violation was part of an ongoing, good faith exchange between you and us

External review

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

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

- Your claim is denied, reduced or terminated because we determined that it was **experimental or investigational** or it did not meet our requirements for:
    - **Medical necessity**
    - Appropriateness
    - Health care setting
    - Level of care
    - Effectiveness
- Coverage was rescinded. This does not include a cancellation of coverage due to failure to pay any required contribution
- You have received an adverse benefit determination

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

You must submit the request for external review form:

- To the Illinois Department of Insurance
- Within 123 calendar days of the date you received the final adverse determination from us
- With a copy of the notice from us, along with any other important information that supports your request

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

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

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 West Washington Street, 4th Floor
Springfield, Illinois 62767
Toll-free telephone number: (877) 527-9431
E-mail: http://insurance.illinois.gov/ExternalReview/ExternalReviewMain.html

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

The Illinois Department of Insurance will:

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

The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have 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

How long will it take to get an ERO decision?

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

Sometimes you can get a faster external review decision.

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

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
- 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

Upon receipt from the Department of Insurance, we will respond to the eligibility request for an external review within 24 hours. Once assigned to an ERO, a decision will be made within 72 hours.

Recordkeeping

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

Fees and expenses

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

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
- 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. A child residing with you because of a temporary court order is considered an adopted child
    - Foster children
    - Children you are responsible for under a qualified medical support order or court order
    - Your military veteran dependent child (your own or those of your spouse/civil union partner or domestic partner) who:
      - Is a resident of Illinois
      - Is under age 30
      - Served as a member of the active or reserve component of the Armed Forces of the United States, including the Illinois National Guard
      - Received a discharge release, other than a dishonorable discharge

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
- 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.

You can also enroll in these situations:

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

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 maximum benefit.
  - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your 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) rights

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.
Only the medical condition which caused the total disability is covered during your extension.

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 only for services and supplies related to the disabling condition until the earliest of:

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

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

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

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

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

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

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

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

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

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

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

How you can extend coverage for a dependent 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 30 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 the 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.

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

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

- Your marriage ends
- You retired or died

To extend coverage, your former spouse must:

- Apply for continuation of coverage
- Pay the required **premium** within 30 days of the date they receive notice of the right to continue

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

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

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

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

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

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

Discount arrangements

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

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

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

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:

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

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage:

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

Some other money issues

Assignment of benefits

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

Financial sanctions exclusions

If coverage provided under this 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. If we don't do that, we have the right to reduce any future benefit payments by the amount we paid by mistake.

Right of Recovery

Subrogation

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

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

- Information or assistance
- Documentation

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

Reimbursement

If you recover expenses for an **illness** or **injury** that was due to the negligence of a third party, **Aetna** has the right to first reimbursement for all benefits we paid. This includes any and all damages collected from the negligent third party for those expenses by you (or your parents if you are a minor or your legal representative) as a result of that **illness** of **injury**, whether by:

- Action at law
- Settlement
- Compromise

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

- Information or assistance
- Documentation

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

Your health information

We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your 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 and **substance related disorders** in the state where the person practices.

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

Copay, copayment
A dollar amount or percentage paid by a covered person for a **covered service**.

Covered service
See *Coverage and exclusions – Providing covered services*.

Deductible
The amount a covered person pays for **covered services** per year before we start to pay.

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

Drug guide
A list of **prescription** drugs and devices established by us or an affiliate. It does not include all **prescription** drugs and devices. This list can be reviewed and changed by us or an affiliate. 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, available 7 days a week and 24 hours a day. This includes evaluation of and treatment to stabilize the **emergency medical condition**. This also includes transportation services, including but not limited to **ambulance** services.

Experimental or investigational

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

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

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

Formulary exclusions list

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

Generic prescription drug

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

- Dosage
- Safety
- Strength
- Quality
- Performance

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

- The inability to:
  - Conceive after 1 **year** of unprotected heterosexual sexual intercourse or 6 months of unprotected heterosexual sexual intercourse if the female partner is over age 35
  - Conceive after 1 **year** or attempts to produce conception
  - Conceive after diagnosed with a condition affecting fertility
  - Sustain a successful pregnancy
- A disease defined by the failure to become pregnant:
  - For an individual or their partner who has been clinically diagnosed with gender identity disorder

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

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 other carrier.

