Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call the number on your ID card.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

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

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Language Assistance

TTY:711

English	**To access language services at no cost to you, call the number on your ID card.**
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਨਿਾਂ ਕਸਿੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦੱਤਿੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Mon-Khmer, Cambodian	ដើម្បីទទួលហានសវោកម្មភាសាដលែឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដលែមាននៅលើបណ្ណាសម្គាល់ខ្លួន របស់លោកអ្នក។
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Hindi	बनिा कसिी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน

Preferred provider organization (PPO) medical plan

Certificate of coverage

OA Managed Choice POS Silver
Plan name: CA 65/50 2600
PPID: CAM0140010124871 - 14052955

Underwritten by Aetna Life Insurance Company in the state of California

Table of contents

Welcome

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

Welcome to Aetna.

Introduction

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

It's really important that you read the entire certificate and your schedule of benefits.

If you need help or more information, see the *Contact us* section below.

How we use words

When we use:

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

Contact us

For questions about your plan, complaints, including those regarding *Timely access to care*, or to request a confidential communication to keep your medical information private, **you can contact us by**:

- **Calling the toll-free number on your ID card or 1-800-872-3862**
- **Writing us at 151 Farmington Ave, Hartford, CT 06156**
- **Visiting https://www.aetna.com to access your member website**

If we don't provide a resolution after you contact us, **you can contact the California Department of Insurance at**:

California Department of Insurance-Consumer Services Division
300 Spring Street, South Tower, Los Angeles, CA 90013
1-800-927-HELP (4357), TDD: 1-800-482-4TDD (4833)
www.insurance.ca.gov

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

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

Your ID card

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

Wellness and other rewards

You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to access certain health services or categories of healthcare **providers**, participate in programs, utilize tools, improve your health metrics or continue participation as an Aetna member through incentives. Talk with your **provider** about these and see if they are right for you. We may provide incentives based on your participation and outcomes such as:

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

Discount arrangements

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

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We are not responsible; but, we have the right to change or end the arrangements at any time.

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

Timely access to care

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

- Urgent care within 48 hours of the request
- Non-urgent primary care or non-physician behavioral health care within 10 business days of the request and follow-up care for non-physician behavioral health 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

Standards for timely access to pediatric vision and oral essential health benefits include:

- Urgent care within 48 hours of the request
- Non-urgent care within 36 business days of the request
- Preventive care within 40 days of the request

Important note:
You will be covered for in-network and out-of-network benefits regardless of where you live. See *Who provides the care* section for details.

You will be covered for **emergency services** at the in-network level.

Coverage and exclusions

Providing covered services

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

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

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

For example:

Physician care generally is covered but **physician** care for cosmetic **surgery** is never covered. This is an exclusion.

Home health care is generally covered but it is a **covered service** only up to a set number of visits a year. This is a limitation.

Your **provider** may recommend services that are considered **experimental or investigational** services. But an **experimental or investigational** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of services below.

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

The **covered services** and exclusions below appear alphabetically to make it easier to find what you're looking for. You can find out about limitations for **covered services** in the schedule of benefits. If a service isn't listed here as a **covered service** or is listed as not covered under a specific service, it still may be covered. If you have questions, ask your **provider** or contact us. You can find out about limitations for **covered services** in the schedule of benefits.

Abortion

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

Acupuncture

Covered services include manual or electro acupuncture.

The following are not **covered services**:

- Acupressure

Ambulance services

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

Emergency

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

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

Non-emergency

Covered services also include **precertified** transportation by a licensed ambulance or psychiatric transport van when it is the only safe way to transport you.

The following are not **covered services**:

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

Behavioral health

Medically necessary treatment of **mental health disorders** and **substance use disorders** are covered under the same terms and conditions applied to other medical conditions.

Mental health disorders treatment

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

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group, and family therapies for the treatment of **mental health disorders**
  - Other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease

- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- Observation
- Behavioral health crisis services provided by a 988 Crisis Hotline Center or mobile crisis team
- Peer counseling support by a peer support specialist (includes **telemedicine** consultation)

Substance use disorders treatment

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

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group, and family therapies for the treatment of **substance use disorders**
  - Other outpatient **substance use disorders** treatment such as:
    - Partial hospitalization treatment provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
    - Ambulatory or outpatient **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Behavioral health crisis services provided by a 988 Crisis Hotline Center or mobile crisis team
    - Peer counseling support by a peer support specialist (includes **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**.

Clinical trials

Routine patient costs

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

The following are not **covered services**:

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

Experimental or investigational therapies

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

- You are eligible to participate in the approved clinical trial
- Your participation is appropriate to treat the disease or condition based on your **provider's** conclusion or based on medical and scientific information provided by you

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, or treatment of cancer or other life-threatening disease or condition.

Dental care anesthesia

Covered services 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.

The following are not **covered services**:

- The related dental service unless specifically listed as a covered service in this certificate or the schedule of benefits.

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

Covered services include:

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

Durable medical equipment (DME)

Covered services are DME and the accessories needed to operate it 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. In addition to Medicare guidance, covered items include:

- Bone stimulator
- Cervical traction (over door)
- Dry pressure pad for a mattress
- Enteral pump and supplies
- IV pole
- Nebulizer and supplies
- Peak flow meters
- Phototherapy blankets for treatment of jaundice in newborns
- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Tracheostomy tube and supplies

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

Covered services also include:

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

The following are not **covered services**:

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

Emergency services

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

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

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

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

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

Foot orthotic devices

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

Gender affirming treatment

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

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

Habilitation services

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

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

Outpatient physical, occupational, and speech therapy

Covered services include:

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

The following are not **covered services**:

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

Hearing exams

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

The following are not **covered services**:

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

Home health care

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

- You are homebound
- Your **physician** orders them
- The services are a part of a home health care plan
- The services are **skilled nursing services**, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker

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

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 services* in this section and the schedule of benefits.

The following are not **covered services**:

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

Hospice care

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

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

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

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

The following are not **covered services**:

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

Hospital care

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

- Semi-private **room and board**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge.
- Services of **physicians** employed by the **hospital**.
- Administration of blood and blood derivatives.

The following are not **covered services**:

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

- Health resorts
- Spas
- Schools or camps

Infertility services

Basic infertility

Covered services include seeing a **provider**:

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

Advanced reproductive technology (ART)

Advanced reproductive technology**,** also called "assisted reproductive technology", is a more advanced type of **infertility** treatment. **Covered services** include the following service provided by an 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 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**. You can call the NIU at 1-800-575-5999.

Fertility preservation

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

Covered services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned services that are proven to result in **infertility** such as:
  - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**
  - Other gonadotoxic therapies
  - Removing 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

The following are not **covered services**:

- **Infertility** services associated with or in support of an ovulation induction cycle while on injectable medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Intrauterine/intracervical insemination services.
- **Infertility** services associated with or in support of an Advanced Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, and professional services

  - In vitro fertilization (IVF), except for fertility preservation
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers
  - Gestational carrier cycles
  - Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery).
- Thawing of cryopreserved (frozen) eggs, 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 eggs or donor sperm. The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- 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.
- **Infertility** treatment when **infertility** is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's **infertility** clinical policy.
- Treatment for dependent children, except for fertility preservation as described above.
- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.

Jaw joint disorder treatment

Covered services include the diagnosis, surgical, and non-surgical, treatment of **jaw joint disorder** by a **network 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 services include pregnancy (prenatal) care, care after delivery and obstetrical services. After your child is born, **covered services** include:

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

If the mother is discharged earlier, the plan will pay for 1 home visits after delivery by a health care **provider**. **Covered services** also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

- Births that take place in the home or in any other place not licensed to perform deliveries

Nutritional support

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

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

The following are not **covered services**:

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

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 services include:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- 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
- Travel and lodging expenses for you and a companion (if you live 50 miles or more from the facility)

The following non-preventive care services are not **covered services:**

- Weight management treatment
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate.
- Stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

See *Counseling services* in the *Preventive care* section and *Obesity drugs* in the *Prescription drugs - outpatient* section for other **covered services**.

Oral and maxillofacial treatment (mouth, jaws and teeth)

Covered services include the following when provided by a **physician**:

- Cutting into gums and tissues of the mouth:
  - Only when not associated with the removal, replacement or repair of teeth

Outpatient surgery

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

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

The following are not **covered services**:

- A **stay** in a **hospital** (see *Hospital care* in this section)
- Services of another **physician** for the administration of a local anesthetic

Pediatric dental care

Covered services include dental services and supplies, described in the Pediatric dental care section of the schedule of benefits, when provided by a dental provider. We have grouped them as Type A, B and C, and orthodontic treatment services in the schedule of benefits. **Medically necessary** orthodontic treatment is covered when medically necessary to:

- Prevent disease
- Promote oral health
- Restore oral structures to the health and function
- Treat **emergency medical conditions**

Covered services also include dental services provided for an **emergency medical condition**.

You should consider calling your network **dental provider** who may be more familiar with your dental needs. Services given for other than the temporary relief of the **emergency medical condition** by an **out-of-network provider** can cost you more. To get the maximum level of benefits, services should be provided by your network **dental provider**.

The following are not covered under this benefit:

- **Cosmetic** services and supplies including:
  - Plastic **surgery**, reconstructive **surgery**, **cosmetic surgery**, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Substances to protect, clean, whiten bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons
  - Facings on molar crowns and pontics will always be considered **cosmetic**
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge

- Dental implants (that are determined not to be **medically necessary**), mouth guards and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic **surgery**, and treatment of malocclusion or devices to alter bite or alignment except as covered in the *Jaw joint disorder treatment* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another **covered service**
- Orthodontic treatment except as covered in the schedule of benefits.
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs
- Replacement of teeth beyond the normal complement of 32
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a **provider**
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons, except as **medically necessary**
- Treatment by other than a dentist or dental **provider** that is legally qualified to furnish dental services or supplies

Physician services

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

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

Important note:
Your **telemedicine covered services** are the same as your **covered services** in-person.

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

Physician surgical services

Covered services include the services of:

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

The following are not **covered services**:

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

Prescription drugs - outpatient

This plan covers all **medically necessary prescription** drugs. Read this section carefully. This plan does not cover all **prescription** drugs and some coverage may be limited. This doesn't mean you can't get **prescription** drugs that aren't covered; you can, but you have to pay for them yourself. For more information about **prescription** drug benefits, including limits, see the schedule of benefits.

Important note:
A pharmacy may refuse to fill or refill a **prescription** when, in the professional judgement of the pharmacist, it should not be filled or refilled.

Your plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication's FDA-approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

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

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

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

Prescription drug synchronization

If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, your network pharmacy may be able to coordinate that for you. This is called synchronization. We will apply a prorated daily cost share rate, to a partial fill of a maintenance drug, if needed, to synchronize your **prescription** drugs.

Partial fill dispensing for Schedule II controlled substances

You or your **provider** may request your pharmacist to dispense a partial fill of a Schedule II controlled substance. Your out of pocket expenses for a partial fill will be prorated accordingly.

How to access network pharmacies

A network pharmacy will submit your claim. You will pay your cost share to the pharmacy. You can find a network pharmacy either online or by phone. See the *Contact us* section for how. You may go to any of our network pharmacies.

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

The pharmacy may substitute a **generic prescription drug** for a **brand-name prescription drug**. Your cost share may be less if you use a **generic drug** when it is available.

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 30 day supply of **prescription** drugs.

Mail order pharmacy

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. A mail order pharmacy may be used for up to a 90 day supply of a prescription drug.

Prescription refills after the initial fill can be filled at a network **mail order pharmacy**.

After you obtain your first refill at a network **retail pharmacy**, you must tell us whether you want to use your network **mail order pharmacy** benefit, a CVS pharmacy or continue to use your network **retail pharmacy**. See the *Contact us* section for how. If you don't tell us your choice, the next **prescription** refill and any other refills at a network **retail pharmacy** will not be covered. You can tell us at any time that you intend to use a network **retail pharmacy** for future **prescription** refills.

Specialty pharmacy

A **specialty pharmacy** may be used for up to a 30 day supply of a **specialty prescription drug.** You can view the list of **specialty prescription drugs**. See the *Contact us* section for help. **Specialty prescription drugs** typically include high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected ways of giving them.

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

Some **specialty prescription drugs** may qualify for third-party **copayment** assistance programs that could lower your out of-pocket costs. Any manufacturer coupon or rebate assistance amount received through one of these programs will not apply towards your **deductible** or **maximum out-of-pocket limit**.

