



151 Farmington
Ave
Hartford, CT,
06156

Re: Group Number 0285657

We're sending you an electronic file with your plan documents

Thank you for doing business with Aetna. Enclosed are your plan documents. Here are a couple of other things to keep in mind as you review this material.

For your employees

Members can always find their benefit information on their member website. They can go to [Aetna.com](https://www.aetna.com) to log in or register. They may also contact us for a free paper copy.

We offer free aids and services for anyone with disabilities. If a member needs these services, have them call the number on their member ID card.

Have questions?

Contact your plan representative or account manager for help.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

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AETNA HEALTH INC.

Group agreement

The HMO group agreement is by and between

AETNA HEALTH INC. and
STATE OF IL (CIP HNO)
Contract holder

Group agreement number: 0285657
Effective date: July 01, 2026
Contract situs: Illinois

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

Term of the HMO group agreement:

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

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

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.

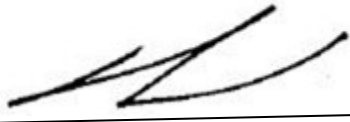
By: 
Edward C. Lee.
Vice President and Secretary

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The HMO group agreement

The HMO group agreement consists of the following documents:

- Your group application
- This group agreement
- The certificate(s) of coverage
- The schedule of benefits
- Riders and amendments

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.

If you want to discuss your coverage

If you have questions about your coverage under the group agreement, or if you wish to discuss it, contact your agent. If you have additional questions, you may contact us at:

Aetna

1425 Union Meeting Road
Blue Bell, Pennsylvania 19422
1-800-872-3862

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

Definitions

You will see some words in bold type in the group 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 (CIP HNO) and entities associated with it for purpose of coverage under this group 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

Effective date

Date your coverage begins under this group agreement.

Premium due date

The **effective date** and the 1st day of each month after that.

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 will be on record with you and us. You will receive a new rate sheet when the premium rates change. Any rate sheet will state its **effective date**.

We charge premium based on the premium rates in effect on the **premium due date**.

The premium due on any **premium due date** is the total of the premium charges for your coverage.

When we calculate premium due, we will use our records to determine who is a **covered person**.

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

Premium – individual proration

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

Premiums shall be adjusted as outlined below for persons whose:

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

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

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

Premium – changes in rates

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

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

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

We will let you know in writing of any change in premium rate 30 days before they take effect.

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).

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

As a condition of us giving you an experience credit, we can require you to share it, in an agreed upon manner. We will require you to apply at least the excess experience credit for the sole benefit of the employees, if the sum of employee contributions for coverage exceeds the premium paid, less any experience credits.

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 premium 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, unless you choose to pay by check. 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 your 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 1 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 **effective date** or **renewal 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

We may change any fee not already agreed to and included in your premium with 30 days advance notice to you.

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 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** upon invoice.

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, unless you choose to pay by check. 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 court costs.

Some of our other responsibilities

We will prepare the certificate and schedule of benefits that are part of the group 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 group agreement. We will administer the coverage as required by the group agreement and applicable laws.

We will protect the personal health information of **covered persons** as required by 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 group agreement. For a copy of our Notice of Privacy Practices log on to <https://www.aetna.com/>.

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

Distribution – certificate and schedule of benefits

You will distribute as required by applicable 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 group 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 group agreement.

Information – enrollment

You shall send us enrollment information we request to administer the group 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 enrollment information includes but is not limited to data needed to:

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

We can and will rely on the information that you send and that it is correct.

You shall:

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

We will not start covering a person under the group agreement until you send us the information to enroll that person. Subject to applicable laws and the group 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 ends
- A dependent loses eligibility under the group agreement

You must notify us when a request for retroactive termination is a result of either 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 group agreement

Your duties and our rights in this *Information – enrollment* provision survive termination of the group 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 15 calendar days to a person becoming eligible for continuation coverage.

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

Workers' compensation coverage

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

You will provide us with monthly reports of all workers' compensation coverage cases. The report will list:

- Each case
- The employee name
- Identifying number
- Date of loss
- Diagnosis

Termination

Automatic termination

The group 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 group 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 group 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 group 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 group 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 group 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 laws require,) if we cease to offer the product provided by this group agreement

- Upon 180 days written notice to you (or such longer notice period as applicable laws require,) if we act as required by applicable federal and state laws for uniform termination of coverage

We may rescind the group agreement and all coverage it provides for fraud or intentional misrepresentation of material fact with 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 apply.

Non-renewal for failure to respond

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

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

whichever is later.

You must reply 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 group 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 group 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 group agreement states are to occur following termination.

You, **covered persons**, and we have the rights and duties following termination of the group agreement, as stated specifically in the group agreement.

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

Reinstatement

You may request that we reinstate the group agreement and coverage after we end it. You must make the request within 30 days of the **termination date**. We will reinstate the group 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 group 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 willful misconduct, criminal conduct or material breach of this group 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 group 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 group agreement or your role as employer or Plan Sponsor, as defined by ERISA.

These indemnification obligations end with the group 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 group 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 group agreement.

General provisions

General provisions – content and interpretation of the group agreement

Applicable law

Applicable law means all federal and state laws that apply to the matters covered by the group 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 group agreement if possible so it complies with applicable federal and state laws.

If the group agreement omits or misstates any right or duty under applicable federal and state laws, you and we shall implement the group agreement as though the right or duty is stated correctly.

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

Changes to the group agreement

The group agreement may be amended by mutual consent and in writing.

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

We have to give you 90 days advance written notice, and you have to consent in writing to changes in the group agreement. 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 group 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 group agreement do not require the consent of any employee or of any other person.

Entire group agreement

The group agreement replaces and supersedes:

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

Waiver

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

We may fail to implement or fail to insist upon compliance with a provision of the group 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 group 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 group agreement.

Assignment and delegation

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

We may assign or delegate functions under the group agreement to third parties. For example, management or administration of prescription drug benefits will be performed by CaremarkPCS Health L.L.C. and/or its affiliates (CVS Caremark®), each of which is an affiliated, licensed pharmacy benefit manager. We may also change or end these delegations. We do not need to give you advance notice to enter into, change or end these arrangements, and we do not need your consent.

Claim determinations

We have complete authority to review all denied claims for benefits under this group agreement:

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

We shall be deemed to have properly exercised our authority unless we abuse by acting arbitrarily and capriciously.

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

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

Correcting our administrative errors

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

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

Correcting your honest mistakes

If you or any employee 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 group 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 group 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 group 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 group 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, fax or other electronic means, effective upon sending

Mail notices to us by mail and commercial carrier:

Aetna Health Inc.

1425 Union Meeting Road
Blue Bell, Pennsylvania 19422

We will send notices to you by mail and commercial carrier:

STATE OF IL (CIP HNO)

801 SOUTH 7TH ST, 6TH FL ANNEX
SPRINGFIELD, IL 62794

You and we must designate specific e-mail addresses, fax 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 group 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 group agreement.

Third party rights

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

Aetna Health Inc.

Amendment

Effective date: 07/01/2026

Your group agreement has changed. This amendment shows the changes made to your agreement. It's effective on the date shown above. The changes appear below.

- The *Premium – overdue amounts* provision in the *Premium* section of the agreement is replaced with the following:

Premium – overdue amounts

If you don't pay your premium on time, we have the right to 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 court costs.

- The *Fees and assessments – overdue amounts* provision in the *Fees for special services and assessments* section of the agreement is replaced with the following:

Fees and assessments – overdue amounts

We have the right to collect 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 court costs.

The following provision is added to the *Responsibility for conduct* section of the agreement:

Indemnification – regulatory reporting requirements

We are entitled to rely on the information supplied by you in connection with the services we provide and our other obligations under the group agreement.

You agree to indemnify and hold us harmless from liability caused by your failure to furnish us with correct information in a timely manner. These liabilities may include:

- Fines
- Penalties
- Any fees assessed in connection with reporting delays or errors

This amendment makes no other changes to the group agreement.

Aetna Health Inc.
Amendment HI GrpAgAmend-2025 01
Amends form: HI HGrpAg 07

Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่ายโปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Ukrainian	Щоб безкоштовно отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікаційній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý

Open Access Health Network Only

**Health maintenance organization (HMO)
Certificate of coverage**

Prepared for:

Contract holder: STATE OF IL (CIP HNO)

Contract holder number: 0285657

Group agreement effective date: July 01, 2026

Plan effective date: July 01, 2026

Underwritten by Aetna Health Inc. in the State of Illinois



1425 Union Meeting Road, Blue Bell, PA 19422

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Schedule of benefits

Issued with your certificate of coverage

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. It also describes how we manage the plan, according to our policies, federal and state laws and regulations. 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 Health Inc. (Aetna)
- Words that are in bold, these are defined 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
- Writing us at 1425 Union Meeting Road, Blue Bell, PA, 19422
- Visiting <https://www.aetna.com> to register and access your member website

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

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

Your ID card

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

Wellness and other rewards

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

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

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 are not responsible; but, we have the right to change or end the arrangements at any time.

