Re: Group Number 0170207

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

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

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

We appreciate your business.

Sincerely,

aetna® *

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

AETNA HEALTH INC.

Group agreement

The HMO agreement is by and between

AETNA HEALTH INC.
(**Aetna**, we, us, or our)
and
TEXAS OPERATORS ASSOCIATION
(**Contract holder**, you, or your)

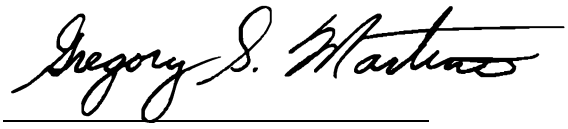
Group agreement number: 0170207
Effective date: January 01, 2021

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

Term of the HMO agreement: The initial term shall be the 12 consecutive month period beginning on the **effective date**.
Subsequent terms shall be the 12 consecutive month period beginning with the **renewal date**.

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

Signed at **Aetna's** Home Office 2777 Stemmons Freeway, Dallas, TX 75207.

By: 

Gregory S. Martino
Vice President

Important Note:
This is not a policy of workers' compensation insurance. The employer does not become a subscriber to the workers' compensation system by purchasing this policy, and if the employer is a non-subscriber, the employer loses those benefits which would otherwise accrue under the workers' compensation laws. The employer must comply with the workers' compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.

Table of contents

The HMO agreement

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

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

If you want to discuss your coverage

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

AETNA HEALTH INC.
2777 Stemmons Freeway
Dallas, TX 75207
1-800-MY-Health(694-2358)

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

Glossary

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

Contract holder

TEXAS OPERATORS ASSOCIATION and entities associated with it for purpose of coverage under this HMO agreement.

Covered person

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

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

Dates:

Effective date

Date we first cover you under this HMO agreement.

Final rates and fees schedule effective date

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

Premium due date

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

Renewal date

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

Termination date

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

Premium

Premium – rates and amount due

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

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

You owe premium for a **covered person** starting with the first **premium due date** on or after the day the person's coverage starts. You stop paying premium for a **covered person** as of the last day of the month after you notify us the day the person's coverage ends. Or, as of the first **premium due date** on or after the day the person's coverage ends if you notify us:

- At least 30 days before coverage ends, or
- Before the last day of the month the **covered person** becomes covered under:
    - COBRA or state continuation
    - Another health plan

Premium – individual proration

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

Premiums shall be adjusted as outlined below for persons whose:

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

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

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

Premium – changes in rates

We may change the premium rates as of a **premium due date** during the initial term only if there is a change in factors that materially affects the risk we assumed with this coverage. We will explain these changes in factors in our rate quote to you.

We may change the premium rates as of a **premium due date** during any following term. Any rate change, however, will not be applied more frequently than annually or as allowed by federal or state law or regulation.

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

Premium – experience credit

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

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

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

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

Premium – when due

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

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

Premium – how billed and paid

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

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

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

Premium – overdue amounts

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

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

Premium – eligibility corrections

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

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

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

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

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

Premium – waiver

Payment of premiums

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

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

Repayment of the waived premium

We may require you to pay back the premium waived if you terminate the group agreement within 12 months of your original **effective date**. We will give 10 days prior written notice to you of the requirement for the repayment of the waived premium.

Fees for special services and assessments

Special services

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

The special services are:

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

Special services – fees

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

Payment for third party technology provider

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

Assessments

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

Fees and assessments – when due

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

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

Fees and assessments – how billed and paid

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

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

Fees and assessments – overdue amounts

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

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

Some of our other responsibilities

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

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

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

Our duties in this *Some of our other responsibilities* section survive termination of the HMO agreement.

Some of your other requirements and responsibilities

Participation and contribution

You must comply with our participation and contribution requirements.

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

You shall distribute two documents required by the federal ACA:

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

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

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

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

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

Distribution – certain Employee Retirement Income Security Act (ERISA) of 1974 requirements

You are responsible for creating and distributing all reports and disclosures required by ERISA. These include:

- Summary plan descriptions
- Summary of material modifications
- Summary annual reports

Distribution – EOC and schedule of benefits

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

Information – access

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

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

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

Information – eligibility

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

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

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

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

You shall:

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

We will not start covering a person under the HMO agreement until you send us the information to enroll that person. Subject to applicable federal and state laws and the HMO agreement, we will not stop covering a person until you send us the information to terminate coverage. A **covered person** is eligible until the end of the month in which you notify us coverage ends. See the *Premium* section for more information.