Prescription drugs covered by this plan are subject to misuse, waste, or abuse utilization review by us, your **provider**, and/or your network pharmacy. The outcome of this review may include:

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

What if the pharmacy you use leaves the network

Sometimes a pharmacy might leave the network. If this happens, you will have to get your **prescriptions** filled at another network pharmacy. You can use your **provider** directory or call us to find another network pharmacy in your area.

How to get an emergency prescription filled

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

Type of pharmacy	Your cost share is
A network pharmacy	The plan cost share
An out-of-network pharmacy	The full cost of the **prescription**

When you pay the full cost of the **prescription** at an out-of-network pharmacy:

- You will fill out and send a **prescription** drug refund form to us, including all itemized pharmacy receipts
- Coverage will be limited to items obtained in connection with the out-of-area emergency or urgent situation
- Submission of the refund form doesn't guarantee a refund. If approved, you will be reimbursed the cost of the **prescription** less your network cost share

Other covered services

Abortion drugs

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

Anti-cancer drugs taken by mouth, including chemotherapy drugs

Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the **Food and Drug Administration** (FDA) for this treatment.

Asthma supplies for children

Covered services include but are not limited to the following:

- Inhaler spacers
- Nebulizers, including face masks and tubing
- Peak flow meters

Contraceptives (birth control)

For females, **covered services** include all drugs and devices, and other products that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at a network pharmacy. **Covered services** include education and follow-up care. You can access a list of covered drugs and devices. See the *Contact us* section for help.

We also cover over-the-counter (OTC) drugs, devices and products without a **prescription** from your **provider** at no cost to you.

Diabetic supplies

Covered services include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid Continuous glucose monitors
- Diabetic syringes, needles and pens

- Insulin infusion disposable pumps
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine

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

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

Infertility drugs
Covered services include oral ovulation induction **prescription** drugs used to treat the underlying medical cause of **infertility**.

Obesity drugs
Covered services include **prescription** drugs used only for the purpose of weight loss. These are sometimes called anti-obesity agents. You must have a **prescription** and get it filled at a network pharmacy. You must be diagnosed by your **provider**, including a physical exam and outpatient diagnostic lab work, with morbid obesity.

Pharmacy consultation services
State licensed pharmacists are allowed to prescribe certain **prescription** drugs.

Covered services include consultation services by your state licensed pharmacist to:
- Determine the **medical necessity** of a specific **prescription** drug for your illness or condition
- Prescribe specific **medically necessary prescription** drugs

Preventive care drugs and supplements
Covered services include preventive care drugs and supplements, including OTC ones, as required by the ACA. **Covered services** also include COVID-19 therapeutics.

Risk reducing breast cancer prescription drugs
Covered services include **prescription** drugs used to treat people who are at:
- Increased risk for breast cancer
- Low risk for medication side effects

Sexual enhancement or dysfunction prescription drugs
Covered services include prescription drugs for the treatment of sexual dysfunction or enhancement. For the most up-to-date information on covered **prescription** drugs and doses, contact us.

Tobacco cessation prescription and OTC drugs
Covered services include FDA approved **prescription** and OTC drugs to help stop the use of tobacco products. You must receive a **prescription** from your **provider** and submit the **prescription** to the pharmacy for processing.

Outpatient prescription drugs exclusions

The following are not **covered services**:

- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a **covered service**
- Dietary supplements
- Drugs or medications
  - Which do not require a **prescription** by law, even if a **prescription** is written, unless we have approved a medical exception, or as described in the *Other covered services – Contraceptives (birth control)* section
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a **covered service**
  - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Immunizations related to travel or work unless recommended by the United States Preventive Services Task Force (USPSTF)
- **Infertility**:
  - Injectable **prescription** drugs used primarily for the treatment of **infertility**
- Injectables including:
  - Any charges for the administration or injection of **prescription** drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription** drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or **prescription** drugs for the treatment of a dental condition unless stated as a **covered service**
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
  - That are drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen **prescriptions**

- Test agents except diabetic test agents
- A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
- Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

Preventive care

Preventive **covered services** are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing, you may pay more as these services aren't preventive, except for COVID-19 screening and diagnostic testing, items, services, or immunizations intended to prevent or mitigate COVID-19. Coverage for covid-19 screening and diagnostic testing does not include bonus payments for the use of specialized equipment or expedited processing.

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

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

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

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

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

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

Breast-feeding support and counseling services

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

Breast pump, accessories and supplies

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

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

Counseling services

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

- Alcohol or drug misuse
  - Preventive counseling and risk factor reduction intervention
  - Structured assessment
- Chronic conditions
- 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 , including sexually transmitted disease home test kits and laboratory costs for processing the kits when ordered by a **network provider**
- Stress management
- Tobacco cessation
  - Preventive counseling to help stop using tobacco products
  - Treatment visits
  - Class visits

Family planning services – female contraceptives

Covered services include family planning services as follows:

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

The following are not **covered services**:

- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA

Immunizations

Covered services include preventive immunizations including Acquired Immune Deficiency Syndrome (AIDS) for infectious diseases.

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

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

Prenatal care

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

- Anemia screening
- Blood pressure
- Chlamydia infection screening

- Diagnosis of fetal genetic disorders
- Fetal heart rate check
- Fundal height
- Gestational diabetes screening
- Gonorrhea screening
- Hepatitis B screening
- Maternal weight
- Rh incompatibility screening

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp, 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 (USPSTF).
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screening for blood lead levels in children under age 19 who are at risk for lead poisoning.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
    - Screening and counseling services on topics such as:
        - Interpersonal and domestic violence
        - Sexually transmitted diseases
        - Human immune deficiency virus (HIV) infections
    - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

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

Well woman preventive visits

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

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

Prosthetic device

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

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

- Bone anchored hearing aid
- Cochlear implants, including accessories and upgrades

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
- Specifically but not limited to:
  - Contact lenses to treat aniridia (missing iris) or aphakia (absence of the crystalline lens of the eye)
  - Speech generating devices (does not include electronic voice-producing machines or communication aids)

You may receive a prosthetic device as part of another **covered service** and therefore it will not be covered under this benefit.

The following are not **covered services**:

- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace or required for the treatment of or to prevent complications of diabetes
- Trusses, corsets, and other support items
- Repair and replacement due to loss or misuse,

Reconstructive breast surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prostheses (including adhesive skin supports and three brassieres every 12 months)

Reconstructive surgery and supplies

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

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects or repairs abnormal structures of the body caused by:
  - anatomical defect present at birth
  - cleft palate (includes medically necessary dental or orthodontic services
  - developmental abnormalities
  - disease
  - infection
  - trauma
  - tumors
- The purpose of the **surgery** is to improve function or create normal appearance

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

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

These dental related services are limited to:

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

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation services

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

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

Covered services include:

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

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

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

  (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
  - Help you maintain or prevent loss of cognitive function

The following are not **covered services**:

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

Skilled nursing facility

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

- **Room and board**, up to the **semi-private room rate.** Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services and supplies provided during a **stay** in a **skilled nursing facility**

Telemedicine

Covered services include **telemedicine** consultations when provided by a **physician, specialist, behavioral health provider** or other **telemedicine provider** acting within the scope of their license. Your **telemedicine covered services** are the same as your **covered services** in-person.

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

The following are not **covered services**:

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

Tests, images and labs – outpatient

Diagnostic complex imaging services

Covered services include:

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

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

Diagnostic x-ray and other radiological services

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

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

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

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

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

Key Terms

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

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

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

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

GCIT are defined as any services that are:
- Gene-based
- Cellular and innovative therapeutics

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

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

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

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

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

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

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

Infusion therapy

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

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

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

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

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

Radiation therapy

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

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

Transplant services

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

This includes the following transplant types even when you are infected with the human immune deficiency virus (HIV):

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

Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as IOE facilities in your **provider** directory.

You must get transplant services from the IOE facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the network **copayment, coinsurance**, **deductible**, maximum out of pocket and limits, unless stated differently in this certificate and schedule of benefits.

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

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

The following are not **covered services**:

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

Urgent care services

Covered services include services and supplies to treat an **urgent condition** at an urgent care center. An urgent condition is an illness or injury that requires prompt medical attention but is not a life-threatening **emergency medical condition**. An urgent care center is a facility licensed as a freestanding medical facility to treat **urgent conditions**.

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

- **Urgent condition** within the network (in-network)
  - If you need care for an **urgent condition**, you should first seek care through your **physician** or **PCP**. If your **physician** is not reasonably available, you may access urgent care from an urgent care center that is in-network.
- **Urgent condition** outside the network (out-of-network)
  - You are covered for urgent care obtained from a facility that is out-of-network if you are temporarily unable to get services in-network and getting the health care service cannot be delayed.

If you go to an urgent care center for what is not an urgent condition, the plan will not cover your expenses.

Vision care

Pediatric vision care

Covered services include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing
- Eyeglass frames, **prescription** lenses, contact lenses and their fitting, and follow-up care
- Coatings and special lenses, including:
  - Ultraviolet protective coating
  - Standard progressives
  - Plastic photosensitive lenses (Transitions)
  - Blended segment lenses
  - Intermediate vision lenses
  - Premium progressive lenses
  - Select or ultra-progressive lenses
  - Photochromic glass lenses
  - Polarized lenses
  - Anti-reflective coating (standard/premium/ultra)
  - High-index lenses

The following are not **covered services**:

- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Walk-in clinic

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

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

General plan exclusions

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

Behavioral health treatment

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

- **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- Education service, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Sexual deviations and disorders except described in the *Coverage and exclusions* section
- Tobacco use disorders and nicotine dependence except as described in the *Counseling services* and *Tobacco cessation prescription* sections

Cosmetic services and plastic surgery

Any treatment, **surgery** (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body

Cost share waived

Any cost for a service when any **out-of-network provider** waives all or part of your **copayment**, **coinsurance**, **deductible**, or any other amount

Court-ordered testing

This includes court-ordered testing or care unless they are **medically necessary**

Custodial care

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

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

- For behavioral health (mental health treatment and **substance use disorder** treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function
    - Provide a place free from conditions that could make your physical or mental state worse

Dental care for over the age of 19

- Alveolectomy
- Apicoectomy (dental root resection)
- Augmentation and vestibuloplasty treatment of periodontal disease
- Cutting into gums and tissues of the mouth only when not associated with the removal, replacement, or repair of teeth
- Cutting out:
  - Teeth partly or completely impacted in the bone of the jaw
  - Teeth that will not erupt through the gum
  - Other teeth that cannot be removed without cutting into bone
  - The roots of a tooth without removing the entire tooth
  - Cysts, tumors, or other diseased tissues
- Dental implants
- Dental services related to the gums
- False teeth
- Orthodontics
- Root canal treatment
- Removal of soft tissue impactions
- Teeth - care, filling, removal, or replacement, including treatment of disease

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Foot care

Routine services and supplies for the following:

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

Growth/height care

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

Hearing aids

Any tests, appliances and devices to:

- Improve your hearing
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Medical supplies – outpatient disposable

Any outpatient disposable supply or device. Examples of these include:

- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages
- Bedpans
- Home test kits not related to diabetic testing
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Missed appointments

Any cost resulting from a canceled or missed appointment

Other non-covered services

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

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

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

Private duty nursing

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

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

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

Sexual dysfunction and enhancement
Any treatment or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Implants, devices or preparations to correct or enhance erectile function or sensitivity
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

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

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

Vision care for adults
- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing
- Vision care services and supplies

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

How your plan works

How your medical plan works while you are covered in-network

Your in-network coverage helps you get and pay for a lot of – but not all – health care services. Your cost share is lower when you use a **network provider**.

Providers

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

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

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

Service area

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

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

With your out-of-network coverage:

- You can get care from **providers** who are not part of the Aetna network
- You may have to pay the full cost for your care, and then submit a claim to be reimbursed
- You are responsible to get any required **precertification**
- Your cost share will be higher

Who provides the care

Network providers

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

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

- **Emergency services** – see the description of **emergency services** in the *Coverage and exclusions* section.
- Urgent care – see the description of urgent care in the *Coverage and exclusions* section.
- **Network provider** not reasonably available – You can get services from an **out-of-network provider** if an appropriate **network provider** is not reasonably available. You must request approval from us before you get the care. You pay your in-network cost share. Your cost share will count towards your in-network **deductible, if any,** and in-network **maximum out-of-pocket limit.** Contact us for assistance.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

- Involuntary services –See the *Allowable amount* section and *You might not have to pay for a surprise bill* section.

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

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

Your PCP

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

How you choose your PCP

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

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

What your PCP will do for you

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

Changing your PCP

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

Out-of-network providers

You can also get care from **out-of-network providers**. When you use an **out-of-network provider**, your cost share is higher. You are responsible for:

- Your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over the **allowable amount**
- Submitting your own claims and getting **precertification**

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

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

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

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

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	As long as the condition lasts
Serious chronic condition	No more than 12 months.