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

Entire Contract

This policy, including the application and any amendments or inserts, constitute your entire policy. A change to the policy is not valid unless approved by an executive officer of Aetna Life Insurance Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED.

YOU CAN EXPECT TO PAY MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE POLICY IN NON-EMERGENCY SITUATIONS. Except in limited situations governed by the federal No Surprises Act or Section 356z.3a of the Illinois Insurance Code (215 ILCS 5/356z.3a), non-participating providers furnishing non-emergency services may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. If you elect to use a non-participating provider, plan benefit payments will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. Participating providers have agreed to **ONLY** bill members the cost-sharing amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free telephone number on your identification card.

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.
- Services that are not prohibited by law. See *Services not permitted by law* in the *General plan exclusions* section 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.
- Treatment, testing, screening, and vaccinations provided by a pharmacist are covered the same as a physician.
- Your **provider** may recommend services that are considered **experimental** or **investigational** services. But an **experimental** or **investigational** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of services below
- Preventive services. Usually, the plan pays more and you pay less. Preventive services are designed to help keep you healthy, supporting you in achieving your best health. To find out what these services are, see *Preventive care* 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. If a service isn't listed here as a **covered service** or is listed as not covered under a specific service, it still may be covered. If you have questions, ask your **provider** or contact us.

Important note:

- We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **medically necessary, experimental or investigational**. They are subject to change. You can find these bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>. You can also contact us. See the *Contact us* section for how.
- We cover **medically necessary**, sex-specific **covered services** regardless of identified gender.

Abortion

Covered services include services provided and supplies used in connection with an abortion.

Abortion drugs (abortifacients)

Covered services include prescription drugs used for elective termination of pregnancy, including those prescribed or ordered for off label use.

Acupuncture

Covered services include manual or electro acupuncture.

The following are not **covered services**:

- Acupressure

Ambulance services

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

Emergency

Covered services include mobile integrated health care services and emergency transportation when your condition is unstable and requires medical supervision and rapid transport. These emergency ambulance services are limited to transportation by a licensed ambulance:

- To the first facility to provide **emergency services**
- From one facility to another if the first can't provide the **emergency services** you need

You may receive mobile integrated health care services by emergency medical services personnel if:

- You have received care in an emergency room three or more times in four consecutive months within the past twelve months
- Your **provider** decides mobile integrated health care would likely prevent inpatient admission or readmission or allow discharge from a facility

Mobile integrated health care services include:

- Health assessment
- Chronic disease monitoring and education
- Medication compliance
- Immunizations and vaccinations
- Laboratory specimen collection
- Hospital discharge follow-up care
- Minor medical procedures as approved by the emergency medical services medical director

The following are not **covered services**:

- Ambulance services for non-emergency transportation
- Ambulance services for routine transportation to receive outpatient or inpatient services

Applied behavior analysis

Covered services include applied behavior analysis for a diagnosis of autism spectrum disorder. Applied behavior analysis is a process of applying interventions that:

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

At-home pregnancy tests

Covered services include two at-home, urine-based pregnancy tests every 30 days.

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 **provider** with expertise in treating autism spectrum disorder or 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 also 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

These services will be covered regardless of the location where you receive them.

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 (including **telemedicine** consultation)

Substance use disorders treatment

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

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), 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 use disorders**
 - Other outpatient **substance use disorders** treatment such as:
 - Partial hospitalization treatment provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
 - Intensive outpatient program provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
 - 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
 - Ambulatory or outpatient **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
 - Observation
 - Peer counseling support by a peer support specialist including **telemedicine** consultation)

Behavioral health important note:

A peer support specialist serves as a role model, mentor, coach, and advocate. A peer support specialist must be supervised by a **behavioral health provider**.

Breast cancer treatment

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

Cardiopulmonary monitors

Covered services include cardiopulmonary monitors.

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. "Routine patient costs" are the items and services that are typically covered when you are not enrolled in an "approved clinical trial".

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

The following are not **covered services**:

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

Experimental or investigational therapies

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

- Standard therapies have not been effective or are not appropriate

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

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

Dental care anesthesia and hospitalization

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

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

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

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

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

- Be under 26 years of age.
- Make 2 visits to the **dental provider** before seeking other coverage.

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

- A severe, chronic disability, other than mental illness. It must result in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services that are similar. For purposes of this definition, autism is considered a related condition.
- It is likely to continue indefinitely.
- It results in substantial limitations in 3 or more areas of major life activity:
 - Self-care
 - Speech or self-expression
 - Learning
 - Being able to move
 - Self-direction
 - The ability to live alone
 - Financial independence.
- It reflects the individual’s need for a combination and series of specialized or generic services and individualized supports or other forms of assistance for an extended or permanent period of time.

Covered services can be provided in a dental office, oral surgeon's office, **hospital**, or outpatient surgical treatment center. **Covered services** only include the anesthesia and associated hospitalization.

The following are not **covered services**:

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

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

Covered services include:

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

Durable medical equipment (DME)

Covered services are DME and the accessories needed to operate it when:

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

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

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

Covered services also include:

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

The following are not **covered services**:

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

- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

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

Covered services include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room or an independent freestanding emergency department. However, you can also get **emergency services** from **out-of-network providers** at no greater cost as services from **network providers**

Emergency services will be provided at no cost for the examination and testing of a victim of criminal sexual assault or abuse will be provided to determine:

- Whether sexual contact occurred
- The presence or absence of a sexually transmitted disease or infection.

Your coverage for **emergency services** will continue until the following conditions are met:

- You are evaluated and your condition is stabilized
- Your attending **physician** determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another **provider** if you need more care

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. See 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**.

Prior authorization is not required for covered post-stabilization services during the course of an emergency room visit.

Non-emergency services

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

Fibrocystic breast condition

Covered services include the treatment of a fibrocystic breast condition.

Foot orthotic devices

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

Gender affirming treatment

Covered services include gender affirming treatment. The services must follow a specific treatment plan ordered by your **provider** and include:

- Behavioral health counseling
- Hormone therapy
- **Surgery** such as:
 - Breast removal or augmentation
 - Removal of testicles, uterus, ovaries
 - Genital reconstruction

Habilitation therapy services

Habilitation therapy services are services needed to keep, learn, or improve your 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**
- Licensed audiologist, nurse, optometrist, nutritionist or social worker

Outpatient physical, occupational, and speech therapies

Covered services include:

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

(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

Covered services include hearing instruments and related hearing aid services, as described below:

Hearing instrument means:

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

Hearing aid services include:

- Audiological exams
- Selection, fitting and adjustments of ear molds (excluding batteries and cords)
- Hearing instrument repairs

Covered services also include bone anchored hearing aids and cochlear implants.

The following are not **covered services**:

- Replacement of a hearing aid that is lost, stolen or broken
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any hearing aid prescribed by someone other than a hearing care professional

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

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

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

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

Covered services also include coverage for community-based pediatric palliative care and hospice care. This care shall be delivered to any covered child with a serious illness by a trained interdisciplinary team that allows a child to receive community-based pediatric palliative care and hospice care while continuing to pursue curative treatment and disease-directed therapies for the qualifying illness.

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 products

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

Immunizations

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

Infertility services

Basic infertility

Covered services include seeing a **network 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**.
- For artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination.

See the *Coverage and exclusions-Prescription drugs – outpatient* section for information on coverage of infertility **prescription** drugs.

Advanced reproductive technology (ART)

Advanced reproductive technology, also called “assisted reproductive technology”, is a more advanced type of infertility treatment.

Covered services include the following services provided by an ART **specialist**:

- Ovulation induction cycle(s) using medication to stimulate the ovaries. This may include the use of ultrasound and lab tests.
- In vitro fertilization (IVF).
- Uterine embryo lavage.
- Home pregnancy tests
- Zygote intrafallopian transfer (ZIFT).
- Gamete intrafallopian transfer (GIFT).
- Cryopreserved (frozen) embryo transfers (FET).
- Cryopreservation when a necessary medical treatment may directly or indirectly cause iatrogenic infertility.
- **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 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.
- 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. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)
- 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
- **Prescription** drugs injected by your **provider** to stimulate the ovaries.

ART **covered services** include cycle limits.

For plans with ovulation induction cycle limits, an ovulation induction cycle is defined as an attempt at ovulation induction while on medication to stimulate the ovaries with or without artificial insemination.