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

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

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

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

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

90 day waiting period limitation

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

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

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

Notices – termination of coverage

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

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

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

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

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

Workers' compensation coverage

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

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

Termination

Automatic termination

The HMO agreement and all coverage end as of the last day of the grace period if you have not paid us all premiums and fees and assessments due as of the beginning of the grace period. The grace period is described in the *Premium* section.

Termination by you

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

Termination by us

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

- Upon 30 days written notice to you:
  - If you no longer have any employees under the plan who live, reside, or work in the service area
  - If you are a member of an association and your membership in the association ceases
  - If you breach a provision of the HMO agreement and you do not cure the breach within the notice period
  - If you cease to be a group as defined under applicable state law
  - If you do not certify your compliance with our policies and procedures upon request
  - If you change your eligibility or participation requirements without our consent
  - If you perform any act or practice that constitutes fraud or if you make any intentional misrepresentation of a material fact relevant to the coverage

- Upon the renewal date after you fail to meet our contribution or participation requirements that apply to this HMO agreement. We will only do this if you fail to meet them for six months in a row.

- Upon 90 days written notice to you (or such longer notice period as applicable federal and state laws requires,) if we cease to offer the product line provided by this HMO agreement. We will tell you if we offer a similar product that you can buy to replace the coverage.

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

We may rescind the HMO agreement and all coverage it provides for fraud or intentional misrepresentation of material fact upon 30 days advance written notice. The notice will state the **effective date** of rescission.

Non-renewal for failure to respond

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

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

whichever is later.

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

Effective time of termination

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

Effect of termination

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

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

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

Reinstatement

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

Intentional deception

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

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward
- Denial or termination of benefits
- Recovery of amounts we already paid

We also may report fraud to federal and state law enforcement.

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

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

- We will give the **covered person** 30 days advance written notice of any rescission of coverage
- The **covered person** has the right to an **Aetna** appeal
- The **covered person** has the right to a third party review conducted by an independent external review organization

Responsibility for conduct

Employees and agents

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

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

Indemnification – in general

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

You agree to indemnify and hold us harmless against that portion of our liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by your negligence, breach of the HMO agreement, breach of applicable federal and state laws, willful misconduct, criminal conduct, fraud, or your breach of a fiduciary responsibility in the case of an action under ERISA, related to or arising out of this HMO agreement or your role as employer or Plan Sponsor, as defined by ERISA.

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

Indemnification – federal law requirements

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

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

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

Your and our rights and duties in this *Responsibility for conduct* section survive termination of the HMO agreement.

General provisions

General provisions – content and interpretation of the HMO agreement

Applicable law

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

Compliance with law

You and we shall interpret the HMO agreement if possible so it complies with applicable federal and state laws.

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

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

Changes to the HMO agreement

The HMO agreement may be amended by a writing to which we both consent.

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

We may amend the HMO agreement by notice. We must give you 90 days advance written notice. Our amendment:

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

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

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

Changes to the HMO agreement may only be approved and signed by an officer of **Aetna**.

Entire agreement

The HMO agreement replaces and supersedes:

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

Waiver

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

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

General provisions – administration of the HMO agreement

Aetna name, symbols, trademarks and service marks

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

Assignment and delegation

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

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

Claim determinations – ERISA claim fiduciary

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

- To determine whether and to what extent **covered persons** are entitled to benefits
- To construe any disputed or doubtful terms under the HMO agreement. We shall be deemed to have properly exercised our authority unless we abuse our discretion by acting arbitrarily and capriciously.

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

- An individual's claim history
- A provider's billing patterns

- Complexity of the service or treatment
- Amount of time and degree of skill needed
- The manner of billing

Correcting our administrative errors

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

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

Correcting your honest mistakes

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

Discrimination prohibited

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

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

Incontestability

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

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

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

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

Notices

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

Notice may be delivered:

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

Notice sent to us by mail and commercial carrier shall be sent to:
AETNA HEALTH INC.
2777 Stemmons Freeway
Dallas, TX 75207
1-800- MY-Health (694-3258)

Notice sent to you by mail and commercial carrier shall be sent to:
TEXAS OPERATORS ASSOCIATION

,

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

Policies and procedures

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

Third parties rights

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

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

Non-Discrimination

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

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

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-982-3862.

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

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

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

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

Language Assistance

TTY: 711

To access language services at no cost to you, call 1-888-982-3862.