Pregnancy	All three trimesters of pregnancy and the immediate post-partum period
Maternal mental health condition (**mental health disorder** 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 a 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 **provider** leaving the network

If this situation applies to you, contact us for details. If the **provider** did not leave the network because of fraud, lack of quality standards, or our termination of the **provider**, you'll be able to receive transitional care from your **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 **provider** remained in the network.

Medical necessity and precertification requirements

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

- The service is **medically necessary**
- For in-network benefits, you get the service from a **network provider**
- You or your **provider precertifies** the service when required

Medically necessary, medical necessity

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

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

Precertification

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

In-network

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

Out-of-network
When you go to an **out-of-network provider**, you are responsible to get any required **precertification** from us. If you don't **precertify**:

- Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details.
- You will be responsible for the unpaid bills.
- Your additional out-of-pocket expenses will not count toward your **deductible** or **maximum out-of-pocket limit**, if you have any.

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

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

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

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

We will tell you and your **physician** in writing of the **precertification** decision within 5 business days or within 72 hours for urgent requests. An approval is valid for 180 days as long as you remain enrolled in the plan.

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

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

Types of out-of-network 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 when you use an out-of-network provider:

Inpatient services and supplies	**Outpatient services and supplies**

Gene-based, cellular and other innovative therapies (GCIT)	ART services
Obesity (bariatric) **surgery**	Complex imaging
Stays in a **hospice** facility	
Stays in a **hospital**	Gene-based, cellular and other innovative therapies (GCIT)
Stays in a **rehabilitation facility**	Home health care
Stays in a **residential treatment facility** for treatment of **mental health disorders** and **substance use disorders**	Hospice care
Stays in a **skilled nursing facility**	Injectables, (immunoglobulins, growth hormones*, hormone blockers*, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
	Kidney dialysis
	Knee **surgery**
	Non-emergency transportation by fixed wing airplane
	Outpatient back **surgery** not performed in a **physician's** office
	Reconstructive **surgery***
	Wrist **surgery**
	* **Precertification** is not required for these services when provided for the treatment of gender dysphoria

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

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

For certain drugs, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**. We will tell your **provider** the decision within 72 hours or within 24 hours when you have an **emergency medical condition**. Your advance approval request is approved if we do not respond within the timeframe.

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. You do not have to repeat step therapy if you went through step therapy under your prior plan.

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

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

- Contact member services using the number on the back of your Aetna ID card
- Logging in to the Aetna website at https://www.aetna.com/
- Submitting the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road Richardson, TX 75081

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your prescriber of our decision.

Your **provider** can continue to prescribe the same **prescription drug** for your medical condition under this plan if you had approval for a **prescription drug** under a prior Aetna plan.

What the plan pays and what you pay

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

The general rule

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

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

When we say "expense" in this general rule, we mean the **negotiated charge** for a **network provider**, and **allowable amount** for an **out-of-network provider**.

Negotiated charge

For health coverage:

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

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

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

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

Some of these arrangements are called:

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

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

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

Allowable amount

This is the amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all charges above this amount. The **allowable amount** depends on the geographic area where you get the service or supply. **Allowable amount** doesn't apply to involuntary services. These are services or supplies that are:

- Provided at a network facility by an **out-of-network provider**
- Not available from a **network provider**

The table below shows the method for calculating the **allowable amount** for specific services or supplies:

Service or supply:	**Allowable amount is based on:**
Professional services and other services or supplies not mentioned below	100% of Medicare allowed rate
Services of **hospitals** and other facilities	100% of Medicare allowed rate
Prescription drugs	110% of average wholesale price (AWP)
Dental expenses	80% of prevailing charge rate

Important note:
See *Special terms* used, below, for a description of what the **allowable amount** is based on.
If the **provider** bills less than the amount calculated using a method above, the **allowable amount** is what the **provider** bills.

Special terms used:

- Average wholesale price (AWP) is the current average wholesale price of a **prescription** drug as listed in the Facts & Comparisons®, Medi-Span daily price updates or any other similar publication we choose to use.

- Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific **provider** performance. We update our system with these when revised within 180 days of receiving them from CMS. If Medicare doesn't have a rate, we use one or more of the items below to determine the rate for a service or supply:
  - The method CMS uses to set Medicare rates
  - How much other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable

  We may make the following exceptions:
  - For inpatient services, our rate may exclude amounts CMS allows for operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) programs
  - Our rate may exclude other payments that CMS may make directly to **hospitals** or other **providers** and backdated adjustments
  - For anesthesia, our rate may be at least 100% of the rate CMS establishes
  - For lab, our rate may be 75% of the rate CMS establishes
  - For DME, our rate may be 75% of the rate CMS establishes

  For medications that are paid as a medical benefit instead of a pharmacy benefit, our rate may be 100% of the rates CMS establishes.

  When the **allowable amount** is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to **providers** under Medicare programs.

- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health®, a non-profit company. FAIR Health may change these periodically. We update our systems within 180 days of receiving them from FAIR Health. If the database becomes unavailable, we may substitute a different, comparable database. If the alternate data source doesn't contain a value for a service or supply, we will base the **allowable amount** on the Medicare allowed rate.

Our reimbursement policies

We have the right to apply our reimbursement policies to all out-of-network services excluding involuntary services. This may affect the **allowable amount**. When we do this, we consider:

- The length and difficulty of a service
- Whether additional expenses are needed, when multiple procedures are billed at the same time
- Whether an assistant surgeon is needed
- If follow up care is included
- Whether other conditions change or make a service unique
- Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
- The educational level, licensure or length of training of the **provider**

We base our reimbursement policies on our review of:

- CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and aren't appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in relevant clinical areas

We use commercial software to administer some of these policies. Policies may differ for professional services and facility services.

Get the most from your benefits:
We have online tools to help you decide whether to get care and if so, where. Use the 'Estimate the Cost of Care' tool or 'Payment Estimator' tool on the Aetna website. The website may contain additional information that can help you determine the cost of a service or supply.

Paying for covered services – the general requirements

There are several general requirements for the plan to pay any part of the expense for a **covered service**. For in-**network** coverage, they are:

- The service is **medically necessary**
- You get your care from a **network provider**

For **out-of-network** coverage:

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

For outpatient **prescription** drugs, your costs are based on:

- The type of **prescription** you're prescribed
- Where you fill the **prescription**

The plan may make some **brand-name prescription drugs** available to you at the **generic prescription drug** cost share.

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

You pay the entire expense when:

- You get services or supplies that are not **medically necessary**.
- Your plan requires **precertification**, your **physician** requests it, we deny it and you get the services without **precertification**.
- You get care from an **out of-network provider** and the **provider** waives all or part of your cost share.

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

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

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

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

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

Ancillary services mean any professional services including:

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

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

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

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

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

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

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

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

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

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

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

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

Coordination of benefits

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

Key Terms

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

Allowable expense means 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.

Determining who pays

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

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

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

How COB works with Medicare

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

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

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

Other health coverage updates – contact information

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

Our rights

We have the right to:

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

Benefit payments and claims

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

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

Claim type and timeframes

Urgent care claim

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

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

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. We will make a decision within 5 business days.

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

Concurrent care claim extension
A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 5 business days.

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

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

Filing a claim

When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider** must send us the bill within 12 months of the date you received services, unless you are legally unable to notify us. You must send it to us with a claim form that you can either get online or contact us to provide. We will send you a claim form within 15 days of your request. You should always keep your own record of the date, **providers** and cost of your services.

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

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

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

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

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

Appeal

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

Claim decisions and appeal procedures

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

Any time we deny even part of the claim, it is an "adverse benefit determination" or "adverse decision." For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don't agree, you can also appeal that decision.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will give you an answer within 36 hours for an urgent appeal and within 5 business days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

Any other claim appeal

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

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

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 calendar days for a post-service claim. After 30 days, or after three days for an urgent care claim, you can request an independent medical review (IMR) from the California Department of Insurance within 6 months of either date.

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

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

Independent medical review

An IMR is a review done by the California Department of Insurance.
You have a right to an IMR only if all the following conditions are met:

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

You may apply for an IMR within six months of the date you received the decision from us. The date may be extended by the Commissioner of Insurance. You may also request external review if you are seeking to determine if the federal surprise bill law applies to your situation.

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

You must submit the request for external review form:
To
California Department of Insurance, Consumer Services Division
300 Spring Street, South Tower
Los Angeles, CA 90013
1-800-927-HELP (4357), TDD: 1-800-482-4TDD (4833)
www.insurance.ca.gov
https://www.insurance.ca.gov/01-consumers/110-health/60-resources/01-imr/index.cfm

- Within 6 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

You will pay for any information that you send and want reviewed by the ERO. We will pay for information we send to the ERO plus the cost of the review.

The IMR will:

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

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

How long will it take to get an IMR decision?

You will receive a decision from the IMR within 30 calendar days of the date the IMR received your application.
We will give you the ERO decision not more than 45 calendar days after we receive your notice of external review form with all the information you need to send in.

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

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

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

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

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

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

Utilization review

Prescription drugs covered under this plan are subject to misuse, waste or abuse utilization review by us, your **provider** or your network pharmacy. The outcome of the review may include:

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

Recordkeeping

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

Fees and expenses

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

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

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

When you can join the plan

You can enroll:

- At the end of any waiting period, up to 90 days, the policyholder 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
- Your domestic partner
- Dependent children – yours or your spouse's or partner's
    - Dependent children must be:
        - Under 26 years of age
        - 26 years of age or older and disabled. Refer to *How you can extend coverage for your disabled child beyond the plan age limits* section
    - 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
        - Grandchildren in your legal custody
        - Any other child with whom you have a parent-child relationship

Effective date of coverage

Your coverage will start after we have received your completed enrollment form. Depending on when you enroll, the start date will be either:

- On the date the policyholder tells us
- As described under *Special times you can join the plan* (later in this section)

Dependent coverage will start:

- On your effective date, if you enrolled them at that time.

- Generally, the first day of the month based on when we receive your completed enrollment form, if you enrolled them at another time. See *Adding new dependents* and *Special times you can join the plan* for more information.

You can't have coverage as an employee and a dependent and you can't be covered as a dependent of more than one employee on the plan.

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
- You have added a dependent because of marriage, birth, adoption or foster care. See the Adding new dependents section above for more information.
- You or your dependent qualify for access to new plans because you have moved to a new permanent location.

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.

Effective date of coverage

Your coverage will start based on when we receive your completed enrollment application:

- No later than the first day of the month following the date we receive your completed enrollment information
- In accordance with the effective date of a court order
- An appropriate date based on the circumstances of the special enrollment period

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
- Change in marital status
- 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 policyholder 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.

When will your coverage end

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The policyholder 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:
  - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.
- The date this plan no longer allows coverage for domestic partners or civil unions.
- The date the domestic partnership or civil union ends.
  - You will need to complete a Declaration of Termination of Domestic Partnership.

What happens to your dependents if you die?

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

Why would we end your coverage?

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

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

Special coverage options after your coverage ends

When coverage may continue under the plan

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have. Contact the policyholder 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 policyholder and we have agreed to do so. It is the policyholder's responsibility to let us know when your work ends. If the policyholder and we agree in writing, we will extend the limits.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

The federal COBRA law usually applies to employers of group sizes of 20 or more and gives employees and 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.

California Continuation Benefits Replacement Act (Cal-COBRA) Rights

The Cal-COBRA law applies to employers of group sizes two to 19 and gives employees and their covered dependents the right to keep their health coverage for 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 dependent under the plan
- You die
- Your COBRA coverage ends before 36 months (you can continue coverage for 36 months from the date your COBRA coverage began)

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

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" they cannot engage in most normal activities like a healthy person of the same age and gender.

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

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

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

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

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

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year after two years from the date you first send us proof. 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

How you can extend coverage for dental work when coverage ends

If you are not totally disabled when your coverage ends, coverage for dental services may be extended if they were ordered while you were covered by the plan and must be completed within 30 days after your coverage ends.

Covered services include:

- Inlays
- Onlays
- Crowns
- Removable bridges
- Cast or processed restorations
- Dentures if impressions were taken while you were covered by the plan
- Fixed partial dentures (bridges)
- Root canals if the pulp chamber was opened while you were covered by the plan

For any other item in the list above the teeth must have been fully prepared to receive an item or impressions must have been take for the item while you were covered by the plan.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this certificate

We prepared this certificate according to ERISA and other federal and state laws that apply. This certificate is interpreted according to these laws.

How we administer this plan

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

Who's responsible to you

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

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

Coverage and services

Your coverage can change

Sometimes things happen outside of our control. These are things such as natural disasters, epidemics, fire, and riots. We will try hard to get you access to the services you need even if these things happen.

