AWH Southern CA HMO

Health maintenance organization (HMO)
Evidence of coverage (EOC)

Prepared exclusively for:
Contract holder: TERRAKOTTA, INC. DBA LAGUNA CLAY COMPANY
Contract holder number: 0269319
Group agreement effective date: June 01, 2026
Plan effective date: June 01, 2026

Underwritten by Aetna Health of California Inc. in the State of California

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Welcome

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

Welcome to Aetna.

Introduction

This is your evidence of coverage or "EOC." It describes your **covered benefits** – what they are and how to get them. The schedule of benefits tells you how we share expenses for **covered benefits** 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 EOC takes the place of any others sent to you before.

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

This combined EOC and schedule of benefits constitutes only a summary of the health plan. The health plan group agreement must be consulted to determine the exact terms and conditions of coverage.

How we use words

When we use:

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

Contact us

For questions about your plan or request a confidential communication to keep your medical information private, you can contact us by:

- Calling the toll-free number on your ID card
- Logging on to the Aetna website at https://www.aetna.com/
- Writing us at 1385 East Shaw Ave, Fresno, CA 93710

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

- See your coverage, benefits and costs
- Print an ID card and various forms
- Find a **health care provider**, research **health care 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 benefits** from a **health care 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 benefits**, or if you lose it, you can print a temporary one using the Aetna website.

Some hospitals and other health care providers do not provide one or more of the following services that may be covered under your plan that includes:

- **Family planning**
- **Contraceptive services, including emergency contraception**
- **Sterilization, including tubal ligation at the time of labor and delivery**
- **Infertility treatments**
- **Abortion**

Call your health care provider or contact us for help if you have any questions.

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 participate in programs, including but not limited to:

- Fitness reimbursement
- Get Active
- Lifestyle and condition coaching
- Neighborhood wellness

Contact us for more information or contact us by using the contact details on the wellness and other reward information you receive once enrolled.

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.

Timely access to care

Network health care providers agree to provide timely access to care. You will see your **network health care providers** when you call for an appointment within these timeframes:

- Urgent care within 48 hours of the request
- Non-urgent primary or non-**physician mental health or substance use disorder** care within 10 business days of the request and follow-up care for non-physician **mental health or substance use disorder** care within 10 business days of the prior appointment
- Non-urgent specialty care or ancillary services within 15 business days of the request
- Telephone screening within 30 minutes of the request

Network health care providers may have exceptions to appointment wait times when the Department of Managed Health Care allows such exceptions. Interpreter services will be made available to you at the time of your appointment.

You can contact us when you have a complaint or you cannot access care in a timely manner. Contact us by calling the number on your ID card or write to us at:
Customer Service
Aetna Health of California, Inc.
PO Box 24030, Fresno, CA 93779

You can also contact the California Department of Managed Health Care with your concerns at:
California Department of Managed Health Care
980 9th Street, Suite 500, Sacramento, CA 95814-2725
1-888-466-2219, Fax: 916-255-5241, TDD: 1-877-688-9891

MEMBERS' RIGHTS AND RESPONSIBILITIES

As a member, you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your plan, the services your plan offers you, and the **health care providers** available to care for you.
- Make recommendations regarding the plan's **member** rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the plan may impose certain limitations on those services.
- Know the costs for your care, and whether your **deductible** or out-of-pocket maximum have been met.
- Choose a **health care provider** in your plan's network, and change to another doctor in your plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a **health care provider** in your plan's network, including one with a **specialist**.
- Have an appointment with a **health care provider** outside of your plan's network when your plan cannot provide timely access to care with an in-network **health care provider**.
- Certain accommodations for your disability, including:
    - Equal access to medical services, which includes accessible examination rooms and medical equipment at a **health care provider's** office or facility.
    - Full and equal access, as other members of the public, to medical facilities.

    - Extra time for visits if you need it.
    - Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
    - **Trans-inclusive health care**, which includes all **medically necessary** services to treat gender dysphoria or intersex conditions.
    - To be addressed by your preferred name and pronoun.
- Receive from your **health care provider**, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or **medically necessary** treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your **health care providers** in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or **medically necessary** treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive **medically necessary** treatment of a **mental health or substance use disorder.**
- Receive certain preventive health services, including many without a **copay**, **coinsurance**, or **deductible**.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on your plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a **health care provider**.
- Request from your plan a second opinion by an **appropriately qualified health care provider**. Expect your plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most **health care providers** for information regarding who has received your personal health information.
- Ask your plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your **health care provider** or medical group leaves your plan or you are a new plan **member**.
- Have an **advanced health care directive**.

- Be fully informed about your plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
    - Your plan or **health care provider**.
    - Any care you receive, or access to care you seek.
    - Any covered service or benefit decision that your plan makes.
    - Any improper charges or bills for care.
    - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans- Inclusive Health Care, including **medically necessary** services to treat gender dysphoria or intersex conditions.
    - Not meeting your language needs.
- Know why your plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your plan.
- To ask for an **independent medical review** if your plan denied, modified, or delayed a health care service.