For plans with ART cycle limits, an ART “cycle” is defined as:

ART service	Procedure	Cycle count
IVF	One complete fresh cycle with transfer (egg retrieval, fertilization, and transfer of embryo)	One full cycle
IVF	One fresh cycle with attempted egg aspiration (with or without egg retrieval) but without transfer of embryo	One half cycle
IVF	Fertilization of egg and transfer of embryo	One half cycle
IVF	One cryopreserved (frozen) embryo transfer	One half cycle
GIFT	One complete cycle	One full cycle
ZIFT	One complete cycle	One full cycle

Aetna’s National Infertility Unit

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with determining eligibility for benefits and **precertification**. They can also give you information about our infertility Institutes of Excellence™(IOE) facilities. You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your infertility services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

Fertility preservation

Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use.

Covered services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned medical services that are proven to result in infertility such as:
 - Chemotherapy or radiation therapy that is established in medical literature to result in infertility
 - Other gonadotoxic therapies
 - Removing both ovaries or testicles
- The eggs that will be retrieved for use are likely to result in a pregnancy

Premature ovarian insufficiency

If your infertility has been diagnosed as premature ovarian insufficiency (POI), you are eligible for ART services using donor eggs/embryos.

Infertility services exclusions:

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
- **Experimental** or **investigational** treatment as determined by the American Society for Reproductive Medicine
- Infertility medication. See the Coverage and exclusions-Prescription drugs – outpatient section for information on coverage of infertility prescription drugs
Infertility medication not injected by your provider, including but not limited to menotropins, hCG, and GnRH agonists. See the Coverage and exclusions-Prescription drugs – outpatient section for information on coverage of infertility prescription drugs.
- All non-medical charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Treatment for dependent children, under the age of 18, except for fertility preservation as described above.

Jaw joint disorder treatment

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

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome and craniomandibular joint disorder
- The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)
- A major injury to the jaw caused by an accident or disease

The following are not **covered services**:

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

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. 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. If an earlier discharge is recommended, **covered services** include an in-home nurse visit or post-discharge physician visit within the first 48 hours after discharge

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

Covered services also include coverage for:

- Clinically appropriate case management programs if you are identified as experiencing a high-risk pregnancy
- Treatment of a mental, emotional, nervous, or substance use disorder or condition

Covered services for your child includes:

- Routine inpatient **hospital** nursery charges.
- One routine inpatient exam when done by a **physician** other than the delivering **physician**.
- One inpatient hearing test.
- The 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, unless care is rendered by perinatal doulas or licensed certified professional midwives
- Any services and supplies related to births in any other place not licensed to perform deliveries

Neuromuscular, neurological, or cognitive impairment coverage for children

Covered services include therapy, diagnostic testing, and equipment necessary to increase quality of life for children who have been clinically or genetically diagnosed with any disease, syndrome, or disorder that includes low tone neuromuscular impairment, neurological impairment, or cognitive impairment. These services will be covered regardless of the location where you receive them.

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 human breast milk which may include milk fortifiers for infants

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

The following are not **covered services**:

Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- Medical foods
- Other nutritional items

Opioid medically assisted treatment

Covered services include **prescription drugs** for medically assisted treatment (MAT) of opioid use disorder. These **prescription drugs** will not be subject to:

- **Precertification**
- Dispensing limitations
- Lifetime limits

Opioid antagonist prescription drugs

Covered services include opioid antagonist **prescription** drugs with doses of 50 MME or higher, including the medication product, administrative devices and any pharmacy administrative fees relating to the dispensing of opioid antagonists. Included are refills for expired or utilized opioid antagonists.

An “opioid antagonist” is a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.

Opioid reversal agents

Covered services include at least 1 intranasal opioid reversal agent **prescription** for the initial **prescription** of opioids with dosages of 50 MME or higher.

Prescription inhalants

Covered services include inhalant **prescription drugs** for diagnoses of asthma or other life-threatening bronchial ailments. Coverage will be provided at the same level as any other **prescription drug**. There will be no restrictions on when you can refill the inhaler when it is ordered or prescribed by the treating **physician** and it is medically appropriate.

Oral and maxillofacial treatment (mouth, jaws and teeth)

Covered services include the following when provided by a **physician**, dentist and **hospital** to treat a major injury to the jaw caused by an accident or disease:

- Cutting out:
 - Teeth partly or completely impacted in the bone of the jaw
 - Teeth that will not erupt through the gum
 - Other teeth that cannot be removed without cutting into bone
 - The roots of a tooth without removing the entire tooth
 - Cysts, tumors, or other diseased tissues
- Cutting into gums and tissues of the mouth:
 - Only when not associated with the removal, replacement or repair of teeth
- Reconstructive and dental treatment under the *Reconstructive surgery and supplies* section

Outpatient surgery

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

Important note:

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

The following are not **covered services**:

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

Physician services

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

- At the **physician's** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine**. This includes coverage for licensed dietician nutritionists and certified diabetes educators.

Important note:

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

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

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

Physician surgical services

Covered services include the services of:

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

The following are not **covered services**:

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

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 Get Covered Illinois: <https://getcovered.illinois.gov>.
Information: 1-866-311-1119

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
- Mental health prevention and wellness visit for children and for adults up to 60 minutes.
- 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, including syphilis

- 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
 - Tobacco use screening and intervention and expanded counseling for pregnant tobacco users.
 - Treatment visits
 - Class visits

Family planning services –contraceptives

Covered services include family planning services as follows:

- Counseling services provided by a **physician** or other **provider** 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 prescribed, provided, administered, or removed by a **health professional**.
- 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

See other benefits such as Hospital care, Outpatient surgery, and **physician** services which include coverage for complications of voluntary sterilization services.

Epinephrine injectors

Covered 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).

Hormone therapy

Covered services include **prescription** drugs for hormone therapy medications for gender affirming treatment and treatment of menopause. This includes **prescription** vaginal estrogen or therapeutic equivalent approved by the FDA. Includes Non-Hormonal Therapy for menopause.

Human immunodeficiency

Covered services include **prescription** drugs for immunodeficiency virus pre-exposure and post-exposure prophylaxis treatment.

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:
 - Haemophilus 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

Immunosuppressant drugs

Covered services include immunosuppressant **prescription drugs** with a written prescription after an approved organ transplant. When the prescribing **physician** indicates “May not substitute” on your **prescription** orders, we will not require the pharmacy to issue a different **prescription drug** without written notification and documented consent by you and the prescribing **physician**.

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 patients 35-39, a baseline mammogram
 - For patients 40 years of age and older, annually
 - For patients 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, Molecular breast imaging (MBI) 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 individuals who are :
 - Asymptomatic individual age 50 and older
 - Individual men age 40 and over
 - Individual age 40 and over with family history of prostate cancer
 - Colorectal cancer screening
- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp, and a follow-up exam based on an initial screening.
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings for adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years
- Sigmoidoscopies
- Pancreatic cancer screening
- Home saliva cancer screening if they:
 - Are asymptomatic and at high risk for the disease being tested for; or
 - Demonstrate symptoms of the disease being tested for at a physical exam

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 USPSTF.
- 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:
 - o Interpersonal and domestic violence
 - o Sexually transmitted infections
 - o 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 gestational diabetes for women, including women 24-28 weeks pregnant and those at risk of developing gestational diabetes
- Screening for diabetes (type 2) for adults with high blood pressure
- Bone density screenings for osteoporosis
- Aspirin use to prevent cardiovascular disease for men and women of certain ages
- Blood pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Depression screening
- Hepatitis B screening for adults and adolescents age 11-17 at high risk. This includes:
 - o People from countries with 2% or more Hepatitis B prevalence
 - o U.S. born people not vaccinated as infants and with at least 1 parent born in a region with 8% or more Hepatitis B prevalence
- Hepatitis C screening for:
 - o Adults at increased risk
 - o 1 time for everyone born 1945-1965
- Falls prevention in community-dwelling adults age 65 and older who are at increased risk for falls. This includes:
 - o Vitamin D supplementation
 - o Exercise
- Liver disease screening
- Tuberculosis screening for populations at increased risk
- Skin cancer behavioral counseling for fair skinned individuals ages 6 months-24 years
- Whole body skin examination for lesions suspicious for skin cancer

Covered services include:

- Office visit to a **physician**
- Hearing screening
- Vision screening
- A1C testing
- Vitamin D testing
- 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
- Bilateral hearing screening for newborns

- 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 individuals 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 individuals
- 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
- Annual menopause health visit.

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

- Breast Feeding (Lactation) Support, Supplies and Counseling

Prosthetic and customized orthotic 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. A customized orthotic device is a prosthetic device based on your physical illness.

Covered services include a prosthetic or custom orthotic device determined by your **physician** to be the most appropriate model to perform physical activities, such as running, biking, swimming, and lifting weights.

Covered services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers. A customized orthotic device is a prosthetic device based on your physical illness. This includes coverage for:

- Bone anchored hearing aid
- Cochlear implants, including accessories and upgrades
- Wig or other scalp prosthesis worn for hair loss caused by alopecia, chemotherapy, or radiation treatment for cancer or other medical conditions.