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

Physical examination and evaluations

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

Records of expenses

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

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

Honest mistakes and intentional deception

Honest mistakes

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

Intentional deception
If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage within 24 months of your effective date. These serious consequences include, but are not limited to:

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

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

You have special rights if we rescind your coverage:

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

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

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

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

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

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

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

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 policyholder, or another insurance company.

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

- Agreeing to repay us from money you receive because of your injury.
- 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.

Your health information

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

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

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

Glossary

Allowable amount

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

Behavioral health provider

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

- A person that is licensed under Division 2, Healing Arts, (beginning with Section 500), of the Business & Professions Code
- An associate marriage and family therapist or marriage and family therapist trainee
- A qualified autism service provider or qualified autism service professional certified by a national entity
- An associate clinical social worker
- An associate professional clinical counselor or professional clinical counselor trainee
- A registered psychologist or psychological assistant
- A psychology trainee or person supervised under the direction of a licensed psychologist
- A 988 Crisis Hotline Center or mobile crisis team

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 **covered services** you pay after your **deductible**.

Copay, copayment

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

Covered service

The benefits, subject to varying cost shares, covered in this plan. These are:

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

Deductible

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

Dental provider

Any individual legally qualified to provide dental services or supplies.

Designated network provider
A **network provider** listed in the directory under *maximum savings* as a **provider** for your plan.

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

Emergency medical condition
An acute, severe medical condition that:

- Needs immediate medical care
- Leads you to reasonably believe that, without immediate medical care, it could result in:
  - Danger to life or health
  - Loss of a bodily function
  - Loss of function to a body part or organ
  - Danger to the health of an unborn baby

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

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

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

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

Generic prescription drug

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

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional

A person who is authorized by law to provide health care services to the public; for example, **physicians**, nurses and physical therapists. For **mental health disorders** and **substance use disorders**, it includes a **behavioral health provider**.

Home health care agency

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

Hospital

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

Infertile, infertility

A disease defined by the failure to become pregnant:

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

Jaw joint disorder

This is:

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

Mail order pharmacy

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

Maximum out-of-pocket limit

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

Medically necessary, medical necessity (services or supplies other than for Mental health disorder and Substance use disorder)

Health care services or supplies a **provider**, exercising prudent clinical judgment, would provide to you for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, condition, disease or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that are:

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

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community

Medically necessary/Medical necessity (Mental health disorder and Substance use disorder)

Health care services that a **provider** exercising prudent clinical judgment, would provide to you for the purpose of preventing, evaluating, diagnosing or treating an **illness** or **injury**, condition or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms that are:

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

Generally accepted standards of **mental health disorder** and **substance use disorder** care means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of **mental health disorder** and **substance use disorder** care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

All medical necessity determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge of a **covered person** diagnosed with **mental health disorders** and s**ubstance use disorders** will be made using the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

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 **experimental or investigational**. They are subject to change. You can find these bulletins and other information at http: www. aetna.com/health-care-professionals/clinical policy bulletins.html. You can also contact us. See the *Contact us* section for how.

Mental health disorder
A **mental health disorder** is a condition 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* (ICD) or that is listed in the most recent version of the DSM. Changes in terminology, organization, or classification of **mental health disorders** in future versions of the DSM or ICD shall not affect the conditions covered in this section as long as a condition is commonly understood to be a **mental health disorder** by **providers** practicing in relevant clinical specialties.

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

Network provider
A **provider** listed in the directory for your plan. A **network provider** can also be referred to as an in-network provider.

Non-designated network provider
A **provider** listed in the directory under *standard savings* as a **provider** for your plan.

Out-of-network provider
A **provider** who is not a **network provider**.

Physician
A **health professional** trained and licensed to practice and prescribe medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy. Under some plans, a **physician** can also be a **primary care physician** (**PCP**). For **mental health disorders** and **substance use disorders**, it includes a **behavioral health provider.**

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

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

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

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

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

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

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

Provider
A **physician**, pharmacist, **health professional**, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare. For **mental health disorders** and **substance use disorders**, it includes a **behavioral health provider.**

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

Residential treatment facility
An institution specifically licensed by applicable laws to provide residential treatment programs for mental health disorders, or **substance use disorder**s, or both. 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.

Skilled nursing facility
A facility specifically licensed as a **skilled nursing facility** by applicable laws and certified by CMS 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 disorders** or **substance use disorders**.

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.

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

Substance use disorder
A **substance use disorder** is a condition 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* (ICD) or that is listed in the most recent version of the DSM. Changes in terminology, organization, or classification of **substance use disorder** in future versions of the DSM or ICD shall not affect the conditions covered in this section as long as a condition is commonly understood to be a **substance use disorder** by **providers** practicing in relevant clinical specialties.

Surgery, surgical procedure

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

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

Telemedicine

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

Terminal illness

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

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

Your Health Insurance Choices Are Different. You May Qualify for Free or Low-Cost Health Insurance.

Because of changes in federal law, you have different health insurance choices that may save you money.

Covered California

You can buy health insurance through Covered California. The State of California set up Covered California to help people and families, like you, find affordable health insurance. You can use Covered California if you do not have insurance through your employer, or Medicare. You can also apply for Medi-Cal through Covered California.

If you are eligible for the Medicare Program you should examine your options carefully, as delaying Medicare enrollment may result in substantial financial implications

You must apply during an open or special enrollment period, except a Medi-Cal application can be made at any time. Open enrollment begins on October 15 of every year and ends on January 31 of the following year. If you have a life change such as marriage, divorce, a new child or loss of a job, you can apply at the time the life change occurs ("special enrollment period").

Through Covered California, you may also get help paying for your health insurance. You can:

- Reduce your out of pocket costs: Out-of-pocket costs are how much you pay for things like going to the doctor or hospital or getting prescription drugs.

To qualify for help paying for insurance, you must:

- Meet certain household income limits; and
- Be a U.S. citizen, U.S. national or be lawfully present in the U.S.
- In addition, other rules and requirements apply.

You can also buy coverage directly from health insurers, health plans or insurance agents during Open Enrollment and Special Enrollment periods, but the financial help is available only if you select a Covered California product.

Medi-Cal

Free or low-cost health insurance is available through Medi-Cal. Medi-Cal is California's health care program for people with low incomes. You can get Medi-Cal if:

- Your income is low; and
- You are a U. S. citizen, U.S. national or lawfully present in the U.S age 26 and older;
- Your income is low; and
- You are an adult age 19 through 25 who does not have satisfactory immigration status or is unable to establish satisfactory immigration status or to verify United States citizenship.

Your eligibility is based on your income. It is not based on how much money you have saved or if you own your own home. You do not have to be on public assistance to qualify for Medi-Cal. You can apply for Medi-Cal anytime.

You can also get Medi-Cal if you are:

- Age 21 or younger
- Age 65 or older
- Blind
- Disabled
- Pregnant
- In a skilled nursing or intermediate care home
- On refugee status for a limited time, depending how long you have been in the United States
- A parent or caretaker relative of an age eligible child
- Have been screened for breast and/or cervical cancer

Other rules or requirements may apply.

For More Information

To learn more about Covered California or Medi-Cal, visit https://www.coveredca.com/ or call 1-800-300-1506. When you apply for coverage through Covered California, you will find out if you are eligible for Medi-Cal. You can also get more information or apply for Medi-Cal by calling 1-800-430-4263, visiting www.benefitscal.org or www.beneficioscal.org (Spanish) online, or visiting your county human services office in person.

Additional Information Provided by

Your Employer

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Note: This sub-section applies to the Plan if your Employer employs 20 or more employees in accordance with a formula mandated by federal law. Check with your Employer to determine if COBRA continuation applies to the Plan.

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

Note: This sub-section applies to the Plan if your Employer employs 50 or more employees as determined by a formula defined by federal law. Check with your Employer to determine if FMLA applies to the Plan.

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments**, or **coinsurance**, if any, that apply to the **covered services** you get under this plan. You should read this schedule to become aware of these and any limits that apply to the **covered services**. This schedule takes the place of any others sent to you before.

If this is an ERISA plan, you have certain rights under this plan. If the policyholder or contract holder is a church group or a government group, this may not apply. Please contact the policyholder for additional information.

How your cost share works

- You are responsible to pay any **deductibles**, **copayments**, and remaining **coinsurance** if they apply.
- You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit or day limits.

Important note:
All **covered services** are subject to the calendar year **deductible**, **maximum out-of-pocket limit**, limits, **copayment**, or **coinsurance** unless otherwise noted in this schedule. The No Surprises Act may limit your out-of-network cost share in some instances. The *Surprise bill* section of the certificate explains your protection from a surprise bill.

Contact us

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

Plan features

Deductible

You will continue to pay **copayments** or **coinsurance**, if any, for **covered services** after you meet your **deductible**.

Deductible	Network	Out-of-network
Individual	$2,600 per year	$5,200 per year
Family	$5,200 per year	$10,400 per year

Outpatient prescription drug deductible

A separate **deductible** applies to **prescription drugs**.
You will continue to pay **copayments** or **coinsurance**, if any, for **covered services** after you meet your **deductible**.

Deductible	Network	Out-of-network
Individual	$100 per year	N/A
Family	$200 per year	N/A

Network **covered services** will apply only to the network **deductible**. Out-of-network **covered services** will apply only to the out-of-network **deductible**.

Individual deductible

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

Family deductible
You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible** or you have reached the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

Deductible credit
If you paid part or all of your **deductible** under other coverage for the year that this plan went into effect, we will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If we ask, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

Maximum out-of-pocket limit

Maximum out-of-pocket limit	Network	Out-of-network
Individual	$9,000 per year	$18,000 per year
Family	$18,000 per year	$36,000 per year

Network **covered services** will apply only to the network **maximum out-of-pocket limit**. Out-of-network **covered services** will apply only to the out-of-network **maximum out-of-pocket limit**.

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

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

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:
- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:
- All costs for any health care service you get that is not a **covered service**
- Charges, expenses or costs in excess of the **allowable amount**
- Amounts received from a third-party **copay** assistance program, like a manufacturer coupon or rebate, for a **specialty prescription drug**

Precertification covered benefit reduction

This only applies to out-of-network **covered services.** You will find details in the *How your plan works* section of the certificate. If **precertification** for **covered services** isn't completed, when required, it results up to a $400 benefit reduction applied separately to each type of **covered service**. This portion is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**, if you have one.

Your financial responsibility and decisions regarding benefits

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

Covered services

Your cost share for a **covered service** not listed with a specific cost share is based on the type of **covered service** you receive and where your **covered service** is received.

The network and out-of-network limits for **covered services** are combined.

Abortion

Description	Network	Out-of-network
Abortion	0% no **deductible** applies	50% after **deductible**

Acupuncture

Description	Network	Out-of-network
Acupuncture	$50 no **deductible** applies	50% after **deductible**

Ambulance service

Description	Network	Out-of-network
Emergency ambulance	$250 plus 35% after **deductible**	Cost share same as network
Non-emergency ambulance	$250 plus 35% after **deductible**	Cost share same as network

Behavioral health

Mental health disorders and **substance use disorders** are covered under the same terms and conditions as any other illness.

Description	Network	Out-of-network
Inpatient services	Cost share same as Inpatient services under **Hospital** care	Cost share same as Inpatient services under **Hospital** care
Outpatient office visit to a **physician** or **behavioral health provider** (includes **telemedicine** consultation)	$50 no **deductible** applies	50% after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	0% no **deductible** applies	50% after **deductible**

Description	Network	Out-of-network
Other outpatient services including behavioral health services in the home, partial hospitalization treatment, and intensive outpatient program The cost share does not apply to network peer counseling support services (includes **telemedicine** consultation) after you meet your **deductible**, if you have one	0% no **deductible** applies	50% after **deductible**

Durable medical equipment (DME)

Description	Network	Out-of-network
DME	35% after **deductible**	50% after **deductible**

Emergency services

A separate **hospital** emergency room cost share will apply for each visit to an emergency room.

Description	Network	Out-of-network
Hospital emergency room	$250 plus 35% after **deductible**	Cost share same as network

Emergency services important note:
Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. Your cost share, including emergency transportation, is applied to the in-network **maximum out-of-pocket limit**. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by you and the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Habilitation therapy services

Description	Network	Out-of-network
Physical, occupational, and speech therapies	0% no **deductible** applies	50% after **deductible**

Hearing exams

Description	Network	Out-of-network
Hearing exam	$0 no **deductible** applies	50% after **deductible**

Home health care

Description	Network	Out-of-network
Outpatient	35% after **deductible**	50% after **deductible**
Visit limit per year	100	100

Home health care important note:

Limited to 3 intermittent visits per day provided by a **home health care agency**. 1 visit equals a period of 4 hours or less. Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 14 days of discharge.