As a plan member, you have the responsibility to:

- Treat all **health care providers**, **health care provider** staff, and plan staff with respect and dignity.
- Share the information needed with your plan and **health care providers**, to the extent possible, to help you get appropriate care. Participate in developing mutually agreed-upon treatment goals with your **health care providers** and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your **health care provider** if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your plan or **health care providers**.
- Notify your plan if you have any changes to your name, address, or family members covered under your plan.
- Timely pay any premiums, **copayments**, cost-sharing and charges for non-covered benefits.
- Notify your plan as soon as reasonably possible if you are billed inappropriately.

Coverage

Providing covered benefits

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

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

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

Abortion

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

Acupuncture

Covered benefits include manual or electro acupuncture.

Ambulance services

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

Emergency

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

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

Behavioral health

Mental health treatment

Covered benefits 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
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - Observation
    - Peer counseling support by a peer support specialist (including **telemedicine** consultation)

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

Substance use disorders treatment

Covered benefits 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**
    - Ambulatory or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Peer counseling support by a peer support specialist including **telemedicine** consultation)

Medically necessary treatment of a **mental health or substance use disorder**, including but not limited to, behavioral health crisis services, provided to an enrollee by a 988 center or mobile crisis team, and evaluation and treatment provided by a CARE agreement or plan approved by a court are covered regardless of whether the service is provided by a **network health care provider** or **out-of-network health care provider**.

When contacted by a mobile crisis team, Aetna will authorize post-stabilization care or authorize transfer to another **health care provider** no more than 30 minutes after receiving the request from a mobile crisis team.

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

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Aetna Health Care of California Inc. fails to arrange those services for you with an appropriate health care provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network health care provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment

within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization). If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed health care provider, even if the health care provider is not in your health plan's network. To be covered by your health plan, your first appointment with the health care provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Clinical trials

An **approved clinical trial** means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, treatment of cancer, a **life-threatening** condition or any condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted or delayed. You are eligible to participate in a clinical trial if**:**

- You are eligible to participate in the **approved clinical trial** according to the clinical trial rules and procedures
- Your **health care provider** concluded that your participation is appropriate or you provided medical and scientific information to support your participation

Routine patient costs

Covered benefits 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. **Covered benefits** include all routine patient costs provided when you are not participating in an **approved clinical trial**.

Experimental services or investigational services or therapies

Covered benefits include drugs, devices, treatments, or procedures from a **health care provider** only when you have a **seriously debilitating** condition, a **life-threatening** illness or injury, or a **terminal illness**.

You can submit a grievance if we deny, limit, delay or modify your **covered benefit** for a clinical trial. Please refer to the *Independent medical review* section for more information.

Dental care anesthesia

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

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

Covered benefits include:

- Services

  - Foot devices and 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 visual aids, unless required due to a visual impairment
- Prescribed self-care programs with a **health care provider** certified in diabetes self-management training

Durable medical equipment (DME)

DME and the accessories needed to operate it are:

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

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

Covered benefits 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 benefits 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

Emergency services and care

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911, 988 or your local emergency response service for medical and ambulance help.

Covered benefits include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room or inpatient and outpatient services to evaluate and stabilize a behavioral health crisis by a 988 center or mobile crisis team. You can get **emergency services and care** from **network health care providers** or **out-of-network health care providers**. Behavioral health crisis services means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a **mental health or substance use disorder** crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services.

Your coverage for **emergency services and care** 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 **health care 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 and care**. Different benefits and requirements apply. Please refer to the *How your plan works – Medical necessity, referral and precertification requirements* section and the *Coverage* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your network **physician** or **primary care physician** (**PCP**).

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

Foot orthotic devices

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

Gender affirming treatment

Covered benefits include services and supplies for gender affirming treatment.

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

Habilitation therapy services

Habilitation therapy services 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**

Outpatient physical, occupational, and speech therapies

Covered benefits include:

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

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

Home health care

Covered benefits 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 service**s**, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker

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

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

Hospice care

Covered benefits 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

Hospital care

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

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

Infertility services

Basic infertility

Covered benefits include seeing a **network health care 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.

Advanced reproductive technology (ART) for fertility preservation

Advanced reproductive technology**,** also called "assisted reproductive technology", is a more advanced type of **infertility** treatment. **Covered benefits** include the following services provided by a **network** ART **specialist**:

- In vitro fertilization (IVF) for fertility preservation.
- Cryopreservation (freezing), and storage for eggs, embryos, sperm or reproductive tissue for fertility preservation.

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 health care provider** will request approval from us in advance for your **ART** services.

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 benefits for fertility preservation are provided when:

- You are believed to be fertile
- You have planned services that may directly or indirectly cause **infertility** including but not limited to:

  - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**
  - Other gonadotoxic therapies
  - Removing the uterus
  - Removing both ovaries or testicles
- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the FSH level and ovarian responsiveness criteria outlined in Aetna's **infertility** clinical policy

Aetna's clinical policy for fertility preservation and **infertility covered benefits** are consistent with established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Infertility services not covered:

- All **infertility** services associated with or in support of an injectable drug (menotropin) cycle, including, but not limited to, imaging, laboratory services, professional services.
- Intrauterine/intracervical insemination services.
- Thawing of eggs, embryos, sperm or reproductive tissue.
- All 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 or home pregnancy tests.
- The purchase of donor embryos, donor oocytes or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- **Infertility** treatment when either partner has had voluntary sterilization **surgery**, with or without **surgical** reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.