Maximum out-of-pocket limit

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

This is the most you will pay per year in **copayments**, **coinsurance** and any **deductible**, if one applies, for **eligible health services** as listed in the schedule of benefits. Discounts, coupons, or other amounts from third parties, including manufacturer coupons and discount prescription card programs, for prescription brand drugs that have no generic equivalent may count towards the annual limitation on cost sharing.

Medically necessary, medical necessity

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

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

Generally accepted standards of medical practice means:

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

Mental health disorder

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

Negotiated charge

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

Network provider

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

Out-of-network provider

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

Physician

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

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 person from the list of **PCP**s in the directory
- Supervises, coordinates and provides initial care and basic medical services to a 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.

Psychiatric hospital

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

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 or **substance related disorder** residential treatment programs. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

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

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

For substance related residential treatment programs:

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

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

- An R.N. must be onsite 24 hours/day for 7 days/week within a residential setting

- Residential care must be provided under the direct supervision of a **physician**

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

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

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

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

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

Skilled nursing facility does not include institutions that provide only:

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

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

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

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

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

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

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

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

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

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

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

Telemedicine
A consultation between you and a **provider** who is performing a clinical medical or behavioral health service that can be provided electronically by:

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

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

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

Value prescription drugs

A group of medications determined by us that may be available at a reduced **copayment** and are noted on the **drug guide**.

Year

Year may refer to a contract year, calendar year, or plan year depending on your plan type.

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

AETNA HEALTH INC.

Amendment

Contract holder: STATE OF IL (STATE HNO)

Amendment effective date: 07/01/2022

Your group agreement has changed. The certificate of coverage is revised to reflect this. This change is effective on the date shown above.

The *Wellness and other rewards* section of your certificate of coverage is replaced by the following:

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

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

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.

Notice Of Protection Provided By

Illinois Life And Health Insurance Guaranty Association

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage, pay claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations .

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
  $300,000 for death benefits
  $100,000 for cash surrender or withdrawal values
- Health Insurance
  $500,000
- for health benefit plans
  $300,000 for disability insurance benefits
  $300,000 for long-term care insurance benefits
  $100,000 for other types of health insurance benefits
- Annuities
  $250,000 for withdrawal and cash values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health Insurance Guaranty Association
901 Warrenville Road, Suite 400
Lisle, Illinois 60532-4324.

Illinois Department of Insurance
320 West Washington Street 4th Floor
Springfield, Illinois 62767

Insurance companies, health maintenance organizations and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company or health maintenance organization, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

The Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.

AETNA HEALTH INC. Rider

Obesity surgery

Rider effective date: July 01, 2022

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

What you need to know about obesity surgery benefit

Read this rider carefully so you will know:

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

How to find an obesity surgical facility

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

Coverage and exclusions

Covered services

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

Covered services include:

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

Exclusions

The following are not **covered services:**

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

What precertification requirements apply

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

Where your schedule of benefits fits in

How you share in the cost

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

How your cost share works

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

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

Covered services

Obesity surgery

Description	In-network
Inpatient services – **room and board**	$425 per admission
	no **deductible** applies

Outpatient obesity surgery services

Description	In-network
At **specialist** office	$35 per visit
	no **deductible** applies
At **hospital** outpatient department	$425 per visit no **deductible** applies
At facility that is not a **hospital**	$425 per visit no **deductible** applies

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

Aetna Health Inc. Rider

Prescription drug plan

Rider effective date: July 01, 2022

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**. We exclude **prescription** drugs listed on the **formulary exclusions list** unless we approve a medical exception. If it is **medically necessary** for you to use a **prescription** drug that is not on this **drug guide**, you or your **provider** must request a medical exception. See the *Requesting a medical exception* section for more information.

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, up to a 12 month supply at one time. 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.

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**.

Epinephrine injectors

Eligible health services include **medically necessary** epinephrine injectors for individuals age 18 and younger. An epinephrine injector includes an auto-injector and pre-filled syringe approved for the administration of epinephrine by the U.S. Food and Drug Administration (FDA).

Immunizations
Covered services include preventive immunizations as required by the 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

Sexual dysfunction or enhancement drugs
Covered services include **prescription** drugs for the treatment of sexual dysfunction or enhancement. See the *Contact us* section for how to find the most up-to-date information on dosing.

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.