Hospice care

Description	Network	Out-of-network
Inpatient services	35% after **deductible**	50% after **deductible**
Outpatient services	35% after **deductible**	50% after **deductible**

Hospital care

Description	Network	Out-of-network
Inpatient services	35% after **deductible**	50% after **deductible**

Infertility services - Advanced reproductive technology (ART)

Description	Network	Out-of-network
ART	35% after **deductible**	50% after **deductible**

Jaw joint disorder

Description	Network	Out-of-network
Jaw joint disorder treatment	Cost share based on type of service and where it is received	Not Covered

Maternity and related newborn care that is not considered preventive care

Description	Network	Out-of-network
Inpatient delivery services and postpartum care	35% after **deductible**	50% after **deductible**
In a facility or at a **physician** office	35% after **deductible**	50% after **deductible**

Maternity and related newborn care important note:
Any cost share that is collected applies to the delivery and postpartum care services provided by an OB, GYN, or OB/GYN only. Review the *Maternity* section of the certificate. It will give you more information about coverage for maternity care under this plan.

Nutritional support

Description	Network	Out-of-network
Nutritional support	35% after **deductible**	Not Covered

Obesity (bariatric) surgery

Description	Network	Out-of-network
Obesity (bariatric) **surgery**	35% after **deductible**	Not Covered

Obesity (bariatric) surgery travel and lodging

Description	In-network coverage	Out-of-network coverage

Description	In-network coverage	Out-of-network coverage
Maximum benefit payable for travel expenses for each round trip – three round trips covered (one pre-surgical visit, the surgery and one follow-up visit)	$130	Not applicable
Maximum benefit payable for travel expenses per companion for each round trip – two round trips covered (the surgery and one follow-up visit)	$130	Not applicable
Maximum benefit payable for lodging expenses per patient and companion for the pre-surgical and follow-up visits	$100 per day up to two days	Not applicable
Maximum benefit payable for lodging expenses per companion for surgery stay	$100 per day up to four days	Not applicable

Outpatient surgery

Description	Network	Out-of-network
At a **hospital** outpatient department	35% after **deductible**	50% after **deductible**
At a facility that is not a **hospital**	35% after **deductible**	50% after **deductible**

Pediatric dental care

Coverage is limited to covered persons through the end of the month in which the person turns 19.

Description	Network	Out-of-network
Type A services	0% after **deductible**	30% after **deductible**
Type B services	30% after **deductible**	50% after **deductible**
Type C services	50% after **deductible**	50% after **deductible**
Orthodontic services	50% after **deductible**	50% after **deductible**

Diagnostic and Preventive Care (Type A Expenses):			
Visits and Images			
	D0120	Periodic oral evaluation – established patient	once every six months, per provider
	D0140	Limited oral evaluation-problem focused	once per Member per provider
	D0145	Oral evaluation - child under three years of age and counseling with primary caregiver	once every six months, per provider
	D0150	Comprehensive oral exam – new or established patient	once per Member per provider for the initial evaluation
	D0160	Detailed and extensive oral evaluation, problem focused by report	once per Members per provider

	D0170	Reevaluation-limited, problem focused (not post-operative visit)	for ongoing symptomatic care of temporomandibular joint dysfunction: a. up to 6 times in a 3 month period; and b. up to a maximum of 12 in a 12 month period.
	D0171	Re-evaluation – post-operative office visit	
	D0180	Comprehensive periodontal evaluation – new or established patient	
	D0190	Screening of patient	
	D0191	Assessment of patient	
	D0210	Intraoral – comprehensive series of radiographic images	once per provider every 36 months
	D0220	Intraoral - periapical - first radiographic image	maximum of 20 periapicals in a 12-month period by the same provider,
	D0230	Intraoral - periapical - each additional radiographic image	maximum of 20 periapicals in a 12 month period to the same provider
	D0240	intraoral - occlusal image	maximum of two in a six-month period per provider
	D0250	Extraoral – first radiographic image	once per date of service
	D0251	Extra-oral posterior dental radiographic image	once per date of service
	D0270	Bitewing - single radiographic image	once per date of service
	D0272	Bitewing - two radiographic images	once every six months per provider
	D0273	Bitewing - three radiographic images	once every six months per provider
	D0274	Bitewing - four radiographic images	once every six months per provider
	D0277	Vertical Bitewings - 7 to 8 radiographic images	once every six months per provider as (D0274)
	D0310	Sialography	
	D0320	Temporomandibular joint arthrogram, including injection	maximum of three per date of service, limited to the survey of trauma or pathology
	D0322	Tomographic survey	twice in a 12 month period per provider
	D0330	Panoramic radiographic image	Once in a 36-month period per provider
	D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	twice in a 12- month period per provider

	D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	maximum of four per date of service
	D0351	3D photographic image	covered for medically necessary orthodontics
	D0372	Intraoral tomosynthesis-comprehensive series of radiographic images	once per provider every 36 months
	D0373	Intraoral tomosynthesis – bitewing radiographic image	once every six months per provider
	D0374	Intraoral tomosynthesis – periapical radiographic image	maximum of 20 periapicals in a 12 month period to the same provider
	D0387	Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	once per provider every 36 months
	D0388	Intraoral tomosynthesis – bitewing radiographic image – image capture only	once every six months per provider
	D0389	Intraoral tomosynthesis – periapical radiographic image – image capture only	maximum of 20 periapicals in a 12 month period to the same provider
	D0460	Pulp vitality tests	
	D0470	Diagnostic casts	for the evaluation of orthodontic benefits only once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment)
	D0502	Other oral pathology procedures, by report	(must be provided by a certified oral pathologist)
	D0601	Caries risk assessment and documentation, with a finding of low risk	
	D0602	Caries risk assessment and documentation, with a finding of moderate risk	
	D0603	Caries risk assessment and documentation, with a finding of high risk	
	D0701	Panoramic radiographic image – image capture only	Once in a 36-month period per provider
	D0702	2-D cephalometric radiographic image – image capture only	twice in a 12- month period per provider
	D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	maximum of four per date of service

	D0706	Intraoral – occlusal radiographic image – image capture only	maximum of two in a six-month period per provider
	D0707	Intraoral – periapical radiographic image – image capture only	maximum of 20 periapicals in a 12-month period by the same provider,
	D0708	Intraoral – bitewing radiographic image – image capture only	once per date of service
	D0709	Intraoral – comprehensive series of radiographic images – image capture only	once per provider every 36 months
	D0999	Unspecified diagnostic procedure, by report	
	D1110	Prophylaxis - adult	once in a 12 month period
	D1120	Prophylaxis - child	once in a six month period
	D1206	Topical application of fluoride varnish	once in a six month period
	D1208	Topical application of fluoride - excluding varnish	once in a six month period
	D1310	Nutritional counseling for control and prevention of oral disease	
	D1320	Tobacco counseling for the control and prevention of oral disease	
	D1330	Oral hygiene instructions	
	D1351	Sealant - per tooth - for 1st,2nd & 3rd, permanent molars	once per tooth (occlusal surfaces that are free of decay and/or restorations) every 36 months per provider
	D1352	Preventive resin restoration in a moderate to high caries risk patient - for 1st,2nd & 3rd, permanent molars	once per tooth every 36 months per provider
	D1353	Sealant repair – per tooth	
	D1354	Interim caries arresting medicament application – per tooth	
	D1355	Caries preventive medicament application – per tooth	once per tooth every 36 months per provider
	D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	once in a 12 month period
	D9997	Dental case management - patients with special health care needs	

Space Maintainers			
	D1510	Space maintainers fixed (unilateral)	once per quadrant per Member under the age of 18 to maintain the space for a single tooth
	D1516	Space maintainer – fixed – bilateral, maxillary	once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant for members under the age of 18
	D1517	Space maintainer – fixed - bilateral, mandibular	once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant for members under the age of 18
	D1520	Space maintainer – removable (unilateral)	once per quadrant per Member to maintain the space for a single tooth for members under the age of 18
	D1526	Space maintainer – removable – bilateral, maxillary	once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant for members under the age of 18
	D1527	Space maintainer – removable – bilateral, mandibular	once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant for members under the age of 18
	D1551	Re-cement or re-bond bilateral space maintainer - maxillary	once per provider, per applicable quadrant or arch for members under the age of 18
	D1552	Re-cement or re-bond bilateral space maintainer - mandibular	once per provider
	D1553	Re-cement or re-bond bilateral space maintainer - per quadrant	once per provider
	D1556	Removal of fixed unilateral space maintainer - per quadrant	
	D1557	Removal of fixed bilateral space maintainer - maxillary	
	D1558	Removal of fixed bilateral space maintainer - mandibular	(not a Benefit to the original provider who placed the space maintainer)
	D1575	Distal shoe space maintainer – fixed –	once per provider, per applicable

		unilateral	quadrant or arch
Basic Restorative Care (Type B Expenses):			
	D9410	House/extended care facility call	once per date of service per provider
	D9420	Hospital or ambulatory surgical center call	once per date of service per provider
	D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	
	D9440	Office visit - after regularly scheduled hours	once per Member per date of service
Restorative Dentistry			
	D2140	Amalgam - one surface primary or permanent	primary teeth -once in a 12-month period permanent teeth - once in a 36- month period
	D2150	Amalgam - two surfaces primary or permanent	primary teeth -once in a 12-month period permanent teeth - once in a 36- month period
	D2160	Amalgam - three surfaces primary or permanent	primary teeth -once in a 12-month period permanent teeth - once in a 36- month period
	D2161	Amalgam - four or more surfaces primary or permanent	primary teeth -once in a 12-month period permanent teeth - once in a 36- month period
	D2330	Resin-based composite - one surface, anterior	primary teeth -once in a 12-month period permanent teeth - once in a 36 - month period
	D2331	Resin-based composite - two surfaces, anterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
	D2332	Resin-based composite - three surfaces, anterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
	D2335	Resin-based composite - four or more surfaces or involving incisal angle, anterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
	D2390	Resin-based composite crown, anterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
	D2391	Resin-based Composite - one surface, posterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
	D2392	Resin-based composite - two surfaces, posterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
	D2393	Resin-based composite - three surfaces, posterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period

	D2394	Resin-based composite - four or more surfaces, posterior	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
	D2910	Recement or re-bond inlay, onlay, veneer or partial coverage restoration	once in a 12 month period, per provider
	D2915	Recement or re-bond indirectly fabricated or prefabricated post and core	
	D2920	Recement or re-bond crown	Not a benefit within 12 months of a previous re- cementation by the same provider
	D2921	Reattachment of tooth fragment, incisal edge or cusp	
	D2940	Protective resin	once per tooth in a six-month period, per provider
	D2941	Interim therapeutic restoration – primary teeth	
	D2949	Restorative foundation for an indirect restoration	
	D2951	Pin retention - per tooth in addition to restoration (permanent teeth)	once per tooth regardless of the number of pins placed
	D2955	Post removal	one per tooth
Periodontics			
	D4910	Periodontal maintenance (only after completion of all necessary scaling and root planings)	once in a calendar quarter and only in the 24 month period following the last scaling and root planing
Major Restorative Care (Type C Expenses):			
Crowns			
	D2710	Crown - resin-based composite (indirect)	once in a five-year period
	D2712	Crown – ¾ resin-based composite (indirect)	once in a five-year period
	D2721	Crown -resin with predominantly base metal	once in a five-year period
	D2740	Crown - porcelain/ceramic substrate	once in a five-year period
	D2751	Crown -porcelain fused to predominantly base metal	once in a five-year period
	D2781	Crown -3/4 cast predominantly base metal	once in a five-year period
	D2782	Crown - 3/4 cast noble metal	once in a five-year period
	D2783	Crown – ¾ prcelain/ceramic	once in a five-year period
	D2791	Crown - full cast predominantly based metal	once in a five-year period
	D2799	Provisional crown	once per tooth, per provider and for permanent teeth only.
	D2929	Prefabricated	once in a 12- month period

		porcelain/ceramiccrown-primary tooth	
	D2930	Prefabricated stainless steel crown - primary tooth	once in a 12- month period
	D2931	Prefabricated stainless steel crown - permanent tooth	once in a 12- month period
	D2932	Prefabricated resin crown	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
	D2933	Prefabricated stainless steel crown with resin window	primary teeth -once in a 12 - month period permanent teeth - once in a 36 - month period
	D2950	Core buildup, including any pins	
	D2952	Post and core in addition to crown, indirectly fabricated	once per tooth regardless of number of posts placed
	D2953	Each additional indirectly fabricated post, same tooth	
	D2954	Prefabricated post and core in addition to crown	once per tooth regardless of number of posts placed
	D2957	Each additional prefabricated post - same tooth	once per tooth regardless of number of posts placed
	D2971	Additional procedures to construct new crown under existing partial denture framework	once per tooth
	D2980	Crown repair necessitated by restorative material failure	Not a benefit within 12 months of initial crown placement or previous repair for the same provider
	D2999	Unspecified restorative procedure, by report	by report
	D8210	Removable Appliance Therapy	once per member and includes all adjustments
	D8220	Fixed Appliance Therapy	once per member and includes all adjustments
Endodontics			
	D3110	Pulp cap - direct (excluding final restoration)	once per primary tooth
	D3120	Pulp cap - indirect (excluding final restoration)	once per primary tooth
	D3220	Therapeutic pulpotomy (excluding final restoration)	once per primary tooth
	D3221	Pulpal debridement, primary and permanent teeth	once per tooth
	D3222	Partial pulpotomy for apexogensis - permanent tooth with incomplete root development	once per permanent tooth