Coverage includes:

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

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

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

Covered services also include breast reduction surgery

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, cleft palate, cleft lip or major functional impairment of a body part and the purpose of the **surgery** is to improve
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement including major injury to the jaw, or major functional impairment of a body part, and your **surgery** will improve function.
- Your surgery is needed to restore your physical appearance and bodily function after trauma.
- Your **surgery** is to eliminate or provide treatment of port-wine stains

Accidental injury to natural teeth

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 accident-related dental 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
- Dental implants, prosthodontics and otolaryngology treatment to address a major injury to the jaw
- Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement

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 are services needed to restore or develop your skills and functioning for daily living. The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a:

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

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

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure**
- Treat parts of the body affected by multiple sclerosis to maintain your level of function.
- 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** or
 - Help you maintain or prevent loss of function
 - 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 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**

Specialty prescription drugs

Covered services include **specialty prescription drugs** when they are:

- Purchased by your **provider**
- Injected or infused by your **provider** in an outpatient setting such as:
 - A freestanding outpatient facility
 - The outpatient department of a **hospital**

- A **physician** in the office
- A home care **provider** in your home

Certain injected and infused medications may be covered under the outpatient **prescription drug** benefit. Contact us to determine if coverage is under this **specialty prescription drug** or the outpatient **prescription drug** benefit.

Telemedicine

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

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

The following are not **covered services**:

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

Tests, images and labs – outpatient

Diagnostic complex imaging services

Covered services include:

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests
- Comprehensive cancer testing
- Testing of blood or constitutional tissue for cancer predisposition testing
- Biomarker testing

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

Diagnostic x-ray and other radiological services

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

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

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

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

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

Key Terms

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

Gene

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

Molecular

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

Therapeutic

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

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

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

GCIT **covered services** include:

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

- siRNA.
- mRNA.
- microRNA therapies.

Facilities/providers for gene-based, cellular and other innovative therapies

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

Important note:

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

Infusion therapy

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

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

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

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.

Immune gamma globulin therapy will be covered for persons diagnosed with a primary immunodeficiency when medically appropriate and ordered by a **physician**. Initial authorization will be for no less than 3 months with reauthorization every 6 months after. If you have been in treatment for 2 years, reauthorization will be every 12 months, unless more frequently indicated by your **physician**.

Treatment of tick-borne diseases

Covered services includes long-term antibiotic therapy, including office visits and ongoing testing, for a tick-borne disease and ordered by a **physician** after making a thorough evaluation of your:

- Symptoms
- Diagnostic test results
- Response to treatment

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
- Proton Beam Therapy

Topical anti-inflammatory medications

Covered services include topical anti-inflammatory medications for acute and chronic pain.

Topical eye medication prescription drugs

Covered services include topical eye **prescription drugs**. They are paid according to the tier of drug as indicated in the schedule of benefits.

Refills of a **prescription** for topical eye medication will not be denied when:

- The **prescription drug** is used to treat a chronic condition of the eye
- You requested the refill before the last day of the prescribed dosage period and after at least 75% of the predicted days of use
- The **prescriber** indicates on the original **prescription** that refills are permitted and early refills do not exceed the total number of refills prescribed

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 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, coinsurance, deductible**, maximum out-of-pocket and limits, unless stated differently in this certificate and schedule of benefits.

Important note:

If there are no IOE facilities assigned to perform your transplant type in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your transplant services at the facility, we designate, 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 condition is an illness or injury that requires prompt medical attention but is not a life-threatening **emergency medical condition**. An urgent care center is a facility licensed as a freestanding medical facility to treat urgent conditions.

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

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

- Urgent care obtained from an out-of-network facility within the service area
- Non-urgent care in an urgent care center

Walk-in clinic

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

- Scheduled and unscheduled visits for illnesses and injuries that are not **emergency medical conditions**

- Preventive care immunizations, including administrative fees, administered within the scope of the clinic's license
- **Telemedicine** consultation
- 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:

Blood and blood products

Blood, blood products, and related services which are supplied to your **provider** free of charge

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, including cosmetic drugs, medications, and preparations used for cosmetic purposes, except where described in the *Coverage and exclusions* section

Court-ordered services and supplies

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

Custodial care

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

Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- Respite care, adult or child day care, or convalescent care
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and **substance use disorder** treatment):
Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
Services given mainly to:
 - Maintain, not improve, a level of function
 - Provide a place free from conditions that could make your physical or mental state worse

Dental services

The following are not **covered services**:

- Services normally covered under a dental plan

- Dental implants except when part of an approved treatment plan for a **covered service** described in the *Coverage and exclusions - Reconstructive surgery and supplies* section

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
- Any services that are schooling related or similar programs
- Therapeutic programs within a school, vocational, work, or recreational setting. However, **covered services** for autism spectrum disorders or habilitative services for children will not be denied solely because of the location where clinically appropriate services of this type are provided.

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Foot care

Routine services and supplies for the following:

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

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

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

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**.
- All associated services when GCIT services are not covered. Examples include:
 - Infusion

- Lab
- Radiology
- Anesthesia
- Nursing services

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

Growth/height care

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

Hearing exams

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

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, except for compression sleeves to prevent or reduce lymphedema. 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

Prescription or non-prescription drugs and medicines

- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Drugs or medications recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee
- **Specialty prescription drugs** except as stated in the *Coverage and exclusions* section

Private duty nursing

Routine exams and preventive services and supplies

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

Services not permitted by law

Some laws restrict the range of health care services a **provider** may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

Except where described in the *Coverage and exclusions* section, 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

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

Wilderness treatment programs

Wilderness treatment programs, whether or not the program is part of a **residential treatment facility** or otherwise licensed institution

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. The plan usually pays only when you get care from **network providers**.

Providers

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

You may choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care. You don't have to get care through your **PCP**. You may go directly to **network providers**.

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

Service area

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

Who provides the care

Network providers

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

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

- **Emergency services** – see the description of **emergency services** in the *Coverage and exclusions* section.
- Urgent care – see the description of urgent care in the *Coverage and exclusions* section.
- **Network provider** not available in the network – You can get services from an **out-of-network provider** if a **network provider** with the required specialty is not available in the network, and you have made a good faith effort to utilize a **network provider**. Your primary care network provider must request approval from us before you are referred to and receive care from a specialist outside the network.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

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

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

Your PCP

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

How you choose your PCP

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

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

What your PCP will do for you

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

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

But, 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 you are undergoing treatment for an acute or chronic condition and the **provider** didn't leave the network based on fraud or lack of quality standards, you'll be able to receive transitional care from your **provider** for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

Important note:

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

You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.

Medical necessity and precertification requirements

Medically necessary, medical necessity

Covered services under the plan must be **medically necessary**. 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**.

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.

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**. There is no precertification requirement for inpatient services.

See *Medically necessary, medical necessity* in this section and the **medically necessary, medical necessity** definition in the *Glossary* section for more information on what we consider when making a **precertification** decision.

For certain drugs covered under your medical plan or **prescription** drug plan, 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. The **medical necessity** requirements are in the *Glossary* section, where we define “**medically necessary, medical necessity.**”

Requesting a medical exception

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

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 plan.

For directions on how you can submit a request for a review:

- Call the toll-free number on your ID card
- Log in to your member 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.

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.

What the plan pays and what you pay

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

The general rule

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

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

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

Negotiated charge

For health coverage:

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

For surprise bills, calculations will be made based on the median contracted rate.

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.

The plan may make some **brand-name prescription drugs** available to you at the **generic prescription drug** cost share. If a generic drug or a therapeutic equivalent is unavailable due to a supply issue and

dosage cannot be adjusted coverage will be provided for a brand name eligible prescription drug until supply of the generic drug or a therapeutic equivalent is available.

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 may be able to 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.

Anti-cancer drugs taken by mouth

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

Surprise bill

There may be times when you unknowingly receive services or don't consent to receive services from an **out-of-network provider**, even when you try to stay in the network for your **covered services**. You may get a bill at the out-of-network rate that you didn't expect. This is called a surprise bill.

An **out-of-network provider** can't balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirement, such as **deductibles**, **copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider** and ancillary services initiated from your **emergency services**
- Non-emergency services provided by an **out-of-network provider** at an in-network facility, except when the **out-of-network provider** has given you the following:
 - The out-of-network notice for your signature
 - The estimated charges for the items and services
 - Notice that the **provider** is an **out-of-network provider**
- Out-of-network air ambulance services

The **out-of-network provider** must get your consent to be treated and balance billed by them.

Ancillary services mean any professional services including:

- Items and services related to emergency medicine
- Anesthesiology
- Hospitalist services
- Laboratory services
- Neonatology
- Pathology
- Radiology
- Services provided by an **out-of-network provider** because there was no **network provider** available to perform the service

A facility in this instance means an institution providing health care related services or a health care setting. This includes the following:

- **Hospitals** and other licensed inpatient centers

- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory and imaging centers
- Rehabilitation facilities
- Other therapeutic health settings

A surprise bill claim is paid based on the median contracted rate for all plans offered by us in the same insurance market for the same or similar item or service that is all of the following:

- Provided by a **provider** in the same or similar specialty or facility of the same or similar facility type
- Provided in the geographic region in which the item or service is furnished

The median contracted rate is subject to additional adjustments as specified in federal regulations.