Jaw joint disorder treatment

Covered benefits include the diagnosis, surgical, and non-surgical treatment of **jaw joint disorder** by a **health care provider**, including:

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

Maternity and related newborn care

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

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

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

Nutritional support

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

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

Obesity surgery and 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 benefits 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

Outpatient surgery

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

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

Physician services

Covered benefits 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**

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
- Second opinions (you or your **health care provider** can request a second opinion)

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

All office visits are covered if you use **telemedicine** instead.

Telemedicine will have the same cost sharing. See the schedule of benefits for more information.

Physician surgical services

Covered benefits 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**

Preventive care

Preventive **covered benefits** 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, except COVID-19 screening and diagnostic testing. If a **covered benefit** isn't listed here under preventive care, it still may be covered under other **covered benefits** in this section. For more information, see your schedule of benefits.

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

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

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

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

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

Breast-feeding support and counseling services

Covered benefits 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 **health care provider**.

Breast pump, accessories and supplies

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

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

Family planning services – contraceptives

Covered benefits include family planning services as follows:

- Counseling services provided by a **physician** or other **health care provider** on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Contraceptive devices and FDA-approved over the counter 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 **health care provider** for voluntary sterilization procedures and related services and supplies. This also could include tubal ligation, sterilization implants and vasectomies.

Immunizations

Covered benefits include preventive immunizations for infectious diseases.

Prenatal care

Covered benefits include your routine pregnancy physical exams at the **physician**, **PCP**, OB, GYN or OB/GYN office and includes participation in the California Prenatal Screening Program. The exams include initial and subsequent visits for:

- Anemia screening
- Blood pressure
- Chlamydia infection screening
- Fetal heart rate check

- Fundal height
- Gestational diabetes screening
- Gonorrhea screening
- Hepatitis B screening
- Maternal weight
- Rh incompatibility screening

Routine cancer screenings

Covered benefits include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, a pathology exam on any removed polyp, and a follow-up colonoscopy after a positive result on any of the recommended tests or procedures for colorectal cancer screening
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

Routine physical exams

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

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

Covered benefits include:

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

Well woman preventive visits

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

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

Prosthetic device

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

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

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

Reconstructive breast surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prostheses

Reconstructive surgery and supplies

Covered benefits include all stages of reconstructive **surgery** by your **health care 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 or repairs abnormal structures of the body caused by:
  - cleft palate (includes **medically necessary** dental or orthodontic services)
  - congenital defects
  - developmental abnormalities
  - disease
  - infection
  - trauma
  - tumors
- The purpose of the **surgery** is to improve function or create normal appearance

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

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

These dental related services are limited to:

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

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

Covered benefits 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 benefits 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 benefits also include spinal manipulation to correct a muscular or skeletal problem. Your **health care 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 benefits include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure**
- Occupational therapy, but only if it is expected to do one of the following:
  - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or **surgical procedure**
  - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own

- Speech therapy

(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.

Skilled nursing facility

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

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

Specialty prescription drugs

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

- Purchased by your **health care provider**
- Injected or infused by your **health care 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 **health 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 benefits include **telemedicine** consultations when provided by a **physician**, **specialist, behavioral health provider** or other **telemedicine health care provider** acting within the scope of their license.

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

Tests, images and labs – outpatient

Diagnostic complex imaging services

Covered benefits 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 benefits include:

- Lab
- Pathology
- Biomarker testing
- Other tests

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

Diagnostic x-ray and other radiological services

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

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

Covered benefits 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 benefits include FDA approved GCIT provided by a **physician**, **hospital** or other **health care provider**. Refer to the *Clinical trials* section for GCIT not approved by the FDA.

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 benefits** 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 **health care providers** are GCIT-designated facilities/ **health care providers** for Aetna and CVS Health.

Important note:
You must get GCIT **covered benefits** from a GCIT-designated facility/ **health care provider**. If there are no GCIT-designated facilities/ **health care 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/ **health care provider** we designate, they will not be **covered benefits**.

Infusion therapy

Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions. **Covered benefits** 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 **health care provider**

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

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

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

Radiation therapy

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

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

Transplant services

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

This includes the following transplant types:

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

Network of transplant facilities

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

You must get transplant services from the facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the IOE facility **copayment**, **coinsurance**, **deductible**, **maximum out-of-pocket** and limits shown in your 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 benefits**.

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 benefits** is not directly related to your transplant.

Urgent care services

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

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

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

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

Vision care

Adult vision care

Covered benefits include:

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

Pediatric vision care

Covered benefits include:

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

Walk-in clinic

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

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

General plan exclusions

The plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this **evidence of coverage** (**EOC**).

These exclusions and limitations do not apply to **medically necessary** basic health care services required to be covered under California or federal law, including but not limited to **medically necessary** treatment of a **mental health or substance use disorder**, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the plan or required by law.

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

Chiropractic services

This plan does not cover chiropractic services, except as described in this **EOC** in Short-term rehabilitation services or as required by law.

Clinical trials

This plan does not cover clinical trials, except **approved clinical trials** as described in this **EOC** in the *Coverage* section or as required by law.

Coverage of **approved clinical trials** does not include the following:

- The investigational drug, item, or service itself.
- Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the **member**.
- Drugs, items, devices, and services specifically excluded from coverage in this **EOC**, except for drugs, items, devices, and services required to be covered pursuant to state and federal law.
- Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

This exclusion does not limit, prohibit, or modify a **member's** rights to the **experimental services** or **investigational services** independent review process as described in this **EOC** in Grievance and appeal procedures, or to the **independent medical review (IMR)** from the Department of Managed Health Care (DMHC) as described in this EOC in Grievance and appeal procedures.