	D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	once per primary tooth
	D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	once per primary tooth
	D3310	Endodontic therapy- anterior (excluding final restoration)	once per tooth for initial root canal therapy treatment
	D3320	Endodontic therapy- premolar (excluding final restoration)	once per tooth for initial root canal therapy treatment
	D3330	Endodontic therapy – molar tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment
	D3331	Treatment of root canal obstruction-non surgical access	
	D3332	Incomplete endodontic therapy, unrestorable or fractured tooth	once per tooth
	D3333	Internal root repair of perforation defects	
	D3346	Retreatment of previous root canal therapy - anterior	once per tooth
	D3347	Retreatment of previous root canal therapy –bicuspid	once per tooth
	D3348	Retreatment of previous root canal therapy - molar	once per tooth
	D3351	Apexification / recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	once per permanent tooth
	D3352	Apexification / recalcification - interim medication replacement	once per permanent tooth
	D3410	Apicoectomy/periradicular surgery – anterior, permanent teeth	
	D3421	Apicoectomy/periradicular surgery – bicuspid (first root) permanent teeth	
	D3425	Apicoectomy - molar (first root) permanent teeth	
	D3426	Apicoectomy (each additional root) permanent teeth	
	D3430	Retrograde filling - per root	
	D3471	Surgical repair of root resorption-anterior	
	D3472	Surgical repair of root resorption-premolar	

	D3473	Surgical repair of root resorption-molar	
	D3910	Surgical procedure for isolation of tooth with rubber dam	
	D3999	Unspecified endodontic procedure, by report	by report
Periodontal			
	D4210	Gingivectomy/gingivoplasty, , four or more contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older
	D4211	Gingivectomy/gingivoplasty, one to three contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older
	D4249	Clinical crown lengthening – hard tissue	
	D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older
	D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older
	D4265	Biologic materials to aid in soft and osseous tissue regeneration	once per quadrant every 36 months and limited to Members age 13 or older
	D4341	Periodontal scaling and root planing, four or more teeth per quadrant	once per quadrant every 24 months and limited to Members age 13 or older
	D4342	Periodontal scaling and root planing, one to three teeth per quadrant	once per quadrant every 24 months and limited to Members age 13 or older
	D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis on a subsequent visit	once every 24 months
	D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	
	D4920	Unscheduled dressing change (by someone other than treating dentist or their staff	once per Member per provider and limited to Members age 13 or older
	D4999	Unspecified periodontal procedure, by report	by report

Prosthodontics			
	D5110	Complete denture –maxillary (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once in a five year period
	D5120	Complete denture – mandibular (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once in a five year period
	D5130	Immediate denture – maxillary (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once per Member
	D5140	Immediate denture – mandibular (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once per Member
	D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests and teeth) (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once in a five year period
	D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once in a five year period
	D5213	Maxillary partial denture - cast metal framework with resin denture bases (including. any conventional clasps, rests and teeth) (all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)	once in a five year period
	D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (all adjustments made for six months after the date of service, by the same	once in a five year period

		provider, are included in the fee for this procedure)	
	D5221	Immediate maxillary partial denture – resin base (including, retentive/clasping materials rests and teeth)	once in a five year period
	D5222	Immediate mandibular partial denture – resin base (including retentative/claspings materials, rests and teeth)	once in a five year period
	D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentative/clasping materials, rests and teeth)	once in a five year period
	D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentative/clasping materials, rests and teeth)	once in a five year period
	D5225	Maxillary partial denture - flexible base (including any clasps, retentive/clasping materials,rests and teeth)	once in a five year period
	D5226	Mandibular partial denture - flexible base (including any clasps, retentive/clasping materials,rests and teeth)	once in a five year period
	D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	once in a five year period
	D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	once in a five year period
	D5282	Removable unilateral partial denture one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary	once in a five year period
	D5283	Removable unilateral partial denture one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular	once in a five year period
	D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	once in a five year period

	D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	once in a five year period
	D5410	Adjust complete denture – maxillary	once per date of service per provider
	D5411	Adjust complete denture – mandibular	once per date of service per provider
	D5421	Adjust partial denture – maxillary	once per date of service per provider
	D5422	Adjust partial denture – mandibular	once per date of service per provider
	D5511	Repair broken complete denture base, mandibular	once per arch, per date of service per provider
	D5512	Repair broken complete denture base, maxillary	once per arch, per date of service per provider
	D5520	Replace missing or broken teeth - complete denture (each tooth) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once per arch, per date of service per provider
	D5611	Repair resin partial denture base, mandibular	once per arch, per date of service per provider
	D5612	Repair resin partial denture base, maxillary	once per arch, per date of service per provider
	D5621	Repair cast partial framework, mandibular	once per arch, per date of service per provider
	D5622	Repair cast partial framework, maxillary	once per arch, per date of service per provider
	D5630	Repair or replace broken retentive/clasping materials per tooth(all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	maximum of three, per date of service per provider
	D5640	Replace broken teeth - per tooth	maximum of four, per arch, per date of service per provider
	D5650	Add tooth to existing partial denture (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	maximum of three, per date of service per provider

	D5660	Add clasp to existing partial denture – per tooth (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	maximum of three, per date of service per provider
	D5730	Reline complete maxillary (upper) denture, (chairside) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period
	D5731	Reline complete mandibular (lower) denture (chairside) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period
	D5740	Reline maxillary (upper) partial denture (chairside) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period
	D5741	Reline mandibular (lower) partial denture (chairside) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period

	D5750	Reline complete maxillary (upper) denture (laboratory) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period
	D5751	Reline complete mandibular (lower) denture (laboratory) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period
	D5760	Reline maxillary (upper) partial denture (laboratory) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period
	D5761	Reline mandibular (lower) partial denture (laboratory) (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	once in a 12- month period
	D5765	Soft liner for complete or partial removable denture – indirect	once in a 12- month period
	D5850	Tissue conditioning, upper (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	twice per prosthesis in a 36-month period
	D5851	Tissue conditioning, lower (all adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.)	twice per prosthesis in a 36-month period
	D5862	Precision attachment, by report	by report
	D5863	Overdenture – complete maxillary (upper)	once in a five year period
	D5864	Overdenture - partial maxillary (upper)	once in a five year period
	D5865	Overdenture - complete mandibular (lower)	once in a five year period

	D5866	Overdenture – partial mandibular (lower)	once in a five year period
	D5876	Add metal substructure to acrylic full denture (per arch)	once per arch, per date of service per provider
	D5899	Unspecified removable prosthodontic procedure, by report	by report
Maxillofacial Prosthetics		-	-
	D5911	Facial moulage - sectional	
	D5912	Facial moulage - complete	
	D5913	Nasal prosthesis	
	D5914	Auricular prosthesis	
	D5915	Orbital prosthesis	
	D5916	Ocular prosthesis	
	D5919	Facial prosthesis	
	D5922	Nasal septal prosthesis	
	D5923	Ocular prosthesis, interim	
	D5924	Cranial prosthesis	
	D5925	Facial augmentation implant prosthesis	
	D5926	Nasal prosthesis, replacement	
	D5927	Auricular prosthesis, replacement	
	D5928	Orbital prosthesis, replacement	
	D5929	Facial prosthesis, replacement	
	D5931	Obturator prosthesis, surgical	
	D5932	Obturator prosthesis, definitive	
	D5933	Obturator prosthesis, modification	twice in a 12- month period
	D5934	Mandibular resection prosthesis with guide flange	
	D5935	Mandibular resection prosthesis without guide flange	
	D5936	Obturator prosthesis, interim	
	D5937	Trismus appliance (not for TMJ)	
	D5951	Feeding aid	
	D5952	Speech aid prosthesis, pediatric	
	D5953	Speech aid prosthesis, adult	
	D5954	Palatal augmentation prosthesis	
	D5955	Palatal lift prosthesis	
	D5958	Palatal lift prosthesis, interim	
	D5959	Palatal lift prosthesis, modification	twice in a 12- month period
	D5960	Speech aid prosthesis, modification	twice in a 12- month period
	D5982	Surgical stent	
	D5983	Radiation carrier	
	D5984	Radiation shield	

	D5985	Radiation cone locator	
	D5986	Fluoride gel carrier	A benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.
	D5987	Commissure splint	
	D5988	Surgical splint	
	D5991	Topical vesiculobullous disease medicament carrier	
	D5999	Unspecified maxillofacial prosthesis, by report	by report
Implant Services			
	D6010	Surgical placement of implant body: endosteal implant	only when there are exceptional medical conditions
	D6011	Surgical access to an implant body (second stage implant surgery)	only when there are exceptional medical conditions
	D6013	Surgical placement of mini implant	only when there are exceptional medical conditions
	D6040	Surgical placement eposteal implant	only when there are exceptional medical conditions
	D6050	Surgical placement: transosteal implant	only when there are exceptional medical conditions
	D6055	Connecting bar - implant supported or abutment supported	only when there are exceptional medical conditions
	D6056	Prefabricated abutment - includes modification and placement	only when there are exceptional medical conditions
	D6057	Custom abutment- includes placement	only when there are exceptional medical conditions
	D6058	Abutment supported porcelain/ceramic crown	only when there are exceptional medical conditions
	D6059	Abutment supported porcelain fused to metal crown (high noble metal)	only when there are exceptional medical conditions
	D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	only when there are exceptional medical conditions
	D6061	Abutment supported porcelain fused to metal crown (noble metal)	only when there are exceptional medical conditions
	D6062	Abutment supported cast metal crown (high noble metal)	only when there are exceptional medical conditions
	D6063	Abutment supported cast metal crown (predominately base metal)	only when there are exceptional medical conditions
	D6064	Abutment supported cast metal crown (noble metal)	only when there are exceptional medical conditions
	D6065	Implant supported porcelain/ceramic crown	only when there are exceptional medical conditions
	D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy,	only when there are exceptional medical conditions

		high noble metal)	
	D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	only when there are exceptional medical conditions
	D6068	Abutment supported retainer for porcelain/Ceramic FPD	only when there are exceptional medical conditions
	D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	only when there are exceptional medical conditions
	D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	only when there are exceptional medical conditions
	D6071	Abutment supported retained for porcelain fused to metal FPD (noble metal)	only when there are exceptional medical conditions
	D6072	Abutment supported retained for cast metal FPD (high noble metal)	only when there are exceptional medical conditions
	D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	only when there are exceptional medical conditions
	D6074	Abutment supported retainer for cast FPD (Noble metal)	only when there are exceptional medical conditions
	D6075	Implant supported retainer for ceramic FPD	only when there are exceptional medical conditions
	D6076	Implant supported retainer for porcelain fused metal FPD (titanium, titanium alloy, or high noble metal)	only when there are exceptional medical conditions
	D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	only when there are exceptional medical conditions
	D6080	Implant maintenance procedures, when prostheses are removed and reinserted, including cleansing of prosthesis and abutments	only when there are exceptional medical conditions
	D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	only when there are exceptional medical conditions
	D6082	Implant supported crown - porcelain fused to predominantly base alloys	only when there are exceptional medical conditions
	D6083	Implant supported crown - porcelain fused to noble alloys	only when there are exceptional medical conditions
	D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	only when there are exceptional medical conditions
	D6085	Provisional implant crown	only when there are exceptional medical conditions
	D6086	Implant supported crown -	only when there are exceptional

		predominantly base alloys	medical conditions
	D6087	Implant supported crown - noble alloys	only when there are exceptional medical conditions
	D6088	Implant supported crown - titanium and titanium alloys	only when there are exceptional medical conditions
	D6090	Repair implant supported prosthesis, by report	only when there are exceptional medical conditions
	D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	only when there are exceptional medical conditions
	D6092	Re-cement or re-bond implant/abutment supported crown	not a benefit within 12 months of a previous re- cementation by the same provider
	D6093	Re-cement or re-bond Implant/abutment supported fixed partial denture	not a benefit within 12 months of a previous re- cementation by the same provider
	D6094	Abutment supported crown – (titanium)	only when there are exceptional medical conditions
	D6095	Repair implant abutment, by report	only when there are exceptional medical conditions
	D6096	Remove broken implant retaining screw	only when there are exceptional medical conditions
	D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	only when there are exceptional medical conditions
	D6098	Implant supported retainer - porcelain fused to predominantly base alloys	only when there are exceptional medical conditions
	D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	only when there are exceptional medical conditions
	D6100	Implant removal, by report	by report
	D6105	Removal of implant body not requiring bone removal or flap elevation	
	D6110	Implant/abutment supported removable denture for completely edentulous arch - maxillary (upper)	only when there are exceptional medical conditions
	D6111	Implant/abutment supported removable denture for completely edentulous arch - mandibular (lower)	only when there are exceptional medical conditions
	D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary (upper)	only when there are exceptional medical conditions
	D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular (lower)	only when there are exceptional medical conditions
	D6114	Implant/abutment supported fixed denture for completely edentulous arch - maxillary (upper)	only when there are exceptional medical conditions