Any cost share paid with respect to the items and services will apply toward your in-network **deductible** and **maximum out-of-pocket limit** if you have one.

It is not a surprise bill when you knowingly choose to go out-of-network and have signed a consent notice for these services. In this case, you are responsible for all charges.

You may request external review if you want to know if the federal surprise bill law applies to your situation.

The nonparticipating facility-based physicians, out-of-network providers and insurers have the right to try and negotiate reimbursement for surprise bills for covered services and to request binding arbitration if an agreement cannot be reached. They will submit a request for arbitration of a disputed surprise bill claim through either the American Arbitration Association or the American Health Lawyers Association, with a copy to the Illinois Department of Insurance. The party who requests arbitration notifies the other party that it has been initiated and states its final offer before it begins.

If you receive a surprise bill or have any questions about what a surprise bill is, contact us.

Paying for covered services – the general requirements

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

- The expense is for a **covered service**
- For in-network coverage:
 - You get your care from a **network provider**
 - You get your care from:
 - Your **PCP**
 - Another **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 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. Any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by you, or on your behalf, for prescription drugs will be applied towards your deductible, copayment, coinsurance, or maximum out-of-pocket limit.

Limitations include things like maximum age, visits, days, hours and admissions. Out-of-pocket costs include things like **deductibles**, **copayments** and **coinsurance**. Keep in mind that you are responsible for paying your part of the cost sharing. You are also responsible for costs not covered under this plan.

Coordination of benefits

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

Key Terms

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

Allowable expense means 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:
 - o The amount that the secondary plan saved due to COB
 - o Used to cover any unpaid allowable expenses
 - o 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	<ul style="list-style-type: none"> • Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent’s plan if there is no court order 	<ul style="list-style-type: none"> • Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent’s plan
Child – covered by individuals who are not parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

How COB works with Medicare

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

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

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

Other health coverage updates – contact information

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

Other Insurance in this Company

Insurance effective at any one time on the insured under a like policy or policies in this company is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the company will return all premiums paid for all other such policies.

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.

Upon receipt of a notice of a claim, we will furnish such claims forms, as requested, within 15 days of this notice or request. If after 15 days the forms are not furnished, you shall be deemed to have complied with the requirements of this Certificate as to proof of loss upon submitting your initial notice and as long as proof of notice was within the time frames listed.

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. You can review your file and present evidence and testimony as part of the appeals process. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization if the situation is eligible for external review.

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

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 or your **provider** must send us the bill within 12 months of the date you received services, unless you are legally unable to notify us. You must send it to us with a claim form that you can either get online or contact us to provide. You should always keep your own record of the date, **providers** and cost of your services.

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

We have processes to review claims before and after payment to ensure the services billed meet one or more of the following:

- Our reimbursement policies
- Are free from fraud, waste, and abuse

When we review, we will evaluate submitted claim information and determine the accuracy of the procedure and diagnosis codes for the services billed. Sometimes, this review will change how we pay for the services and what we allow on a claim. This doesn't mean that a service isn't a **covered service**. It may mean that the claim should be submitted differently, or the services billed on the claim don't satisfy one of the items above.

We will tell you and your **provider** of our decision if we find any of the items above are not met.

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

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

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.

Payment of Claims to Beneficiary

Indemnity for loss of life will be payable in accordance with the beneficiary designation and provisions respecting the payment effective at the time of payment. If no designation or provision is effective, the indemnity will be payable to the estate of the Covered Person. Any other accrued indemnities unpaid at the insured's death may, at the option of the company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

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 Illinois Department of Insurance, we will respond within 21 days of receiving the complaint.

You may contact the Illinois 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.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

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

Any other claim appeal

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

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 plan sponsor'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, KY 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 calendar days for a post-service claim.

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

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

Exhaustion of appeal process

In most situations, you must complete the appeal process 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 non-binding 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 Illinois Department of Health and Human Services. But you will not be able to proceed directly to external review if:
 - The rule violation was minor and not likely to influence a decision or harm you
 - The violation was for a good cause or beyond our control
 - The violation was part of an ongoing, good faith exchange between you and us

External review

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

You have a right to external review if any of the following conditions are met:

- You have received an adverse benefit determination for one of the following reasons:
 - The service or supply is **experimental or investigational**
 - The service or supply does not meet our requirements for **medical necessity**, appropriateness, health care setting, level of care, or effectiveness
- Coverage was rescinded. This does not include a cancellation of coverage due to failure to pay any required contribution

You may also request external review if you want to know if the federal surprise bill law applies to your situation.

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 with the final adverse benefit determination.

You must submit the request for external review form:

- To the Illinois Department of Insurance
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request
- 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 that you send and want reviewed by the IRO. We will pay for information we send to the IRO plus the cost of the review.

The Illinois Department of Insurance will contact the IRO that will conduct the review of your claim

The ERO will:

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

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

How long will it take to get an ERO decision?

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

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

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

For initial adverse benefit determinations

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

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

Upon receipt from the Illinois Department of Insurance, we will respond to the eligibility request for an external review within 24 hours. Once assigned to an IRO, 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
 - Dependent children must be:
 - under 26 years of age
 - Unmarried and under age 19
 - or they must be:
 - Under age 21 and a full-time student
 - Under age 21 attending school regularly, solely dependent upon you for support
 - Dependent children include:
 - Natural children
 - Stepchildren
 - Adopted children including those placed with you for adoption (a child residing with you because of an interim court order is considered an adopted child)
 - Foster children
 - Children you are responsible for under a qualified medical support order or court order
- Dependent children – yours or your spouse’s or partner’s
 - Dependent children must be:
 - under 26 years of age
 - Unmarried and under age 19
 - or they must be:
 - Under age 21 and a full-time student
 - Under age 21 attending school regularly, solely dependent upon you for support
 - Dependent children include:

- Natural children
- Stepchildren
- Adopted children including those placed with you for adoption (a child residing with you because of an interim 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 moment of birth for newborns or the date of the event for new dependents that 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.

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)

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 covered dependent is "totally disabled" if they can't engage in most normal activities like a healthy person of the same age and gender.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

To extend coverage the leave of absence must:

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

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

How your dependent can extend coverage after you die

Your dependents can continue coverage after your death if:

- You were covered at the time of your death
- The request is made within 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.

How we administer this plan

We administer this plan to comply with all applicable laws and regulations.

We have complete authority to review all denied claims for benefits under this plan. In doing so we will:

- Determine whether and to what extent you are entitled to benefits
- Interpret any disputed or unclear terms under this plan

Our decisions are conclusive and binding. Also, you are bound by our interpretation of this certificate when we administer your coverage.

Who's responsible to you

We are responsible to you for our conduct.

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

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.

Physical examination and evaluations

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

Records of expenses

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

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

Honest mistakes and intentional deception

Honest mistakes

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

Intentional deception

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

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

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

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

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.

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**.

Grace period

You have a grace period of 31 days after the due date to pay your contribution for coverage under the plan. If you haven't paid your contribution by the end of the grace period, we will end your coverage.

Grace period

A grace period of 31 days is allowed for payment of premium after each premium due date.

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** or **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 use disorders** in the state where the person practices.

Brand-name prescription drug

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

Coinsurance

This is the percentage of **covered services** you pay after your **deductible** when one applies.

Copay, copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit. In **prescription** drug plans, it is the amount you pay for covered drugs.

Covered service

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

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

Deductible

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

Detoxification

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

Drug guide

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

Emergency medical condition

An acute, severe medical condition that:

- 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 or an independent freestanding emergency department. This includes evaluation of and treatment to stabilize the **emergency medical condition**. An independent freestanding emergency department means a health care facility that is geographically separate, distinct, and licensed separately from a **hospital** and provides **emergency services**.

Experimental or investigational

A drug, device, procedure, supply, treatment, test, or technology is considered by us to be **experimental or investigational** if any of the following apply:

- It hasn't been shown through well-conducted clinical trials or cohort studies published in peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which it's meant.
 - A well-conducted clinical trial means a randomized, controlled trial where the experimental intervention is compared to a control group receiving care according to best practice and study participants are randomly assigned to the experimental or control group.
 - A well-conducted cohort study means a prospective cohort study from more than one institution where the experimental intervention is compared to a group of subjects receiving care according to best practice and where the comparison group is well matched to the experimental intervention group.
- There isn't FDA approval or clearance to market it for the proposed use.
- A national medical society, dental society, or regulatory agency has written that it's **experimental or investigational**, or mainly for research purposes.
- It's the subject of a Phase I, Phase II, or the experimental or research arm of a Phase III clinical trial. The FDA and Department of Health and Human Services define these.
- Written procedures or consent form used by a facility **provider** says it's **experimental or investigational**.