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862. (Spanish)

如欲使用免費語言服務，請致電 1-888-982-3862。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862. (French)

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

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

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

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

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

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

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

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

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

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

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

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862. (Catalan)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862. (Chamorro)

ᏩᎩᏍᏗ ᏚᎾᏂᎯᏍᏗ ᎤᏩᏫᏓᏁᏗ Ꮭ ᎪᎢᏍᏗ ᏗGEGWᏁᏗ ᎯᎩ, ᏫᏂᎯᏰᎳᏫᏏ 1-888-982-3862. (Cherokee)

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862. (Choctaw)

Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-982-3862. (Cushite-Oromo)

Voor gratis toegang tot taaldiensten, bell 1-888-982-3862. (Dutch)

Pou jwenn sèvis lang gratis, rele 1-888-982-3862. (French Creole-Haitian)

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

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

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

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

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862. (Hmong)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-888-982-3862. (Ibo)

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

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

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

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

လာတ်ကမၤနှၤ်ကျိာ်အတ်ၤမၤစၢၤအတ်ၤဖံးတ်ၤမၤတဖျိလၢတအိာ်ဒီးအပှၤလၢကဘာ်ဟုာ်အီၤအဂီၢ်ဘာ်နှာ် ကိး: 1-888-982-3862 တကှာ်. (Karen)

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

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

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

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

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

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

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

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

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

Të kɔɔr yïn wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-888-982-3862. (Nilotic-Dinka)
For tilgang til kostnadsfri språktjenester, ring 1-888-982-3862. (Norwegian)

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

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

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

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

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

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

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

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

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

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

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

ܐܢ ܚܫܚܬܐ ܗܘܝܢ ܥܠ ܝܠܦܢܘܬܐ ܕܫܘܬܐܣܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ، ܩܪܘܢ:
(Syriac-Assyrian) 1-888-982-3862
మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-888-982-3862 కు కాల్ చేయండి. (Telugu)

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

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

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

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

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

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

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

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

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

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Aetna, Inc.

To get information or file a complaint with your insurance company or HMO:

Call: Aetna's toll-free telephone number at 1-888-416-2277
Toll-free: 1-888-416-2277
Online: www.aetna.com
Email: aetnamemberservices@aetna.com
Mail: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Aetna, Inc.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: al numero de teléfono gratis de Aetna al 1-888-416-2277
Teléfono gratuito: 1-888-416-2277
En línea: www.aetna.com
Correo electrónico: aetnamemberservices@aetna.com
Dirección postal: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Aetna Health Inc.
2777 Stemmons Freeway, Dallas, TX 75207
1-800-MY-Health (694-2358)
www.aetna.com

Health maintenance organization (HMO)

Evidence of coverage (EOC)

Prepared exclusively for:

Contract holder: TEXAS OPERATORS ASSOCIATION
Contract holder number: 0170207
Group agreement effective date: January 01, 2021
Plan effective dates: January 01, 2021

Important note:
This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

This is not a policy of workers' compensation insurance. The employer does not become a subscriber to the workers' compensation system by purchasing this policy, and if the employer is a non-subscriber, the employer loses those benefits which would otherwise accrue under the workers' compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted. The insurance policy under which this EOC is issued is not a policy of workers' compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers' compensation system.

Underwritten by Aetna Health Inc. in the State of Texas

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

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

How we use words

When we use:

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

Contact us

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

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

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

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

Your ID card

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

Wellness and other rewards

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

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

The award of any such inventive shall not depend upon the result of a wellness or health improvement activity or upon a member's health status. Rather, you can obtain these benefits simply by participating in a wellness or health improvement program that we offer you. Once you earn benefits, you can accept or decline them. We won't charge you for choosing to accept any benefits you earn. You can earn benefits as long as we offer wellness and health improvement programs and you participate in them. If we stop offering a wellness and health improvement program or you stop participating in a program, you won't continue to earn these benefits. We will let you know at least 60 days in advance before we stop offering these benefits.

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, referral and preauthorization requirements* section and the *Glossary* for more information.

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

- **Physician** care generally is covered but **physician** care for cosmetic **surgery** is never covered. This is an exclusion.
- Home health care is generally covered but it is a **covered service** only up to a set number of visits a year. This is a limitation.
- Preventive services. Usually the plan pays more and you pay less. Preventive services are designed to help keep you healthy, supporting you in achieving your best health. To find out what these services are, see the *Preventive care* section in the list of services below. To find out how much you will pay for these services, see *Preventive care* in your schedule of benefits.