	D6115	Implant/abutment supported fixed denture for completely edentulous arch - mandibular (lower)	only when there are exceptional medical conditions
	D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary (upper)	only when there are exceptional medical conditions
	D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular (lower)	only when there are exceptional medical conditions
	D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	only when there are exceptional medical conditions
	D6121	Implant supported retainer for metal FPD – predominantly base alloys	only when there are exceptional medical conditions
	D6122	Implant supported retainer for metal FPD – noble alloys	only when there are exceptional medical conditions
	D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	only when there are exceptional medical conditions
	D6190	Radiographic/surgical implant index, by report	only when there are exceptional medical conditions
	D6191	Semi-precision attachment abutment placement	only when there are exceptional medical conditions
	D6194	Abutment supported retainer crown for full partial denture (titanium)	only when there are exceptional medical conditions
	D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	only when there are exceptional medical conditions
	D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	
	D6199	Unspecified implant procedure, by report	by report
Fixed Prosthodontics			
	D6211	Pontic - cast predominantly base metal (for Members age of 13 and older)	once in a five year period
	D6241	Pontic - porcelain fused to base metal (for Members age of 13 and older)	once in a five year period
	D6245	Pontic - porcelain/ceramic (for Members age of 13 and older)	once in a five year period
	D6251	Pontic - resin with predominantly base metal (for Members age of 13 and older)	once in a five year period
	D6721	Retainer crown - resin with predominantly base metal (for Members age of 13 and older)	once in a five year period

	D6740	Retainer crown - porcelain/Ceramic (for Members age of 13 and older)	once in a five year period
	D6751	Retainer crown - porcelain fused to predominantly base metal (not a benefit for Members under the age of 13.)	once in a five year period
	D6781	Retainer crown - 3/4 cast predominantly base metal (not a benefit for Members under the age of 13.)	once in a five year period
	D6783	Retainer Crown - 3/4 porcelain/ceramic (not a benefit for Members under the age of 13.)	once in a five year period
	D6784	Retainer crown ¾ - titanium and titanium alloys	once in a five year period
	D6791	Retainer Crown - full cast predominantly base metal (not a benefit for Members under the age of 13.)	once in a five year period
	D6930	Recement or re-bond fixed partial denture	Not a benefit within 12 months of a previous recementation by the same provider.
	D6980	Fixed partial denture repair necessitated by restorative material failure	Not a benefit within 12 months of initial placement or previous repair, same provider.
	D6999	Unspecified, fixed prosthodontic procedure, by report	by report
Oral Surgery			
	D7111	Extract, coronal remnants - primary tooth	
	D7140	Extraction - erupted tooth or exposed root	
	D7210	Surgical removal of erupted tooth requiring elevation of flap and removal of bone and/or sectioning of tooth	
	D7220	Removal of impacted tooth - soft tissue	
	D7230	Removal of impacted tooth - partially bony	
	D7240	Removal of impacted tooth - full bony	
	D7241	Removal of impacted tooth -complete bony with unusual surgical complications	
	D7250	Surgical removal of residual tooth roots requiring cutting of soft tissue and bone	
	D7260	Oroantral fistula closure	

	D7261	Primary closure of a sinus perforation	
	D7270	Tooth re-implantation of accidental displaced tooth (permanent anterior teeth only)	once per arch regardless of the number of teeth involved
	D7280	Surgical access of unerupted tooth (for 3rd molars)	
	D7283	Placement of device to facilitate eruption of impacted tooth	for Members in active orthodontic treatment
	D7285	Incisional biopsy of oral tissue-hard (bone/tooth)	once per arch, per date of service regardless of the areas involved
	D7286	Incisional biopsy of oral tissue-soft	up to a maximum of three per date of service
	D7290	Surgical repositioning of teeth (permanent teeth only)	for Members in active orthodontic treatment
	D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	for Members in active orthodontic treatment
	D7310	Alveoloplasty in conjunction with extraction- four or more teeth or tooth spaces, per quadrant	only in conjunction with extractions- four or more teeth or tooth spaces, per quadrant
	D7311	Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces, per quadrant	on the same date of service with two or more extractions in the same quadrant
	D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	
	D7321	Alveoloplasty not in conjunction with extraction, one to three teeth	alveoloplasty not in conjunction with extractions- four or more teeth or tooth spaces, per quadrant
	D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	once in a five year period per arch
	D7350	Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	once per arch
	D7410	Excision of benign lesion up to 1.25 cm	
	D7411	Excision of benign lesion greater than 1.25	
	D7412	Excision of benign lesion, complicated	
	D7413	Excision of malignant lesion up to 1.25	
	D7414	Excision of malignant lesion greater than 1.25	
	D7415	Excision of malignant lesion complicated	
	D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	

	D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	
	D7450	Removal of benign odontogenic cyst/tumor - lesion diameter up to 1.25cm	
	D7451	Removal of benign odontogenic cyst/tumor - lesion diameter greater than 1.25cm	
	D7460	Removal of benign non-odontogenic cyst/tumor - lesion diameter up to 1.25cm	
	D7461	Removal of benign non-odontogenic cyst/tumor - lesion diameter greater than 1.25cm	
	D7465	Destruction of lesion(S) by physical or chemical method, by report	by report
	D7471	Removal of lateral exostosis, maxilla (upper) or mandible (lower)	once per quadrant
	D7472	Removal of torus palatinus	once per patient
	D7473	Removal of torus mandibularis	once per quadrant
	D7485	Reduction of osseous tuberosity	once per quadrant
	D7490	Radical resection - of maxilla (upper)/mandible(lower) with bone graft	
	D7509	Marsupialization of odontogenic cyst	
	D7510	Incision and drainage of abscess intraoral soft tissue	once per quadrant
	D7511	Incision and drainage of abscess - intraoral soft tissue, complex	once per quadrant
	D7520	Incision and drainage of abscess - extraoral, soft tissue	
	D7521	Incision and drainage-extraoral complicated (includes drainage of multiple fascial spaces)	
	D7530	Removal foreign body, mucosa, skin, or subcutaneous alveolar tissue	once per date of service
	D7540	Removal of reaction producing foreign body, musculoskeletal system	once per date of service
	D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	once per date of service
	D7560	Maxillary (upper) sinusotomy for removal of tooth fragment or foreign body	
	D7610	Maxilla (upper) - open reduction (teeth immobilized, if present)	

	D7620	Maxilla (upper) - closed reduction (teeth immobilized, if present)	
	D7630	Mandible (lower) - open reduction (teeth Immobilized, if present)	
	D7640	Mandible (lower) - closed reduction (teeth immobilized, if present)	
	D7650	Malar and/or zygomatic arch open reduction	
	D7660	Malar and/or zygomatic arch closed reduction	
	D7670	Alveolus - closed reduction may include stabilization of teeth	
	D7671	Alveolus - open reduction may include stabilization of teeth	
	D7680	Facial bones complicated reduction with fixation and multiple surgical approaches	
	D7710	maxilla (upper) - open reduction	
	D7720	maxilla (upper) - closed reduction	
	D7730	mandible (lower) - open reduction	
	D7740	mandible (lower) - closed reduction	
	D7750	Malar and/or zygomatic arch - open reduction	
	D7760	Malar and/or zygomatic arch - closed reduction	
	D7770	Alveolus - open reduction Stabilization of teeth	
	D7771	Alveolus closed reduction Stabilization of teeth	
	D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches	
	D7810	Open reduction of dislocation	
	D7820	Closed reduction of dislocation	
	D7830	Manipulation under anesthesia	
	D7840	Condylectomy	
	D7850	Surgical discectomy, with/without implant	
	D7852	Disc repair	
	D7854	Synovectomy	
	D7856	Myotomy	
	D7858	Joint reconstruction	
	D7860	Arthrotomy	
	D7865	Arthroplasty	
	D7870	Arthrocentesis	
	D7871	Non-arthrocentesis lysis and lavage	

	D7872	Arthroscopy - diagnosis with/without biopsy	
	D7873	Arthroscopy - surgical lavage and lysis of adhesions	
	D7874	Arthroscopy -surgical disc repositioning and stabilization	
	D7875	Arthroscopy - surgical synovectomy	
	D7876	Arthroscopy - surgical discectomy	
	D7877	Arthroscopy - surgical debridement	
	D7880	Occlusal orthotic device, by report	
	D7881	Occlusal orthotic device adjustment	
	D7899	Unspecified TMD (Temporomandibular Joint Dysfunctions) therapy, by report	by report
	D7910	Suture of recent small wound less than 5 cm	
	D7911	Complicated suture - up to 5 cm	
	D7912	Complicated suture greater than 5 cm	
	D7920	Skin graft (identify defect covered, location and type of graft)	
	D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	
	D7940	Osteoplasty for orthognathic deformities	
	D7941	Osteotomy - mandibular rami	
	D7943	Osteotomy - rami, opened with bone graft	
	D7944	Osteotomy-segmented or subapical	
	D7945	Osteotomy - body of mandible	
	D7946	Lefort I - (maxilla (upper) -total)	
	D7947	Lefort I - (maxilla (upper) - segmented)	
	D7948	Lefort II or Lefort III-osteoplasty of facial bones (osteoplasty of facial for midface hypoplasia or retrusion) – without bone graft	
	D7949	Lefort II or Lefort III - with bone graft	
	D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible (lower) or maxilla (upper) - autogenous or non autogenous, by report	
	D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	
	D7952	Sinus augmentation with bone or bone substitute via a vertical approach	
	D7955	Repair of maxillofacial soft/hard tissue	

		defect	
	D7961	Buccal / labial frenectomy (frenulectomy)	once per arch per date of service
	D7962	Lingual frenectomy (frenulectomy)	once per arch per date of service
	D7963	Frenuloplasty(only when the permanent incisors and cuspids have erupted)	once per arch per date of service
	D7970	Excision of hyperplastic tissue - per arch	once per arch per date of service
	D7971	Excision of pericoronal gingiva	fee inclusive with other associated procedures performed on the same tooth, same day
	D7972	Surgical reduction of fibrous tuberosity	once per arch per date of service
	D7979	non-surgical sialolithotomy	
	D7980	Surgical Sialolithotomy	
	D7981	Excision of salivary gland, by report	by report
	D7982	Sialodochoplasty	
	D7983	Closure of salivary fistula	
	D7990	Emergency tracheotomy	
	D7991	Coronoidectomy	
	D7995	Synthetic graft – mandible (lower) or facial bones, by report	
	D7997	Appliance removal (not by dentist who placed appliance),including removal archbar	once per arch per date of service
	D7999	Unspecified oral surgery procedure, by report	by report
Adjunctive			
	D9110	Palliative treatment of dental pain – per visit	once per date of service per provider
	D9211	Regional block anesthesia	once per date of service per provider
	D9212	Trigeminal division block anesthesia	once per date of service per provider
	D9120	Fixed partial denture sectioning	once per date of service per provider
	D9210	Local anesthesia not in conjunction with outpatient surgical procedures	once per date of service per provider
	D9215	Local anesthesia in conjunction with operative or surgical procedures	once per date of service per provider
	D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	
	D9222	Deep sedation/general anesthesia – first 15 minutes	
	D9223	Deep sedation/general anesthesia - each subsequent 15 minutes.	