Important note:

We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **medically necessary, experimental or investigational**. They are subject to change. You can find these bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>. You can also contact us. See the *Contact us* section for how.

Generic prescription drug

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

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional

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

Home health care agency

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

Hospital

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

Infertility

A disease defined by the failure to become pregnant:

- For a female with a male partner, after:
 - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
 - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
 - At least 12 cycles of donor insemination if under the age of 35
 - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
 - At least 2 abnormal semen analyses obtained at least 2 weeks apart

For an individual or their partner who has been clinically diagnosed with gender dysphoria

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**, **coinsurance** and **deductible**, if any, for **covered services**.

Medically necessary, medical necessity

Health care services or supplies that prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are all of the following:

- In accordance with “generally accepted standards of medical practice”
- Clinically appropriate, in terms of type, frequency, extent, site, place of service, duration, and considered effective for your illness, injury or disease
- Not primarily for your convenience, the convenience of your **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 your illness, injury or disease

Generally accepted standards of medical practice mean:

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

Important note:

We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **medically necessary, experimental or investigational**. They are subject to change. You can find these bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>. You can also contact us. See the *Contact us* section for how.

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*.

Serious mental illness means the following mental disorders as classified in the current Diagnostic and Statistical Manual, published by the American Psychiatric Association:

- Schizophrenia
- Paranoid and other psychotic disorders
- Bipolar disorders (hypomanic, manic, depressive and mixed)
- Major depressive disorders (single episode or recurrent)
- Schizoaffective disorders (bipolar or depressive)
- Pervasive developmental disorders
- Obsessive-compulsive disorders
- Depression in childhood and adolescence
- Panic disorder
- Post-traumatic stress disorders (acute, chronic or with delayed onset)
- Eating disorders, including but not limited to:
 - Anorexia nervosa and bulimia nervosa
 - Bulimia nervosa
 - Pica
 - Rumination disorder
 - Avoidant/restrictive food intake disorder
 - Other specified feeding or eating disorder (OSFED)
 - Any other eating disorder contained in the most recent version of the DSM

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 provider (PCP)**.

Precertification, precertify

Pre-approval that you or your **provider** receives from us before you receive certain **covered services**.

Prescription

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

Primary care provider (PCP)

A **provider** who:

- The directory lists as a **PCP**
- Is selected by you from the list of **PCPs** in the directory
- Supervises, coordinates and provides initial care and basic medical services to you
- 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
- Physician assistant
- Pediatrician
- OB, GYN, and OB/GYN
- Medical group primary care office, or another **provider** allowed by the plan

Provider

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

Psychiatric hospital

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

Referral

This is a written or electronic authorization made by your **PCP** to direct you to a **network provider** for services and supplies.

Residential treatment facility

A facility that provides **mental health disorder** services or **substance use disorder** services and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed **physician** for the level of care provided
- Maintains a written treatment plan prepared by a licensed **behavioral health provider** (RN or master's level) requiring full-time residence and participation
- Has a licensed **behavioral health provider** (RN or master's level) on-site 24 hours per day, 7 days per week
- And is:
 - Credentialed by us, or
 - Certified by Medicare, or
 - Accredited by The Joint Commission (TJC); The Committee on Accreditation of Rehabilitation Facilities (CARF); The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP); or The Council on Accreditation (COA)

Retail pharmacy

A community pharmacy that dispenses **outpatient prescription drugs**.

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 that provides skilled nursing care and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed **physician** for the level of care provided
- Maintains a written treatment plan prepared by a licensed **provider** (RN or master's level) requiring full-time residence and participation
- Has a licensed **provider** (RN or master's level) on-site 24 hours per day, 7 days per week
- And is:
 - Credentialed by us, or
 - Certified by Medicare, or
 - Accredited by The Joint Commission (TJC) or The Committee on Accreditation of Rehabilitation Facilities (CARF)

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

Skilled nursing facility does not include institutions that provide only:

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

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

Specialist

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

Specialty prescription drug

An FDA-approved **prescription** drug that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:

- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

Specialty pharmacy

A pharmacy that fills **prescriptions** for specialty drugs.

Stay

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

Substance use disorder

The use of drugs, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association, that directly affect the brain's reward system in an amount or frequency that causes problems with normal activities.

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 **physician, specialist, or behavioral health provider or telemedicine provider** who is performing a clinical medical or behavioral health service by means of electronic communication.

Terminal illness

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

Value prescription drugs

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

Walk-in clinic

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

- Drug store
- Pharmacy
- Retail store
- Supermarket

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

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

Important Information about the Affordable Care Act (ACA)

Non-discrimination Rule

The Office of Civil Rights recently issued a Non-discrimination Rule in response to Section 1557 of the Affordable Care Act (ACA). Section 1557 prohibits discrimination because of race, color, national origin, sex, age or disability in health-related insurance or other health-related coverage. This applies to Aetna. Changes to health insurance plans are effective on the first day of the policy or plan year beginning on or after January 1, 2017.

Some language changes may not be in the enclosed certificate of coverage or policy. This may be because the language is still under official review for approval. See the *Important note* below for how this affects your policy or plan.

Important note:

We will comply with the requirements of the Rule for all new and renewing policies or plans with an effective date on or after January 1, 2017.

Below is a summary of some of the recent Non-discrimination Rule changes.

An insurer covered by the Rule that provides or administers health-related insurance or other health-related coverage:

- Shall not:
 - Cancel, limit or refuse to issue or renew a policy or plan
 - Deny or limit coverage of a claim
 - Apply additional cost sharing

to a person because of race, color, national origin, sex, age, or disability.

- Shall not:
 - Deny or limit coverage
 - Deny or limit coverage of a claim
 - Apply additional cost sharing

to a transgender person, if it results in discrimination against that person.

- Shall not exclude or limit health services related to gender transition.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates. Aetna companies that receive funds from the federal Department of Health and Human Services are subject to the Rule.

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, 2026

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	\$250 per admission

	no deductible applies
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Outpatient obesity surgery services

Description	In-network
At specialist office	\$30 per visit
	no deductible applies
At hospital outpatient department	\$0 per visit
	no deductible applies
At facility that is not a hospital	\$0 per visit
	no deductible applies

Aetna Health Inc. Rider

1425 Union Meeting Road, Blue Bell, PA 19422

Prescription drug plan

Rider effective date: July 01, 2026

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
- 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, about **prescription** drug benefits, including limits, 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 U.S. Food and Drug Administration (FDA) approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

Covered services are based on the drugs in the **drug guide**. The **drug guide** contains a formulary exclusions list. This list is subject to change. We exclude **prescription** drugs listed on the formulary exclusions list unless we approve a medical exception. See the *How your plan works – Medical necessity and precertification requirements – Requesting a medical exception* section for more information on medical exceptions or just contact us.

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

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

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.

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

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 may be able to 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.

How to access network pharmacies

A network pharmacy will submit your claim. You will pay your cost share to the 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.

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 90 day supply of a **prescription** drug.

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. A **mail order pharmacy** may be used for up to a 90 day supply of a **prescription** drug.

Prescriptions can be filled at a network **mail order pharmacy**.

Specialty pharmacy

A **specialty pharmacy** may be used for up to a 30 day supply of a **specialty prescription drug**. You can view the list of **specialty prescription drugs**. See the *Contact us* section for how.

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

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. If you must fill a **prescription** in one of these situations, you may obtain your **prescription** from an out-of-network pharmacy.

The out-of-network pharmacy may ask you to pay the full cost of the **prescription**. When you pay the full cost of the **prescription** at an out-of-network pharmacy:

- You can 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 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

Other covered services

Abortion drugs

Covered services include **prescription** drugs used for elective termination of pregnancy.

Anti-cancer drugs taken by mouth

Covered services include any drug prescribed for cancer treatment, including chemotherapy drugs. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment. We pay oral anti-cancer drugs the same as intravenous (IV) anti-cancer drugs.

Contraceptives (birth control)

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

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

Preventive contraceptives important note:

You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review. If the exception is approved, the **brand-name prescription drug** contraceptive will be covered at 100%.

Diabetic supplies

Covered services include items such as:

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

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

Epinephrine injectors

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

Immunosuppressant drugs

Covered services include immunosuppressant **prescription drugs** with a written prescription after an approved organ transplant. When the prescribing **physician** indicates “May not substitute” on your **prescription** orders, we will not require the pharmacy to issue a different **prescription drug** without written notification and documented consent by you and the prescribing **physician**.

Infertility drugs

Covered services include oral and injectable ovulation induction **prescription** drugs.