Treatment of tick-borne diseases
Eligible health services includes long-term antibiotic therapy, including office visits and ongoing testing, for a tick-borne disease when **medically necessary** and ordered by a **physician** after making a thorough evaluation of your:

Symptoms
Diagnostic test results
Response to treatment

"Long-term antibiotic therapy" is the administration of oral, intramuscular or intravenous (IV) antibiotics singly or in combination for periods of time longer than 4 weeks. **Experimental or investigational drugs** and off-label **prescription drugs** may be used when approved by the U.S. Food and Drug Administration (FDA).

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**
- Dietary supplements including medical foods and amino acid based elemental formulas
- Drugs or medications
    - Administered or entirely consumed at the time and place they are prescribed or provided
    - Which do not require a **prescription** by law, even if a **prescription** is written
    - That include the same active ingredient or a modified version of an active ingredient as a covered **prescription** drug unless we approve a medical exception
    - That are therapeutically the same or an alternative to a covered **prescription** drug, unless we approve a medical exception
    - That are therapeutically the same or an alternative to an OTC drug unless we have approved a medical exception
    - Not approved by the FDA or not proven safe or effective
    - Provided under your medical plan while inpatient at a healthcare facility
    - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee
    - 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, the use of or intended use of which is illegal, unethical, imprudent, abusive, not **medically necessary** or otherwise improper and drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- Treatment, drug, service or supply to stop or reduce smoking or the use of tobacco products or to treat or reduce nicotine addiction, dependence or craving including medications, nicotine patches and gum unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

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.

All **specialty prescription drug** fills including the initial fill must be filled at a network **specialty pharmacy** unless it is an urgent situation.

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**, 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**.

Step therapy is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. You will find **step therapy prescription** drugs in the **drug guide**.

See the *Contact us* section for how to get the most up-to-date **precertification** requirements and list of **step therapy** drugs.

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** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- You are responsible to pay any **deductibles** and **copayments**, 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.

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

How your prescription drug deductible works

Your **prescription** drug **deductible** is the amount you pay for **covered services** before the plan starts to pay. This schedule of benefits shows the **prescription** drug **deductible** that applies to your plan. Once you have met the **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments**, if any, for **covered services** after you meet your **deductible.**

How your cost share works

Your **copayment** 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	$3,000 per **year**
Family	$6,000 per **year**

General coverage provisions

This section explains the **deductible** and **maximum out-of-pocket limits** in this schedule.

Prescription drug deductible provisions

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

Individual prescription drug deductible

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

Family prescription drug deductible

You and your covered dependents pay for **covered services** each **year** before the plan begins to pay. After you reach this family **deductible**, this plan will begin to pay for **covered services** that you and your covered dependents have for the rest of the **year**.

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** 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.

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**.

This plan has an individual and family **prescription** drug **maximum out-of-pocket limit**.

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

Preferred generic prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$16
	after **deductible**
90 day supply at **retail pharmacy**	$10
90 day supply at a **mail order pharmacy**	$10
	after **deductible**

Preferred brand name prescription drugs

Description	In-network
30 day supply at **retail pharmacy**	$33
90 day supply at **retail pharmacy**	$82.50
90 day supply at a **mail order pharmacy**	$82.50
	after **deductible**

Non-preferred generic prescription drugs

Description	In-network
30 day supply at **retail pharmacy**	$57
90 day supply filled at **retail pharmacy**	$142.50
90 day supply at a **mail order pharmacy**	$142.50
	after **deductible**

Non-preferred brand name prescription drugs

Description	In-network
30 day supply at **retail pharmacy**	$57
90 day supply at **retail pharmacy**	$142.50

90 day supply at a **mail order pharmacy**	$142.50
	after **deductible**

Anti-cancer prescription drugs taken by mouth

Description	In-network
30 day supply at **retail pharmacy**	$0
90 day supply at **retail pharmacy**	$0
90 day supply at **mail order pharmacy**	$0
	after **deductible**

Contraceptives (birth control)

Brand name prescription drugs and devices are covered at 100% when a generic is not available

Description	In-network
90 day or 12 month supply of generic and OTC drugs and devices	$0
90 day or 12 month supply of **brand name prescription drugs** and devices	Paid based on the tier of drug in the schedule
	no **deductible** applies

Diabetic supplies, drugs and insulin

Description	In-network
30 day supply at **retail pharmacy** Insulin is limited to $100 per 30 day supply	Paid based on the tier of drug in the schedule
90 day supply at a **retail pharmacy**	Paid based on the tier of drug in the schedule
90 day supply at **mail order pharmacy**	Paid based on the tier of drug in the schedule
	after **deductible**

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.

	no **deductible** applies

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.

	no **deductible** applies

If you or your **provider** requests a covered **brand name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the generic drug and the brand name drug, plus the cost share that applies to the brand name drug. The cost difference does not apply toward your **prescription** drug **deductible** or **maximum out-of-pocket limit**.