Cosmetic services, supplies, or surgeries

This plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in this **EOC** in the *Coverage* section, or as required by law. The plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this **EOC** in the *Coverage* section, or as required by law.

This exclusion does not apply to the following:

- **Medically necessary** treatment of complications resulting from cosmetic **surgery**, such as infections or hemorrhages.
- Reconstructive **surgery** as described in this **EOC** in the *Coverage* section.
- For gender dysphoria, reconstructive **surgery** of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a **member** identifies, in accordance with the standard of care as practiced by **physicians** specializing in reconstructive **surgery** who are competent to evaluate the specific clinical issues involved in the care requested as described in this EOC in the *Coverage* section.

Custodial or domicillary care

This plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as described in this **EOC** in the *Coverage* section or as required by law.

This exclusion does not apply to the following:

- Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or **health professionals**.
- Assistance with activities of daily living that is provided as part of covered hospice, **skilled nursing facility**, or inpatient **hospital** care.
- Custodial care provided in a healthcare facility.

Dental services

This plan does not cover dental services or supplies, except as described in this **EOC** in the *Coverage* section or as required by law.

Dietary or nutritional supplements

This plan does not cover dietary or nutritional supplements, except as described in this **EOC** in the *Coverage* section or as required by law.

Disposable supplies for home use

This plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this **EOC** in the *Coverage* section or as required by law.

Experimental services or investigational services

This plan does not cover **experimental services** or **investigational services**, except as described in this **EOC** in the *Coverage* section or as required by law.

Experimental services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. **Experimental services** are not undergoing a clinical investigation.

Investigational services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

- Testing is not complete; and
- The efficacy and safety of such services in human subjects are not yet established; and
- The service is not in wide usage.

The determination that a service is an **experimental service** or **investigational service** is based on:

- Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
- Consultation with provider organizations, academic and professional **specialists** pertinent to the specific service;
- Reference to current medical literature.

However, if the plan denies or delays coverage for your requested service on the basis that it is an **experimental service** or **investigational service** and you meet all the qualifications set out below, the plan must provide an external, independent review.

Qualifications

- You must have a **life-threatening** or **seriously debilitating** condition.
- Your **health care provider** must certify to the plan that you have a **life- threatening** or **seriously debilitating** condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the plan.
- Either (a) your **health care provider**, who has a contract with or is employed by the plan, has recommended a drug, device, procedure, or other therapy that the **health care provider** certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your **health care provider**, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.
- You have been denied coverage by the plan for the recommended or requested service.
- If not for the plan's determination that the recommended or requested service is an **experimental service** or **investigational service**, it would be covered.

External, Independent Review Process
If the plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the plan will notify you within five business days of its decision and your opportunity to request external review of the plan's decision. If your **health care provider** determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC's Independent Medical Review (IMR)
This exclusion does not limit, prohibit, or modify a **member's** rights to an IMR from the DMHC as described in this EOC in the Coverage section. In certain circumstances, you do not have to participate in the plan's grievance or appeals process before requesting an IMR of denials for **experimental services** or **investigational services**. In such cases you may immediately contact the DMHC to request an IMR of this denial. See the Coverage section.

Hearing aids
This plan does not cover hearing aids, except as described in this **EOC** in the *Coverage* section or as required by law.

Immunizations
This plan does not cover non-medically necessary or non- preventive immunizations solely for foreign travel or occupational purposes, except as described in this **EOC** in the *Coverage* section or as required by law.

Non-licensed or non-certified providers
This plan does not cover treatments or services rendered by a non- licensed or non-certified **health care provider**, except as described in this **EOC** in the *Coverage* section or as required by law. This exclusion does not apply to **medically necessary** treatment of a **mental health or substance use disorder** furnished or delivered by, or under the direction of, a **health care provider** acting within the scope of practice of the provider's license or certification under applicable state law.

Personal or comfort items
This plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.

Private duty nursing
This plan does not cover private duty nursing in the home, **hospital**, or long-term care facility, except as described in this **EOC** in the Coverage section or as required by law.

Reversal of voluntary sterilization
This plan does not cover reversal of voluntary sterilization, except for **medically necessary** treatment of medical complications, except as described in this **EOC** in the *Coverage* section or as required by law.

Routine physical examination

This plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non- preventive purpose, except as described under this **EOC** in the *Coverage* section or as required by law.

Surrogate pregnancy

This plan does not cover testing, services, or supplies for a person who is not covered under this plan for a surrogate pregnancy, except as required by law.

Therapies

This plan does not cover the following physical and occupational therapies, except as described in this **EOC** in the *Coverage* section or as required by law:

- Massage therapy, unless it is a component of a treatment plan;
- Training or therapy for the treatment of learning disabilities or behavioral problems;
- Social skills training or therapy; and
- Vocational, educational, recreational, art, dance, music, or reading therapy.

Travel and lodging

This plan does not cover transportation, mileage, lodging, meals, and other **member**-related travel costs, except for licensed ambulance or psychiatric transport as described in this **EOC** in the *Coverage* section or as required by law.