Opioid antagonist prescription drugs

Covered services include opioid antagonist **prescription** drugs, including the medication product, administrative devices and any pharmacy administrative fees relating to the dispensing of opioid antagonists. Included are refills for expired or utilized opioid antagonists.

An “opioid antagonist” is a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.

Opioid medically assisted treatment

Covered services include **prescription drugs** for medically assisted treatment (MAT) of opioid use disorder. These **prescription drugs** will not be subject to:

- **Precertification**
- Dispensing limitations
- Step therapy
- Lifetime limits

Opioid reversal agents

Covered services include at least 1 intranasal opioid reversal agent **prescription** for the initial **prescription** of opioids with dosages of 50 MME or higher.

Over-the-counter (OTC) drugs

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

Prescription inhalants

Covered services include inhalant **prescription drugs** for diagnoses of asthma or other life-threatening bronchial ailments. Coverage will be provided at the same level as any other **prescription drug**. There will be no restrictions on when you can refill the inhaler when it is ordered or prescribed by the treating **physician** and it is medically appropriate.

Pharmacy consultation services

States authorize licensed pharmacists to prescribe certain **prescription drugs**.

Covered services include a consultation by your state licensed pharmacist to prescribe one of these **prescription drugs** for your illness or condition.

These consultation services may have a different cost share from other **provider** consultations or other **prescription drug** services. See your schedule of benefits.

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.

Topical anti-inflammatory medications

Covered services include topical anti-inflammatory medications for acute and chronic pain.

Topical eye medication prescription drugs

Covered services include topical eye **prescription drugs**. They are paid according to the tier of drug as indicated in the schedule of benefits.

Refills of a **prescription** for topical eye medication will not be denied when:

- The **prescription drug** is used to treat a chronic condition of the eye
- You requested the refill before the last day of the prescribed dosage period and after at least 75% of the predicted days of use
- The **prescriber** indicates on the original **prescription** that refills are permitted and early refills do not exceed the total number of refills prescribed

Treatment of tick-borne diseases

Covered services includes long-term antibiotic therapy, including office visits and ongoing testing, for a tick-borne disease 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**:

- 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, unless we have approved a medical exception
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a **covered service**
- Drugs or medications
 - Administered or entirely consumed at the time and place they are prescribed or provided unless listed in the **drug guide** or we have approved a medical exception
 - Which do not require a **prescription** by law, even if a **prescription** is written, unless listed as a **covered service** or we have approved a medical exception
 - That are therapeutically the same or an alternative to a covered **prescription** drug, unless we approve a medical exception
 - Not approved by the FDA or not proven safe or effective
 - Provided under your medical plan while inpatient at a healthcare facility
 - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
 - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
 - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a **covered service**
 - That are indicated or 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, non-**prescription** appetite suppressants or other medications unless listed as a **covered service**
 - That are drugs or growth hormones used to stimulate growth and prescribed only to treat idiopathic short stature
- 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 unless listed as a **covered service**
- Immunizations related to travel or work
- Immunization or immunological agents unless listed as a **covered service**
- Implantable drugs and associated devices unless listed as a **covered service**

- 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, unless listed in the **drug guide** or we have approved a medical exception
- 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 of 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 used for the purpose of improving visual acuity or field of vision
 - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the member as identified on the ID card
- **Prescription** drugs indicated for the purpose of weight loss.
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- Tobacco cessation drugs unless recommended by the USPSTF
- We reserve the right to exclude:
 - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
 - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

Where your schedule of benefits fits in

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

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. If a generic drug or a therapeutic equivalent is unavailable due to a supply issue and dosage cannot be adjusted coverage will be provided for a brand name eligible prescription drug until supply of the generic drug or a therapeutic equivalent is available.

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**.

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 your member 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.

How to read your schedule of benefits

How your cost share works

- The **deductibles, copayments and coinsurance**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- You are responsible to pay any **deductibles, copayments and coinsurance** if they apply.
- Your **copayment** or **coinsurance** is the amount you pay for each **prescription** fill or refill. The schedule of benefits shows you the cost share you need to pay for a specific **prescription** fill or refill.
- 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, **copayment** or **coinsurance** described in the medical plan schedule of benefits unless otherwise stated in this schedule.

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** or **coinsurance**, if any, for **covered services** after you meet your **deductible**.

Plan features

Deductible

A separate **deductible** applies to the **prescription drug plan**. You have to meet your **deductible** before the plan pays for benefits.

Deductible type	In-network
Individual	\$175 per contract year

General coverage provisions

This section explains the **deductible** in this schedule.

Prescription drug deductible provisions

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.

Prescription drug maximum out-of-pocket limit 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**.

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	\$12
90 day supply at a retail pharmacy	\$30
	after deductible

Value prescription drugs

Description	In-network
30 day supply at a retail pharmacy	\$4
90 day supply at a retail pharmacy	\$10
	after deductible

Preferred brand-name prescription drugs

Description	In-network
30 day supply at a retail pharmacy	\$24
90 day supply at a retail pharmacy	\$60
	after deductible

Non-preferred generic prescription drugs

Description	In-network
30 day supply at a retail pharmacy	\$48
90 day supply at a retail pharmacy	\$120
	after deductible

Non-preferred brand-name prescription drugs

Description	In-network
30 day supply at a retail pharmacy	\$48
90 day supply at a retail pharmacy	\$120
	after deductible

Specialty prescription drugs

Description	In-network
30 day supply at a specialty pharmacy or a retail pharmacy	\$96
	after deductible

Anti-cancer drugs taken by mouth

Description	In-network
30 day supply	\$0
90 day supply	\$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 supply or up to 12 month supply of generic and OTC drugs and devices	\$0
90 day supply or up to 12 month supply of brand-name prescription drugs and devices	Paid based on the tier of drug in the schedule

	no deductible applies
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Diabetic supplies, drugs

Description	In-network
30 day supply at a retail pharmacy	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

Preferred generic and brand name insulin

Description	In-network
30 day supply at a retail pharmacy	\$25, no deductible applies
90 day supply at a retail pharmacy	\$75, no deductible applies

Diabetic insulin important note:
Your cost share will not exceed \$35 per 30 day supply of a covered preferred **prescription** insulin drug filled at a network pharmacy. No **deductible** applies for preferred insulin.

Prescription inhalants important note:
Your cost share will not exceed \$25 per 30 day supply of a covered **prescription** asthma inhalers filled at a network pharmacy. No **deductible** applies for asthma inhalers.

Epinephrine injectors important note:
Your cost share will not exceed \$60 for a twin-pack of covered epinephrine injectors.

Preventive care drugs and supplements

Description	In-network
Preventive care drugs and supplements	\$0
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF). For a current list of covered drugs and supplements or more information see the <i>Contact us</i> section.

	no deductible applies
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Risk reducing breast cancer prescription drugs

Description	In-network
Risk reducing breast cancer prescription drugs	\$0
Limits	<p>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF.</p> <p>For a current list of covered risk reducing breast cancer drugs or more information, see the <i>Contact us</i> section.</p>

	no deductible applies
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Tobacco cessation prescription and OTC drugs

Description	In-network
Tobacco cessation prescription and OTC drugs	<p>\$0 for the first two 90-day treatment programs.</p> <p>Additional treatment programs will be paid based on the tier of drug in the schedule.</p>
Limits	<p>Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF.</p> <p>For a current list of covered tobacco cessation drugs or more information, see the <i>Contact us</i> section.</p>

Prescription drug important note:
 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 share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug.

Schedule of benefits

Prepared for:

Contract holder: STATE OF IL (CIP HNO)

Contract holder number: 0285657

HMO group agreement effective date: July 01, 2026

Plan name: Open Access Health Network Only

Plan effective date: July 01, 2026



**Aetna Health Inc.
1425 Union Meeting Road, Blue Bell, PA 19422**

Schedule of benefits

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

How your cost share works

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

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

Important note:

Covered services are subject to the contract year **deductible**, maximum out-of-pocket, limits, **copayment** or **coinsurance** unless otherwise stated in this schedule. The *Surprise bill* section in the certificate explains your protections from a surprise bill.

How your PCP or physician office visit cost share works

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

How your maximum out-of-pocket works

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

Contact us

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

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

Plan features

Maximum out-of-pocket limit

Includes the deductible.

Maximum out-of-pocket type	In-network
Individual	\$3,000 per contract year
Family	\$6,000 per contract year

General coverage provisions

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

Copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit. In **prescription** drug plans, it is the amount you pay for covered drugs.

Coinsurance

This is the percentage of **covered services** you pay after your **deductible** when one applies.