Schedule of benefits

Prepared for:
Contract holder: STATE OF IL (STATE HNO)
Contract holder number: 0285654
HMO group agreement effective date: July 01, 2022
Plan name: Open Access Health Network Only
Plan effective date: July 01, 2022

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles** and **copayments**, if any, that 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** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- You are responsible to pay any **deductibles** or **copayments** if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits.
  See the schedule of benefits 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.

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

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

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 of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that **year**.

Contact us

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

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

Plan features

Maximum out-of-pocket limit

Maximum out-of-pocket type	In-network
Individual	$3,000 per **year**

Family	$6,000 per **year**

General coverage provisions

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

Copayment

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

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 **copayments** and **deductible**, if any, for **covered services**. **Covered services** that are subject to the **maximum out-of-pocket limit** may include those provided under the medical plan and the outpatient **prescription** drug plan.

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 SOB

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	Covered based on type of service and where it is received

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

Autism spectrum disorder

Description	In-network
Diagnosis and testing	$35 per visit
	no **deductible** applies
Treatment	$35 per visit
	no **deductible** applies
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	$0 per visit
	no **deductible** applies

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services-**room and board** including **residential treatment facility**	$425 per admission
	no **deductible** applies

Day limit per year	Unlimited days

Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** consultation	$35 per visit

	no **deductible** applies

Outpatient mental health **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	$0 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

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**
Coverage provided is the same as for any other illness

Description	In-network
Inpatient services – **room and board** during a **hospital stay**	$425 per admission

	no **deductible** applies

Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** consultation	$35 per visit

	no **deductible** applies

Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	$0 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

Clinical trials

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

Diabetic services, 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
Diabetic self-care programs	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network
DME	20% per item

	no **deductible** applies

Emergency services

Description	In-network
Emergency room	$275 per visit

	no **deductible** applies

Emergency services resulting from a criminal sexual assault or abuse	0% (of the **negotiated charge**) per visit 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	$0 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	$0 per visit
	no **deductible** applies
Limit	One per ear every 24 months One bone anchored hearing aid and cochlear implant per ear every 24 months consecutive period

Home health care

A visit is a period of 4 hours or less

Description	In-network
Home health care	$35 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.

Hospice care

Description	In-network
Inpatient services - **room and board**	$0 per admission
	no **deductible** applies
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 8-12 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8-12 hours a day.

Hospital care

Description	In-network
Inpatient services – **room and board**	$425 per admission
	no **deductible** applies
Other inpatient services	No charge

Infertility services

Description	In-network
Treatment of basic **infertility**	Covered based on type of service and where it is received
Comprehensive **infertility** - Inpatient **hospital** (**room and board**)	$425 per admission
	no **deductible** applies
Comprehensive **infertility** services – Other inpatient **hospital** care services and supplies (other than **room and board**)	$0 per admission

Outpatient comprehensive **infertility** services - Performed at an **infertility specialist** office	$35 per visit
	no **deductible** applies
Outpatient comprehensive **infertility** services - Performed in a **hospital** outpatient facility	$35 per visit
	no **deductible** applies
Outpatient comprehensive **infertility** services – Performed in a facility other than a **hospital** outpatient facility	$35 per visit
	no **deductible** applies
Advanced reproductive technology (ART) services - Inpatient **hospital** (**room and board**)	$425 per admission
	no **deductible** applies
ART services - Other inpatient **hospital** care services and supplies (other than **room and board**)	$0 per admission
Outpatient ART services - Performed at an ART **specialist** office	$35 per visit
	no **deductible** applies
Outpatient ART services - Performed in a **hospital** outpatient facility	$35 per visit
	no **deductible** applies
Outpatient ART services – Performed in a facility other than a **hospital** outpatient facility	$35 per visit
	no **deductible** applies
For treatment that includes oocyte retrieval, maximum number of retrievals	4, however if a live birth follows a completed oocyte retrieval, 2 additional egg retrievals will be covered.