	D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	for uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's attempts to perform treatment
	D9239	Intravenous moderate (conscious) sedation/ analgesia – first 15 minutes	
	D9243	Intravenous conscious sedation/analgesia - each subsequent 15 minutes	
	D9248	Non-intravenous conscious sedation	for uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's attempts to perform treatment
	D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	once per date of service per provider
	D9311	Consultation with a medical health professional	once per date of service per provider
	D9610	Therapeutic parenteral drug, single administration	for up to a maximum of four injections per date of service
	D9612	Therapeutic parenteral drug, two or more administrations, different medications	
	D9910	Application of desensitizing medicament	for up to a maximum of four injections per date of service
	D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	
	D9930	Treatment of complications post surgical	once per date of service per provider
	D9950	Occlusal analysis - mounted case (permanent dentition)	once in a 12-month
	D9951	Occlusal adjustment-limited (natural teeth only)	once in a 12-month period per quadrant per provider
	D9952	Occlusal adjustment-complete	once in a 12-month period following occlusion analysis-mounted case
	D9999	Unspecified adjunctive procedure, by	by report

		report	
Orthodontic Care			
		Medically necessary orthodontic treatment (includes all appliances, removal of appliances and construction and placement of retainer)	
	D0801	3D dental surface scan – direct	Medical necessity
	D0802	3D dental surface scan – indirect	Medical necessity
	D0803	3D facial surface scan – direct	Medical necessity
	D0804	3D facial surface scan – indirect	Medical necessity
	D8010	Limited orthodontic treatment of the primary dentition	Medical necessity
	D8020	Limited orthodontic treatment of the transitional dentition	Medical necessity
	D8030	Limited orthodontic treatment of the adolescent dentition	Medical necessity
	D8050	interceptive orthodontic treatment of the primary dentition	Medical necessity
	D8060	interceptive orthodontic treatment of the transitional dentition	Medical necessity
	D8070	Comprehensive orthodontic treatment of the transitional dentition	Medical necessity
	D8080	Comprehensive orthodontic treatment of the adolescent dentition	Medical necessity
	D8090	Comprehensive treatment of adult dentition	Medical necessity
	D8660	Pre-orthodontic treatment examination to monitor growth and development	Medical necessity
	D8670	periodic orthodontic treatment visit (as part of contract)	Medical necessity
	D8680	orthodontic retention (removal of appliances, construction and placement of retainer(s)	Medical necessity
	D8681	Removable orthodontic retainer adjustment	Medical necessity
	D8696	Repair of orthodontic appliance – maxillary	Medical necessity
	D8697	Repair of orthodontic appliance – mandibular	Medical necessity
	D8698	Re-cement or re-bond fixed retainer – maxillary	Medical necessity
	D8699	Re-cement or re-bond fixed retainer – mandibular	Medical necessity
	D8692	Replacement of lost or broken retainer (that is no longer serviceable)	once per arch within 24 months following the date of service of orthodontic retention
	D8701	Repair of fixed retainer, includes	Medical necessity

		reattachment – maxillary	
	D8702	Repair of fixed retainer, includes reattachment – mandibular	Medical necessity
	D8703	Replacement of lost or broken retainer – maxillary	Medical necessity
	D8704	Replacement of lost or broken retainer – mandibular	Medical necessity
	D8999	Unspecified orthodontic treatment, by report	Medical necessity

Physician services

PCP

Description	Network	Out-of-network
Office hours visit (not surgical and not preventive care) (includes **telemedicine** consultation)	$50 no **deductible** applies	50% after **deductible**

Specialist

Description	Network	Out-of-network
Office hours visit (not surgical) (includes **telemedicine** consultation)	$90 no **deductible** applies	50% after **deductible**

Physician surgical services

Description	Network	Out-of-network
Inpatient surgical services	35% after **deductible**	50% after **deductible**
Outpatient surgical services	$125 no **deductible** applies	50% after **deductible**
Office surgical services	35% after **deductible**	50% after **deductible**

Prescription drugs - outpatient

Your **prescription** drug fill greater than a 30 day supply but no more than a 90 day supply can be filled at a CVS pharmacy at the **mail order pharmacy** cost share on tiers 1, 2 and 3.

Your cost share will not be more than the retail drug price or applicable cost share for the drug, whichever is lower.

Tier 1 -- preferred generic prescription drugs and low-cost preferred brand-name prescription drugs

Description	Network	Out-of-network
For each 30 day supply filled at a **retail pharmacy**	$15 no **deductible** applies	Not Covered
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	$30 no **deductible** applies	Not Covered

Tier 2 -- non-preferred generic prescription drugs and preferred brand-name prescription drugs

Description	Network	Out-of-network

Description	Network	Out-of-network
For each 30 day supply filled at a **retail pharmacy**	$70 after **deductible**	Not Covered
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	$140 after **deductible**	Not Covered

Tier 3 -- non-preferred brand-name prescription drugs

Description	Network	Out-of-network
For each 30 day supply filled at a **retail pharmacy**	$120 after **deductible**	Not Covered
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	$240 after **deductible**	Not Covered

Tier 4 -- preferred and non-preferred specialty prescription drugs

Description	Network	Out-of-network
For each 30 day supply filled at **specialty pharmacy**	30% up to $250 after **deductible**	Not Covered

Anti-cancer prescription drugs taken by mouth

Description	Network	Out-of-network
For each 30 day supply filled at a **specialty pharmacy**	$0 no **deductible** applies	Not covered

Contraceptive (birth control)

You can fill up to a 12 month supply at one time.

Description	Network	Out-of-network
For each 30 day supply of **generic prescription drugs** and OTC drugs and devices	$0 no **deductible** applies	Not covered
For each 30 day supply of **brand-name prescription drugs** and devices	Cost share based on the tier of drug above	Not covered

Contraceptive important note:

The **prescription** drug cost share will not apply to contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes over-the-counter (OTC) contraceptive **prescription drugs** and devices for each of the methods identified by the FDA. If a **prescription drug** is not available or inadvisable by your provider, the therapeutic equivalent **prescription drug** for that method will be paid at 100%.

The **prescription** drug cost share will apply to **prescription** drugs that have a generic equivalent or therapeutic equivalent obtained at a network pharmacy unless you receive a medical exception. A therapeutic equivalent is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Preferred generic, low-cost preferred brand-name and preferred brand-name diabetic supplies, drugs, and insulin

Description	Network	Out-of-network
For each 30 day supply filled at a **retail pharmacy**	$0 no **deductible** applies	Paid based on the tier of drug in the schedule
For each 90 day supply filled at a **mail order pharmacy**	$0 no **deductible** applies	Not covered

Preventive care drugs and supplements and risk reducing breast cancer prescription drugs

Description	Network	Out-of-network
For each 30 day supply filled at a **retail pharmacy**	$0 no **deductible** applies	Not covered

Limit

Description	Limit
Preventive care drugs and supplements and risk reducing breast cancer **prescription** drugs	Subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For a current list of covered preventive care drugs and supplements and risk reducing cancer **prescription** drugs, see the *Contact us* section of the certificate.

Sexual enhancement or dysfunction prescription drugs

Description	In-network coverage	Out-of-network coverage
Up to 8 pills for each 30 day supply filled at a **retail pharmacy**	Cost share based on the tier of drug above	Not covered
Up to 27 pills for all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	Cost share based on the tier of drug above	Not covered

Tobacco cessation prescription and over-the-counter drugs

Description	Network	Out-of-network
For each 30 day supply filled at a **retail pharmacy**	$0 no **deductible** applies Cost share only includes **generic prescription drugs** when there is also a brand-name drug available.	Not covered

Limit

Description	Limit
Tobacco cessation drugs	Subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation **prescription** drugs and OTC drugs, see the *Contact us* section of the certificate.

Outpatient prescription drug important note:
If you or your **provider** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the generic drug and the brand-name drug, plus the cost share that applies to the brand-name drug.

Preventive care

Description	Network	Out-of-network
Preventive care	0% no **deductible** applies	50% after **deductible**

Limits

Description	Limit
Breast pump, accessories and supplies limit	Electric pump: 1 every year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump
Immunization limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Prenatal care	See the *Preventive care, Prenatal care* section of the certificate for more information
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: • Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF • The comprehensive guidelines supported by the Health Resources and Services Administration Lung cancer screenings that exceed this limit covered as outpatient diagnostic testing

Description	Limit
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to: 7 exams from age 0-1 year 3 exams age 1-2 3 exams age 2-3 and 1 exam after that every 12 months High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older limited to 1 every 36 months
Well woman routine GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Prosthetic devices

Description	Network	Out-of-network
Prosthetic devices	35% after **deductible**	50% after **deductible**

Short-term cardiac and pulmonary rehabilitation services

Description	Network	Out-of-network
Cardiac and pulmonary rehabilitation	$90 no **deductible** applies	50% after **deductible**

Short-term rehabilitation therapy services

Outpatient physical therapy

Description	Network	Out-of-network
Physical therapy	$90 no **deductible** applies	50% after **deductible**

Outpatient occupational therapy

Description	Network	Out-of-network
Occupational therapy	$90 no **deductible** applies	50% after **deductible**

Outpatient speech therapy

Description	Network	Out-of-network
Speech therapy	$90 no **deductible** applies	50% after **deductible**

Spinal manipulation

Description	Network	Out-of-network
Spinal manipulation	$90 no **deductible** applies	50% after **deductible**
Visit limit per year	20	20

Skilled nursing facility

Description	Network	Out-of-network
Inpatient services	35% after **deductible**	50% after **deductible**
Limit	Coverage is limited to 100 days per benefit period.	Coverage is limited to 100 days per benefit period.

Important note:
A benefit period begins on the date you are admitted to a **skilled nursing facility** for skilled care. It ends on the date you have not been in the facility receiving skilled care for 60 consecutive days.

Telemedicine provider

Description	Network	Out-of-network
Behavioral health provider	0% no **deductible** applies	Not applicable
PCP	0% no **deductible** applies	Not applicable
Specialist	0% no **deductible** applies	Not applicable

Tests, images and lab - outpatient

Diagnostic complex imaging services

Description	Network	Out-of-network
At a facility	35% after **deductible**	50% after **deductible**
At a **physician** office	Included in office visit copay	50% after **deductible**
At a **specialist** office	Included in office visit copay	50% after **deductible**

Diagnostic lab work

Description	Network	Out-of-network
At a facility	$50 no **deductible** applies	50% after **deductible**
At a **physician** office	Included in office visit copay	50% after **deductible**
At a **specialist** office	Included in office visit copay	50% after **deductible**

Diagnostic radiological services (X-ray)

Description	Network	Out-of-network
At a facility	$90 no **deductible** applies	50% after **deductible**
At a **physician** office	Included in office visit copay	50% after **deductible**
At a **specialist** office	Included in office visit copay	50% after **deductible**

Therapies

Outpatient infusion therapy

Description	Network	Out-of-network
In a **physician** office or in a person's home	$90 no **deductible** applies	50% after **deductible**
In an outpatient facility	35% after **deductible**	50% after **deductible**

Transplant services

Description	Network (IOE facility)	Out-of-network (Includes Aetna's **network providers** who are not IOE **providers**)
Services and supplies	35% after **deductible**	Not Covered

Urgent care services

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

Description	Network	Out-of-network
Urgent medical care at a freestanding facility that is not a **hospital**	$90 no **deductible** applies	50% after **deductible**

Vision care

Pediatric vision care

Coverage is limited to covered persons through the end of the month in which the person turns 19.

Description	Network	Out-of-network
Pediatric vision exam (including refraction)	0% no **deductible** applies	Not Covered

Vision care services and supplies

Description	Network	Out-of-network
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	0% no **deductible** applies	Not Covered

Limits

Description	Limit
Limited to one per year	One pair of eyeglasses (**prescription** lenses and frames) or One year supply of contacts

Vision care important note:
See the *Vision care* section of the certificate for more information about vision services and supplies. This plan will cover either the purchase of **prescription** eyeglass lenses or contact lenses but not both.

Voluntary sterilization

Description	Network	Out-of-network
Vasectomy	0% no **deductible** applies	50% after **deductible**

Walk-in clinic visits

Not all preventive care services are available at **walk-in clinics**. All services are available from a network **physician**.

Description	Designated network	Non-designated network	Out-of-network
Non-emergency services	$0 no **deductible** applies	$50 no **deductible** applies	50% after **deductible**
Telemedicine consultation for non-emergency services	$0 no **deductible** applies	Cost share based on type of service and where it is received	50% after **deductible**
Preventive care immunizations and preventive screening and counseling services (Includes **telemedicine** consultation) See the *Preventive care* section for more information	0% no **deductible** applies	0% no **deductible** applies	50% after **deductible**