Maximum out-of-pocket limit

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

Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

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

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

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

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-**covered services** which are identified in the certificate and the schedule

Your financial responsibility and decisions regarding benefits

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

Covered services

Abortion

Description	In-network
Abortion Inpatient Services	\$0 per visit no deductible applies
Outpatient services	\$0 per visit no deductible applies

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	\$30 per visit
	no deductible applies
Treatment	\$30 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	\$250 per admission
	no deductible applies
Other inpatient services and supplies Other residential treatment facility services and supplies	No charge
Outpatient office visit to a physician or behavioral health provider	\$30 per visit no deductible applies
Physician or behavioral health provider telemedicine consultation	\$30 per visit no deductible applies
Other outpatient services including: <ul style="list-style-type: none"> Behavioral health services in the home Partial hospitalization treatment Intensive outpatient program <p>The cost share doesn't apply to in-network peer counseling support services</p>	\$0 per visit
	no deductible applies
Telemedicine provider mental health disorders consultation	Covered based on type of service and provider from which it is received

Substance use 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	\$250 per admission
	no deductible applies
Other inpatient services and supplies during a hospital stay	No charge
Outpatient office visit to a physician or behavioral health provider	\$30 per visit no deductible applies

Physician or behavioral health provider telemedicine consultation	\$30 per visit no deductible applies
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Other outpatient services including: <ul style="list-style-type: none"> Behavioral health services in the home Partial hospitalization treatment Intensive outpatient program <p>The cost share doesn't apply to in-network peer counseling support services</p>	\$0 per visit
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	no deductible applies
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Telemedicine provider substance use disorders consultation	Covered based on type of service and provider from which it is received
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Birth center

Includes **physician** services

Description	In-network
Inpatient services – room and board	\$250 per admission

	no deductible applies
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Other birthing center services and supplies	No charge
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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

Diabetic insulin important note:

Your cost share will not exceed \$35 per 30 day supply of a covered preferred **prescription** insulin drug filled at a network pharmacy. No **deductible** applies for preferred insulin.

Prescription inhalants important note:

Your cost share will not exceed \$25 per 30 day supply of a covered **prescription** asthma inhaler filled at a network pharmacy. No **deductible** applies for asthma inhalers.

Epinephrine injectors important note:

Your cost share will not exceed \$60 for a twin-pack of covered epinephrine injectors.

Durable medical equipment (DME)

Description	In-network
DME	20% per item

	no deductible applies
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Emergency services

Description	In-network
Emergency room	\$200 per visit

	no deductible applies
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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** for 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
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Habilitation therapy services**Outpatient physical (PT), occupational (OT) therapies**

Description	In-network
PT, OT therapies	\$0 per visit no deductible applies

Outpatient speech therapy (ST)

Description	In-network
ST therapy	\$0 per visit no deductible applies

Hearing aids

Description	In-network
Hearing aids	\$0 per item no deductible applies

Limit	One per ear every 24 months
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Home health care

A visit is a period of 4 hours or less

Description	In-network
Home health care	\$30 per visit no deductible applies

Visit limit per day	3 intermittent visits
Limit per year	unlimited

Home health care important note:

Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

Hospice care

Description	In-network
Inpatient services - room and board	\$0 per admission

	no deductible applies
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Other inpatient services and supplies	No charge
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Outpatient services	\$0 per visit
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	no deductible applies
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Hospice important note:

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

Hospital care

Description	In-network
Inpatient services – room and board	\$250 per admission
	no deductible applies
Other inpatient services and supplies	No charge

Infertility services

Description	In-network
Treatment of basic infertility	Covered based on type of service and where it is received

Advanced reproductive technology (ART)

Outpatient services

Description	In-network
Performed at an ART specialist office	Covered based on type of service and where it is received
Performed at a hospital outpatient department	Covered based on type of service and where it is received
Performed at an outpatient facility other than a hospital outpatient department	Covered based on type of service and where it is received
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.
Fertility preservation	Covered based on type of service and where it is received

Limits

Description	In-network
Maximum number of ovulation induction cycles per lifetime while on medications to stimulate the ovaries	6

Jaw joint disorder

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

Maternity and related newborn care

Includes complications and home births provided by perinatal doulas or licensed certified professional midwives.

Description	In-network
Inpatient services – room and board	\$250 per admission
	no deductible applies

Other inpatient services and supplies	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.

Doula

Description	In-network
Home visits by a doula or licensed certified professional midwives (excluding home birth)	\$0 per visit no deductible applies
Prenatal home visit limit per pregnancy	16
Postpartum home visit limit per pregnancy Must occur within the first 12 months after the end of pregnancy	16
Limit per pregnancy Prenatal and postpartum home visits combined	\$8,000

Nutritional support

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

Outpatient surgery

Description	In-network
At hospital outpatient department	\$200 per visit no deductible applies
At facility that is not a hospital	\$200 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
Telemedicine provider consultation Basic medical services	Covered based on type of service and provider from which it is received

Specialist

Description	In-network
Specialist office hours (not surgical, not preventive)	\$30 per visit no deductible applies

Specialist home visit (not preventive)	\$30 per visit no deductible applies
Specialist surgical services	\$30 per visit no deductible applies
Specialist telemedicine consultation	\$30 per visit no deductible applies
Telemedicine provider consultation Specialist services	Covered based on type of service and provider from which it is received

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 this limit are covered the same as physician or specialist office visits
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 drug misuse visit limit per day	1
Counseling for alcohol or drug misuse visit limit	5 visits/12 months
Counseling for obesity, healthy diet visit limit per day	1
Counseling for obesity, healthy diet visit limit	Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Counseling for tobacco cessation visit limit per day	1
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 Visits that exceed this limit are covered the same as physician or specialist office visits

Description	In-network
Immunizations limit	<p>Covered persons age 0-99</p> <p>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</p> <p>For details, contact your physician</p>
Routine cancer screening limits	<p>Subject to any age, family history and frequency guidelines as set forth in the most current:</p> <p>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF</p> <p>The comprehensive guidelines supported by the Health Resources and Services Administration</p> <p>For more information contact your physician or see the <i>Contact us</i> section of your certificate</p>
Routine lung cancer screening limit	<p>1 screening every 12 months</p> <p>Screenings that exceed this limit are covered as outpatient diagnostic testing</p>
Routine physical exam limits	<p>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</p> <p>Limited to</p> <p>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</p> <p>High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months</p>
Well woman routine GYN exam limit	<p>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration</p>

Prosthetic devices

Includes medical wigs and scalp prosthesis

Description	In-network
Prosthetic devices	\$0 per item
	no deductible applies

Reconstructive surgery and supplies

Including breast **surgery**

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

Short-term rehabilitation services

A visit is equal to no more than 1 hour of therapy.

Cardiac rehabilitation

Description	In-network
Cardiac rehabilitation	\$30 per visit no deductible applies

Pulmonary rehabilitation

Description	In-network
Pulmonary rehabilitation	\$30 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
At the physician office	\$30 per visit no deductible applies
At facility that is not a hospital	\$30 per visit no deductible applies
At hospital outpatient department	\$30 per visit no deductible applies

Visit limit per day	1
Visit limit per year Physical, occupational, and speech therapies combined	60

Spinal manipulation

Description	In-network
At the physician office	\$30 per visit no deductible applies
At facility that is not a hospital	\$30 per visit no deductible applies
At hospital outpatient department	\$30 per visit no deductible applies

Skilled nursing facility

Description	In-network
Inpatient services – room and board	\$0 per admission

	no deductible applies
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Other inpatient services and supplies	No charge
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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	\$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

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

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

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

Infusion therapy

Outpatient services

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

Radiation therapy

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

Transplant services

Description	Network (IOE facility)	Network non-IOE facility (Including providers who are otherwise part of Aetna's network but are non-IOE providers)
Inpatient services and supplies	\$250 per admission	Not covered

	no deductible applies	
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Urgent care services

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

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

Description	In-network
Urgent care facility	\$30 per visit

	no deductible applies
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Non-urgent use of an urgent care facility or provider	Not covered
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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	<p>Designated \$0 per visit no deductible applies</p> <p>Non-Designated \$30 per visit no deductible applies</p>
Preventive care immunizations	<p>Designated \$0 per visit no deductible applies</p> <p>Non-Designated \$0 per visit no deductible applies</p>
Preventive care immunization limits	<p>Designated 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</p> <p>For details, contact your physician</p> <p>Non-Designated 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</p> <p>For details, contact your physician</p>
Preventive screening and counseling services	<p>Designated \$0 per visit no deductible applies</p> <p>Non-Designated \$0 per visit no deductible applies</p>
Preventive screening and counseling limits	<p>Designated See the <i>Preventive care services</i> section of the SOB</p> <p>Non-Designated See the <i>Preventive care services</i> section of the SOB</p>

Important note:

Key terms

Designated network provider

A **network provider** listed in the directory under *Best results for your plan* as a **provider** for your plan.

Non-designated network provider

A **provider** listed in the directory under the *All other results* tab as a **provider** for your plan. See the *Contact us* section if you have questions.

You will pay less cost share when you use a designated network **walk-in clinic provider**. Non-designated network **walk-in clinic providers** are available to you, but the cost share will be at a higher level when these **providers** are used.