Jaw joint disorder

Includes TMJ

Description	In-network
Jaw joint disorder treatment	Covered based on type of service and where it is received

Maternity and related newborn care

Includes complications

Description	In-network
Inpatient services – **room and board**	$425 per admission
	no **deductible** applies
Other inpatient services	No charge
Services performed in **physician** or **specialist** office or a facility	$0 per visit
	no **deductible** applies
Other services and supplies	Covered based on type of service and where it is received

Maternity and related newborn care important note:
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.

Nutritional support

Description	In-network
Nutritional support	$0 per item
	no **deductible** applies

Outpatient surgery

Description	In-network
At **hospital** outpatient department	$300 per visit no **deductible** applies
At facility that is not a **hospital**	$300 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)	$30 per visit
	no **deductible** applies
Immunizations that are not considered preventive care	Covered based on type of service and where it is received.
Physician visit during inpatient **stay**	$30 per visit
	no **deductible** applies
Physician home visit (not preventive)	$30 per visit
	no **deductible** applies
Physician surgical services	$30 per visit
	no **deductible** applies
Physician telemedicine consultation	$30 per visit
	no **deductible** applies

Specialist

Description	In-network
Specialist office hours (not surgical, not preventive)	$35 per visit
	no **deductible** applies
Specialist home visit (not preventive)	$35 per visit
	no **deductible** applies
Specialist surgical services	$35 per visit
	no **deductible** applies
Specialist telemedicine consultation	$35 per visit
	no **deductible** applies

Preventive care

Description	In-network
Preventive care services	$0 no **deductible** applies
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump
Counseling for alcohol or **substance related disorder** visit limit per day	1
Counseling for alcohol or **substance related disorder** visit limit per **year**	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
Counseling for tobacco cessation visit limit per day	1

Description	In-network
Counseling for tobacco cessation visit limit	8 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 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
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year 3 exams every 12 months age 1-2 3 exams every 12 months age 2-3 and 1 exam every 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 routine GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Prosthetic devices

Includes medical wigs

Description	In-network
Prosthetic devices	$0 per item
	no **deductible** applies
Limit per **year**	unlimited

Reconstructive surgery and supplies

Including breast **surgery**

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

Short-term rehabilitation services

Cardiac rehabilitation

Description	In-network
Cardiac rehabilitation	$35 per visit no **deductible** applies

Pulmonary rehabilitation

Description	In-network
Pulmonary	$35 per visit no **deductible** applies

Cognitive rehabilitation

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

Physical, occupational and speech therapies

Description	In-network
PT, OT and ST	$35 per visit
	no **deductible** applies
Visit limit per day	1
Visit limit per **year**	60

Spinal manipulation

Description	In-network
Spinal manipulation	$35 per visit
	no **deductible** applies

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

Any benefit maximum listed above does not apply to the treatment of autism spectrum disorders.

Skilled nursing facility

Description	In-network
Inpatient services – **room and board**	$0 per admission
	no **deductible** applies
Day limit per **year**	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** No additional expense, such as a **copayment** or **deductible** amount, will be imposed for mammograms	$30 per visit no **deductible** applies
At **hospital** outpatient department No additional expense, such as a **copayment** or **deductible** amount, will be imposed for mammograms	$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** No additional expense, such as a **copayment** or **deductible** amount, will be imposed for mammograms	$0 per visit no **deductible** applies
At **hospital** outpatient department No additional expense, such as a **copayment** or **deductible** amount, will be imposed for mammograms	$0 per visit no **deductible** applies

Therapies

Chemotherapy

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

Infusion therapy

Outpatient services

Description	In-network
In **physician** office	$35 per visit
	no **deductible** applies
At an infusion location	$300 per visit
	no **deductible** applies
In the home	$35 per visit
	no **deductible** applies
At **hospital** outpatient department	$300 per visit
	no **deductible** applies
At facility that is not a **hospital**	$300 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)	Out-of-network (Including **providers** who are otherwise part of Aetna's network but are non-IOE **providers**)
Inpatient services and supplies	$425 per admission	Not covered
	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	$35 per visit
	no **deductible** applies
Complex imaging, lab and radiology services	No charge
Non-urgent use of an urgent care facility or **provider**	Not covered

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	$30 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