Vision care

This plan does not cover vision services, except as described in this **EOC** in the Coverage section or as required by law.

Weight control programs and exercise programs

This plan does not cover weight control programs and exercise programs, except as described in this **EOC** in the Coverage section or as required by law.

How your plan works

How your plan works while you are covered

Your HMO plan:

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

Please read the following information so you will know from whom or what group of health care provider's health care may be obtained.

Health care providers

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

You choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **health care providers** when you need specialized care. Your plan often will pay a bigger share for **covered benefits** you get through your **PCP**, so choose a **PCP** as soon as you can.

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

Service area

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

Who provides the care

Network health care providers

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

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

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

- **Medically necessary** treatment of a **mental health or substance use disorder**, including but not limited to, behavioral health crisis services, provided to an enrollee by a 988 center or mobile crisis team.
- The evaluation and treatment provided by a CARE agreement or plan approved by a court.

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

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

Your PCP

You must get **covered benefits** through your **PCP**.

How you choose your PCP

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

Each covered family member is required to select a **PCP**. You may each choose a different **PCP**. You must 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 health care providers**.

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

Changing your PCP

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

If you do not select a PCP

Because having a **PCP** is so important, we may choose one for you. You will get an ID card in the mail. We will tell you the name, address and telephone number of your **PCP**. If you wish, you can change the PCP by following the directions above for *Changing your PCP.*

Until a **PCP** is selected, benefits will be limited to care provided by direct access **network health care providers**, **emergency services and care** and urgent care services.

How is my PCP paid?

Your **PCP** and other **health care providers** may be paid in any of the following ways, depending on their contract with us:

- A fixed price per service
- A fixed price per day
- A fee for each service set by a fee schedule
- A fixed monthly amount per **member**

Health care providers who contract with us have no requirement to comply with:

- Specified numbers
- Targeted averages
- Maximum duration for patient visits

We encourage you to ask your **PCP**, us, your **health care provider**, or the **health care provider's** medical group or independent practice association how they are paid, including if their contracts include any financial incentives.

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

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

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

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

Care will continue during a transitional period that will vary based on your condition.

If you have this condition	**The length of transitional period is**
Acute condition (appears suddenly requiring immediate care and does not last long)	As long as the condition lasts
Serious chronic condition (continues or worsens over time and requires ongoing treatment)	No more than 12 months.
Pregnancy	All three trimesters of pregnancy and the immediate post-partum period
Maternal mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery	Up to 12 months after diagnosis or after pregnancy ends, whichever occurs later
Terminal illness	As long as the person lives
Care of child under 3 years	Up to 12 months
An already scheduled **surgery** or other procedure	Within 180 days of you joining the Aetna plan or your **health care provider** leaving the network

If this situation applies to you, contact us for details. As long as the **health care provider** did not leave the network based on fraud or lack of quality standards, you'll be able to receive transitional care from your **health care provide**r for a period based on your condition. You will not be responsible for an amount that exceeds the cost share that would have applied had your **health care provider** remained in the network.

Medical necessity, referral and precertification requirements

Your plan pays for its share of the expense for **covered benefits** only if the general requirements are met. They are:

- The service is **medically necessary**

- You get your care from:
  - Your **PCP**
  - Another **network health care provider** after you get a **referral** from your **PCP**
- You or your **health care provider** precertifies the service when required

Medically necessary, medical necessity

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

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

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 an **experimental service or investigational service**. 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.

Referrals

You need a **referral** from your **PCP** for most **covered benefits**. If you do not have a **referral** when required, you will have to pay for services yourself. You do not need a **referral** for **covered benefits** in a **network walk-in clinic**.

Precertification

You need pre-approval from us for some **covered benefits**. Pre-approval is also called **precertification**. You may need **precertification** during the delivery of your care. We will review your request concurrently.

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

Timeframes for **precertification** are listed below. For **emergency services and care**, **precertification** is not required, but you should notify us as soon as possible. You can submit a grievance if we deny the **emergency services and care** as not **medically necessary**. Please see the *Grievance and appeal procedures* section.

Your **physician**, **PCP**, or the facility must call us within these timelines:

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

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

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

Type of request	Timeframes we decide	Timeframes we provide notification
Urgent care	Within 72 hours as appropriate for the medical condition	Within 24 hours of the decision to your **health care provider** Within two business days of the decision in writing to you
Non-urgent care	Within five business days as appropriate for the medical condition	Within 24 hours of the decision to your **health care provider** Within two business days of the decision in writing to you
Requests for review after you receive care	Within 30 days	Within 30 days

We will tell you and your **physician** in writing of the **precertification** decision. An approval is valid for 180 days as long as you remain enrolled in the plan. If you or your **health care provider** request **precertification** and we don't approve coverage, we will tell you why and explain how you or your **health care provider** may request review of our decision. See the *Grievance and appeal procedures* section.

Types of services that require precertification
Precertification is required for inpatient **stays** and certain outpatient services and supplies.