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

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

Acupuncture

Covered services include acupuncture services provided by a **physician**, if the service is provided as a form of anesthesia in connection with a covered **surgical procedure**.

The following are not **covered services**:

- Acupuncture, other than for anesthesia
- Acupressure

Alzheimer's disease

Covered services include the following services by a **physician** to diagnose Alzheimer's disease:

- A history and physical
- A neurological evaluation
- A psychological or psychiatric evaluation
- Lab services

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

Your plan also covers transportation to a **hospital** by professional air or water ambulance when:

- Professional ground **ambulance** transportation is not available.
- Your condition is unstable and requires medical supervision and rapid transport.
- You are traveling from one **hospital** to another and
  - The first **hospital** cannot provide the **emergency medical services** you need, and
  - The two conditions above are met.

Non-emergency

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

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

The following are not **covered services**:

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

Applied behavior analysis

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

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

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

Autism spectrum disorder

Autism spectrum disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder – not otherwise specified.

Covered services include the "generally recognized services" provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder.

We will cover screenings of your dependent children for autism spectrum disorder. This is done at ages 18 months and 24 months.

Treatment for autism spectrum disorder is covered from the date of diagnosis.

We will cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan. You can receive treatment from a **provider** that meets at least one of the following criteria:

- Is licensed, certified or registered by an appropriate agency of Texas.
- Has professional credentials that are recognized and accepted by an appropriate agency of the United States.
- Is certified as a **provider** under the TRICARE military health system.

You can also receive treatment from someone working under the supervision of a **provider** as described above.

As used here, "generally recognized services" can include:

- Evaluation and assessment services
- Applied behavior analysis
- Behavior training and behavior management
- Speech therapy
- Physical therapy
- Occupational therapy
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder

Services for children with developmental delays

Covered services for a child with developmental delays:

- Occupational therapy evaluations and services
- Physical therapy evaluations and services
- Speech therapy evaluations and services
- Dietary or nutritional evaluations

The therapy should follow a specific treatment plan that:

- Details treatment, and specifies frequency and duration
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

If the child is homebound, therapy services may be provided in the child's home.

Cardiovascular disease testing

Covered services include certain lab tests for the early detection of cardiovascular disease when a covered person has:

- Diabetes
- An intermediate or higher risk of getting coronary heart disease based on Framingham Heart Study prediction algorithms.

The following lab tests may be done to screen for hardening and abnormal artery structure and function:

- Computed tomography (CT) scanning
- Ultrasonography

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in a phase I, phase II, phase III or phase IV "approved clinical trial" as a "qualified individual" for the prevention, detection, or treatment of cancer or other life-threatening disease or condition, as defined in the federal Public Health Service Act, Section 2709. An approved clinical trial must satisfy one of the following:

- Federally funded trials:
  - The study or investigation is approved or funded by one or more of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare & Medicaid Services
    - Cooperative group or center of any of the entities described above or the Department of Defense or the Department Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy
    - The Food and Drug Administration
    - An institutional review board of a Texas institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services
- The study or investigation is a drug trail that is exempt from having such an investigational new drug application

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

The following are not **covered services**:

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

Experimental or investigational therapies

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

- Standard therapies have not been effective or are not appropriate
- Your **provider** determines, and we agree, that based on published, peer-reviewed scientific evidence you may benefit from the treatment

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

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

Dental care services and anesthesia in a hospital or surgery center

Covered services include dental care and anesthesia in a **hospital** or **surgery center** only if your **provider** tells us you:

- Have physical, mental, or medical condition that requires you be treated in a **hospital** or **surgery center**
- Are developmentally disabled
- Are in poor health and have a medical need for general anesthesia

Diabetic services, supplies, equipment, and education

Covered services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Insulin and insulin analog preparation
  - Diabetic needles and syringes
  - Injection aids, including devices used to assist with insulin injection and needleless systems
  - Diabetic test agents, including but not limited to, visual reading and urine Test strips
  - Lancet/lancing devices
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Injectable glucagon's
  - Glucagon emergency kit
  - Biohazard disposal containers
- Equipment
  - External and implantable insulin pumps
    - Repairs and necessary maintenance of insulin pumps if not covered by manufacturer's warranty or purchase agreement

    - Rental fees for pumps during repair and maintenance
  - Blood glucose monitors without special features, unless required due to blindness
  - Podiatric appliances, including therapeutic shoes to prevent complications of diabetes
- Training
  - Self-management training provided to you by a health care **provider** certified in diabetes self-management training. We will also cover training for a person who cares for you, if a **provider** sends a written order.