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

Inpatient services and supplies	Outpatient services and supplies
Gene-based, cellular and other innovative therapies (GCIT)	Applied behavioral analysis
Obesity (bariatric) **surgery**	ART services
Stays in a **hospice** facility	Complex imaging
Stays in a **hospital**	Comprehensive **infertility** services
Stays in a **rehabilitation facility**	**Cosmetic** and reconstructive **surgery**
Stays in a residential treatment facility for treatment of **mental health or substance use disorders** treatment	Gene-based, cellular and other innovative therapies (GCIT)
	Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
	In vitro fertilization (IVF) for fertility preservation
	Kidney dialysis
	Knee **surgery**
	Outpatient back **surgery** not performed in a **physician's** office
	Partial hospitalization treatment – **mental health disorder** or **substance use disorders** treatment
	Sleep studies
	Transcranial magnetic stimulation (TMS)
	Wrist **surgery**

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

Precertification is not required for services provided by a 988 center or mobile crisis team or treatment provided by a CARE agreement or plan approved by a court (except **prescription drugs**).

Sometimes you or your **health care 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 **health care provider** requests the pre-service clinical review of a service that does not require **precertification**.

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

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

For certain drugs, your **health care provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**. We will tell your **health care provider** the decision within 72 hours or within 24 hours when you have an **emergency medical condition**

Step therapy is a type of **precertification** where you must try one or more prerequisite drugs before a **step therapy** drug is covered. A 'prerequisite' is something that is required before something else. Prerequisite drugs are FDA-approved, may cost less and treat the same condition. If you don't try the prerequisite drugs first, the **step therapy** drug may not be covered.

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

Requesting a medical exception
Sometimes you or your **health care 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 **health care 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 **health care 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 decision within 24 hours after we receive your request. We will tell you, someone who represents you and your **health care provider** of our decision.

If you had approval for a prescription drug under a prior plan, your prescriber can continue to prescribe the same prescription drug for your medical condition under this plan.

What the plan pays and what you pay

Who pays for your **covered benefits** – 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 benefit**. 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 health care provider**.

Negotiated charge

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

We may enter into arrangements with **network health care 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.

Surprise bill

There may be times when you unknowingly receive services or don't consent to receive services from an **out-of-network health care provider**, even when you try to stay in the network for your **covered benefits**. 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 health care 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 and care** provided by an **out-of-network health care provider** and ancillary services initiated from your **emergency services and care**
- Non-emergency services provided by an **out-of-network health care provider** at an in-network facility, except when the **out-of-network health care provider** has given you the following:
  - The out-of-network notice for your signature for your consent to be treated and balance billed
  - The estimated charges for the items and services
  - Notice that the **health care provider** is an **out-of-network health care provider**
- Out-of-network air ambulance services

The **out-of-network health care 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 health care provider** because there was no **network health care 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:

- **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 settings

A surprise bill claim is paid based on the greater of the average contracted rate or 125 percent of the Medicare reimbursement 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 **health care 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

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.

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

Paying for covered benefits – the general requirements

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

- The service is **medically necessary**
- You get your care from a **network health care provider**
- You get your care from:
  - Your **PCP**

  - Another **network health care provider** after you get a **referral** from your **PCP**
- You or your **health care provider** precertifies the service when required

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

You pay the entire expense when:

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

In all these cases, the **health care provider** may require you to pay the entire charge or you may receive a bill. You or your **health care provider** may file a post-services claim. Any amount you pay will not count towards your **deductible** or your **maximum out-of-pocket limit**.

If we fail to pay the **network health care provider**, you will not have to pay the **network health care provider** for any sums that we owe.

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 benefits** and any benefit limitations that apply to your plan. It also shows any **maximum out-of-pocket limits** that apply.

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

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

Post-service claims

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

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

Filing a claim

When you see a **network health care provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network health care 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 or pay for services, you or your **health care 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, **health care providers** and cost of your services.

Claim decisions and notifications

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 **health care provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely.

We 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 *Grievance and appeal procedures* section for that information.

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. Please see the *Grievance and appeal procedures* section for that information.

Coordination of benefits

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

Key Terms

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

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

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

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other government benefits

- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

How COB works

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

Determining who pays

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

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

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

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

How 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 enrolled in Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare.

Other health coverage updates – contact information

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

Our rights

We have the right to:

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

Grievance and appeal procedures

Grievance

You may not be happy about a **health care provider**, your quality of care, or an operational issue, and you may want to complain. You can contact us at any time. Grievances are:

- Appeals
- Complaints
- Disputes
- Inquiries (considered grievances when a distinction is not determined between them)
- Requests for reconsideration

Your grievance 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. You can submit your grievance by:

- Calling the toll-free number on your ID card
- Logging on to the Aetna website at https://www.aetna.com/
- Writing us at PO Box 24030, Fresno, CA 93779

Some reasons you may file a grievance include:

- Your **PCP** refused to provide a **referral** to a **specialist** or facility
- We were not courteous or prompt when providing services to you
- You are dissatisfied with having to wait so long for an appointment
- We ended your coverage and you think that decision is unfair

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-800-445-5299 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

Grievance and appeal procedures

You or your **health care provider** may contact us at various times to make a grievance. 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. You can request an IMR from the DMHC. See the *Independent medical review* section below.

Urgent grievance

You may appeal or your **health care provider** may appeal for you without having to fill out an appeal form.

Post-service claim appeal

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

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

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

We will assign your appeal to someone who was not involved in making the original decision. You will receive an acknowledgment letter within five calendar days. You will receive a decision within 30 calendar days for a post-service grievance. You will receive a decision within five business days for a post-service grievance for a service or supply that is an **experimental service** or **investigational service.**

Another person may submit an appeal for you, including a **health care 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 **health care 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.