Covered services also include new or improved diabetic treatment, equipment and supplies that become available. They must be:

- Approved by the United States Food and Drug Administration
- **Prescribed** by your **provider**
- Sent to us in writing by your **provider**

All supplies, including medications and equipment for diabetes will be dispensed as written, and are not subject to preauthorization or step therapy requirements.

Durable medical equipment (DME)

DME and the accessories needed to operate it are:

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

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

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

Covered services also include:

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

The following are not **covered services**:

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

Emergency services

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

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

The types of services that are eligible for coverage include:

- A medical screening examination or other evaluation required by state or federal law and provided to covered enrollees in a **hospital** emergency facility, freestanding emergency care facility or comparable facility, necessary to determine if an **emergency medical condition** exists.
- Treatment to stabilize your condition
- Care in an emergency facility, freestanding emergency care facility or comparable facility after you become stable. But only if the treating **provider** asks us, and we approve the service. We will approve or deny the request within an hour after receiving the request.

Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.

If 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, referral and preauthorization requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your network **physician** or **primary care physician** (**PCP**).

Non-emergency services

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

Orthotic devices

Covered services include the initial orthotic device and subsequent replacement that your **physician** orders and administers to support or brace weak or ineffective joints or muscles of the foot.

We will cover the same type devices that are covered by Medicare. Your **provider** will tell us which device best fits your need. But we cover it only if we **preauthorize** the device.

Orthotic device means a customized medical device applied to a part of the body to:

- Correct a deformity
- Improve function
- Relieve symptoms of a disease

Coverage Includes:

- Repairing or replacing the original device. Examples of these are:
  - 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
- Instruction and other services (such as attachment or insertion) so you can properly use the device.

Habilitation therapy services

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

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

Outpatient physical, occupational, and speech therapy

Covered services include:

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

The following are not **covered services**:

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

Hearing aid and cochlear implants and related services

Covered services include hearing aids or cochlear implants and the following related services and supplies:

- Fitting and dispensing services and ear molds necessary to maintain optimal fit of hearing aids
- Treatment related to hearing aids and cochlear implants, including:
  - Habilitation and rehabilitation necessary for educational gain
  - For cochlear implants, an external speech processor and controller
- Internal replacement of cochlear implants as **medically necessary** or audiologically necessary

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

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

Hearing exams, except as provided in the *Hearing aid and cochlear implants and related services* section of the *Coverage and exclusions* section.

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

The following are not **covered services**:

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

Home health care

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

- Your **physician** orders them
- The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**
- 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

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

The following are not **covered services**:

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

Hospice care

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

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

The following are not **covered services**:

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

Hospital care

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

- Semi-private **room and board**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians**.
- Operating and recovery rooms
- Intensive or special care units of a **hospital**
- General nursing care
- Private duty nursing
- Administration of blood and blood derivatives, including the cost of the blood or blood product. (e.g. blood plasma and blood plasma expanders) that is not replaced by you or for you
- Radiation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy
- Anesthesia, oxygen and oxygen therapy
- Inhalation therapy
- Radiological services, laboratory testing and diagnostic services

- Meals and special diets
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a **hospital**

The following are not **covered services**:

- All services and supplies provided in:
  - Rest homes
  - Assisted living facilities, except if you have an acquired brain injury
  - Any place considered a person's main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

Infertility services

Covered services include seeing a **network provider**:

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

The following are not **covered services**:

- All **infertility** services associated with or in support of an injectable drug (menotropin) cycle, including, but not limited to, imaging, laboratory services, and professional services.
- Intrauterine/intracervical insemination services.
- All **infertility** services associated with or in support of an Assisted Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, professional services
  - In vitro fertilization (IVF)
  - 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)
- Cryopreservation (freezing), storage or thawing of eggs, embryos, sperm or reproductive tissue.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- Obtaining sperm from a person not covered under this plan for ART services.
- The purchase of donor embryos, donor oocytes or donor sperm.

Maternity and related newborn care

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

- No less than 48 hours of inpatient care in a **health care facility** after a vaginal delivery
- No less than 96 hours of inpatient care in a **health care facility** 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 post- delivery home visits by a health care **provider**. **Covered services** also include services and supplies needed for circumcision by a **provider**.

These time frames apply if your child is born without any problem. If your **provider** tells us that you had a problem during your pregnancy or during childbirth, we will cover the **stay** the same as we would for any other illness or injury.