Independent medical review (IMR)

An IMR is a review done by an Independent Medical Review Organization (IMRO) managed by the DMHC.

You have a right to an IMR when within six months of the grievance decision if:

- You have received an adverse benefit determination
- We decided the service or supply is not **medically necessary** but your **health care provider** recommends or determines your service is **medically necessary**
- We decided the service or supply is an **experimental service** or **investigational service** and your **health care provider** certifies you have a **life-threatening** or **seriously debilitating** illness and has recommended treatment for it
- You have been seen by a network **health care provider** for the diagnosis or treatment of a medical condition

- A grievance has remained unsolved for more than 30 days or three days for an **urgent condition** or an **emergency medical condition** or a grievance was filed and the decision was upheld

If our grievance decision is one for which you can seek an IMR, 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 IMR process and will include a copy of the IMR application. You will not be charged for an IMR.

You should send the completed application to the DMHC. They will review your grievance and determine if it is eligible for an IMR. We will submit the required documents to the DMHC within three days, or 24 hours for urgent requests, after we receive notice the IMR is approved. The DMHC sends your grievance to the IMRO. The IMRO will determine whether or not the care is **medically necessary**. You will receive a copy of the IMR decision.

How long will it take to get an IMR decision?

The IMR will make their decision in 30 days, or three days for an urgent request

There are two scenarios when you may be able to get a faster IMR:
For initial adverse benefit determinations

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

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.

Recordkeeping

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

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a grievance or appeal.

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

The contract holder decides and tells us who is eligible for health coverage. The contract holder is responsible for paying premiums and will tell you the amount and how to pay it.

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

Adding new dependents

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

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

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

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

Special times you can join the plan

You can enroll in these situations:

- You didn't enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan

We must receive the completed enrollment information within 31 days after the event date.

You can also enroll in these situations:

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

We must receive the completed enrollment information within 60 days of the date when coverage ends.

Notification of change in status

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

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

Starting coverage

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

Stopping coverage

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

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends at least 30 days prior to that date.

Your coverage under this plan will end if:

- This plan is no longer available

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

When dependent coverage ends

Dependent coverage will end if:

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

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?

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 within 24 months of your effective date. These serious consequences include:

- Rescission of coverage (you lose coverage both going forward and going backward)
- Ending your coverage
- Recovery of amounts we already paid

We also may report fraud to criminal authorities. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind or end your coverage:

- We will give you 30 days advance written notice of any rescission of coverage or ending your coverage
- You have the right to an Aetna appeal
- You have the right to a third-party review conducted the Department of Managed Health Care

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

We will not end your coverage because of your health status or health care needs. We also will not end your coverage because you filed an appeal. You can submit a grievance to us or California Department of Managed Health Care within 180 days from the date of the notice you receive if you believe your coverage has been or will be improperly cancelled, rescinded, or not renewed. Your coverage will continue while your grievance is under review and you pay your premium if you submitted your grievance before the effective date of the improperly cancelled, rescinded, or not renewed coverage for reasons other than nonpayment.

You also have a grace period of 30 consecutive days beginning the date of the notice you receive is dated. We will give you an answer within 72 hours.

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

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

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

How you can extend coverage for your disabled child beyond the plan age limits
You have the right to extend coverage for your dependent child beyond plan age limits, if the child is not able to be self-supporting because of mental or physical disability, and depends mainly (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 will send you a notice at least 90 days before your child reaches the plan age limit. We may ask you to send us proof of the disability within 60 days of the date coverage would have ended or receipt of the notice. 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 after two years. You must send it to us within 60 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 your plan
- The dependent becomes covered by another health benefits plan
- The date your spouse remarries

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

General provisions – other things you should know

Administrative provisions

How you and we will interpret this EOC

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

How we administer this plan

We apply policies and procedures to administer this plan.

Who's responsible to you

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

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

Coverage and services

Your coverage can change

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

Legal action

You must complete the internal appeal process before you take any legal action against us for any expense or bill. See the *Grievance and appeal procedures section*.

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

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.

Some other money issues

Assignment of benefits

When you see a **network health care provider**, they will usually bill us directly. When you see an **out-of-network health care provider**, we may choose to pay you or to pay the **health care provider** directly. When you assign your benefits to your **out-of-network health care provider**, we will pay them directly.

Financial sanctions exclusions

If coverage provided under this EOC violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **covered benefits** 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 benefits** or pay for something that this plan doesn't cover. If we do, we can require the person we paid, you or your **health care provider**, to return what we paid. If we don't do that, we have the right to reduce any future benefit payments by the amount we paid by mistake.

When you are injured

If someone else caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money. We are entitled to that money, up to the amount we pay for your care. We have that right no matter whom the money comes from – for example, the other driver, the contract holder, or another insurance company.

To help us get paid back, you are doing these things now:

- Agreeing to repay us from money you receive (not exceeding one third if you used an attorney or one half if you did not use an attorney) because of your injury.
- Giving us the right to seek money in your name, from any person who causes you injury and from your own insurance. We can seek money only up to the amount we paid for your care.
- Agreeing to cooperate with us so we can get paid back in full. For example, you'll tell us within 30 days of when you seek money for your injury or illness. You'll hold any money you receive until we are paid in full. And you'll give us the right to money you get, ahead of everyone else.
- Agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money.

We may reduce the amount we're due if you are partially responsible for your injury.

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 **health care providers** share information with us. We need information about your physical and mental condition and care.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be provided to you upon request.

Glossary

Advanced health care directive

Advanced health care directive means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the plan or the California Attorney General's Office.

Appropriately qualified health care provider

Appropriately qualified health care provider means a **health care provider** who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved clinical trial

Approved clinical trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another **life- threatening** disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
    - The National Institutes of Health.
    - The federal Centers for Disease Control and Prevention.
    - The Agency for Healthcare Research and Quality.
    - The federal Centers for Medicare and Medicaid Services.
    - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
    - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
        - The United States Department of Veterans Affairs.
        - The United States Department of Defense.
        - The United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Behavioral health provider

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

A **health professional** who is qualified to provide **covered benefits** for autism.

Brand-name prescription drug

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

Coinsurance

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

Copay, copayment

This is the dollar amount you pay for **covered benefits**. In **prescription drug** plans, it is the amount you pay for covered drugs.

Covered benefits

Covered benefits means those **medically necessary** services and supplies that you are entitled to receive under a group agreement and which are described in this **evidence of coverage** or under California health plan law.

Deductible

A **deductible** is the amount you pay out-of-pocket for **covered benefits** 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

Emergency medical condition means a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services and care

Emergency services and care means:

- Medical screening, examination, and evaluation by a **physician** and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a **physician** and surgeon, to determine if an **emergency medical condition** or active labor exists

and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the **emergency medical condition**, within the capability of the facility; and/or

- An additional screening, examination, and evaluation by a **physician**, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a **psychiatric emergency medical condition** exists, and the care and treatment necessary to relieve or eliminate the **psychiatric emergency medical condition** within the capability of the facility.

Evidence of coverage

Evidence of coverage means any certificate, agreement, contract, brochure, or letter of entitlement issued to a **member** setting forth the coverage to which the **member** is entitled.

Experimental services

Experimental services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. **Experimental services** are not undergoing a clinical investigation.

Formulary exclusions list

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

Generic prescription drug

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

- Dosage
- Safety
- Strength
- Quality
- Performance

Health care provider

Health care provider means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

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.

Independent medical review (IMR)

Independent medical review (IMR) means a review of your plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your plan related to **medical necessity** of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. Your plan must pay for the services if an IMR decides you need it.

Infertile, infertility

The presence of a demonstrated condition recognized by a licensed **physician** and surgeon as a cause of **infertility** or the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception

Investigational services

Investigational services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

- Testing is not complete; and
- The efficacy and safety of such services in human subjects are not yet established; and
- The service is not in wide usage.

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

Life-threatening

Life-threatening means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

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 benefits**.

Medically necessary, medical necessity

Medically Necessary, medical necessity means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of **mental health or substance use disorder** care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and **members** or for the convenience of the patient, treating **physician**, or other **health care provider**.

Member

Member means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the plan and for whom coverage is active or live.

Mental health or substance use disorder

Mental health or substance use disorder means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Negotiated charge

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

Network health care provider

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

Out-of-network health care provider

A **health care provider** who is not a **health care provider**, or a **network health care provider** that is seen without a **referral**.

Outpatient prescription drug

Outpatient prescription drug means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or **mail order pharmacy**, requires a **prescription**, and has not been provided for use on an inpatient basis.

Physician

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

Precertification, precertify

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

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

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

Prescription drug
Prescription drug or "drug'' means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a **prescription** and is not provided for use on an inpatient basis. The term "drug'' or "**prescription drug**'' includes:

- disposable devices that are **medically necessary** for the administration of a covered **prescription drug**, such as spacers and inhalers for the administration of aerosol **outpatient prescription drugs**;
- syringes for self-injectable **prescription drugs** that are not dispensed in pre-filled syringes;
- drugs, devices, and FDA-approved products covered under the **prescription drug** benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and
- at the option of the health plan, any vaccines or other health care benefits covered under the plan's **prescription drug** benefit.

Primary care physician (PCP)
A **physician** who:

- The directory lists as a **PCP**
- Is selected by a person from the list of **PCP**s in the directory
- Supervises, coordinates and provides initial care and basic medical services to a person
- Initiates **referrals** for **specialist** care, if required by the plan, and maintains continuity of patient care
- Shows in our records as your **PCP**

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

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

Psychiatric emergency medical condition
Psychiatric emergency medical condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

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 or substance use disorders**.

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

Residential treatment facility
An institution specifically licensed as a **residential treatment facility** by applicable laws to provide for **mental health or substance use disorder** residential treatment programs. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

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.

Seriously debilitating
Seriously debilitating means diseases or conditions that cause major irreversible morbidity.

Service area
Service area means the geographic area designated by the plan within which a plan shall provide health care services.

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

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

Skilled nursing facility does not include institutions that provide only:

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

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

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

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

Specialty prescription drugs
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.

Standard fertility preservation services
Standard fertility preservation services means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

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

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

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

The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

Terminal illness

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

Trans-inclusive health care

Trans-inclusive health care means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

Urgent condition

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

Value prescription drugs

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

Walk-in clinic

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

- Drug store
- Pharmacy
- Retail store
- Supermarket

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

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