We will cover congenital defects for a newborn the same as we would for any other **illness** or **injury**

The following are not **covered services**:

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

Mental health treatment

Covered services include the treatment of **mental 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**, and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, crisis stabilization unit, residential treatment center for children and adolescents, or **residential treatment facility.** Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- 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** or **telehealth** consultation)
  - Individual, group, and family therapies for the treatment of mental 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:
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**

        - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease to avoid placing you at risk for serious complications
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23 hour observation
    - Peer counseling support by a peer support specialist

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

Nutritional support

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

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

The following are not **covered services**:

- Any food item, including:
    - Infant formulas
    - Nutritional supplements
    - Vitamins prescription vitamins
    - Medical foods
    - Other nutritional items even if they are the sole source of nutrition

Outpatient prescription drugs

Partial fill dispensing

We allow a partial fill of your **prescription** if:

- Your **pharmacy** or **prescriber** tells us that
    - The quantity requested is to synchronize the dates that the pharmacy fills your **prescription drugs**
    - The synchronization of the date is in your best interest
- You agree to the synchronization

Your out-of-pocket expenses will be prorated based on the number of day's supply.

Prescription eye drops

You may refill **prescription** eye drops to treat a chronic eye disease or condition if:

- The original **prescription** states that additional quantities are needed
- The refill does not exceed the total quantity of dosage units stated on the original **prescription**, including refills
- The refill is dispensed on or before the last day of the prescribed dosage period and not earlier than the:
  - 21st day after the date a 30-day supply is dispensed
  - 42nd day after the date a 60 day supply is dispensed
  - 63rd day after the day a 90-day supply is dispensed

Outpatient surgery

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

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

The following are not **covered services**:

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

Physician services

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

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

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

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

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

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

Physician surgical services

Covered services include the services of:

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

The following are not **covered services**:

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

Preventive care

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

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

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

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

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

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

Breast-feeding support and counseling services

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

Breast pump, accessories and supplies

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

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for

the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Counseling services

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

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

Family planning services – contraceptives

Covered services include family planning services as follows:

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

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

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

Family planning services and supplies

Examples of these are:

- Tubal ligation, vasectomy and other forms of voluntary sterilization, along with related services and supplies, follow-up care and treatment of complications of such procedures
- Family planning services during a **stay** in a **hospital** or other facility for medical care

Immunizations

Covered services include preventive immunizations for infectious diseases.

Immunizations for adults age 18 or more	Immunizations for children from birth to age 18
• Hepatitis A • Hepatitis B • Herpes zoster • Human papillomavirus • Influenza • Measles, mumps, rubella • Meningococcal • Pneumococcal • Tetanus, diphtheria, pertussis varicella	• Diphtheria, tetanus, pertussis • Haemophilus influenza type b • Hepatitis A • Hepatitis B • Human papillomavirus • Inactivated poliovirus • Influenza • Measles, mumps, rubella • Meningococcal • Pneumococcal • Rotavirus • Varicella • Any other immunization that is required for children by law

Covered services also include immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

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

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

Prenatal care

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

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

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)

- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms (All forms of low-dose mammography, including digital mammography and breast tomosynthesis)
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

*See the Routine cancer screenings section in the schedule of benefits for any age, family history and frequency guideline limitations.

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:

Routine physical exams for adults age 18 or more	
• Abdominal aortic aneurysm – a one-time screening for men who have ever smoked • Alcohol misuse screening and counseling in a primary care setting • Blood pressure screening • Cholesterol screening for adults at increased risk for coronary heart disease • Colorectal cancer screening for adults over 50 • Depression screening for adults when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up • Diabetes (Type 2) screening for adults with high blood pressure	• HIV screening for all adults at higher risk • Obesity screening and counseling for all adults • Tobacco use screening for all adults and cessation interventions for tobacco users • Syphilis screening for all adults at higher risk • Sexually transmitted infection prevention counseling for adults at higher risk • Diet counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease • Aspirin use as recommended by their physician

Routine physical exams for children from birth to age 18	
• Autism screening for children of all ages • Cervical dysplasia screening for sexually active females • Congenital hypothyroidism screening for newborns • Developmental screening for children, and surveillance throughout childhood • Dyslipidemia screening for children at higher risk of lipid disorders • Hearing screening for all newborns • Hematocrit or hemoglobin screening for children • Hemoglobinopathies or sickle cell screening for newborns • HIV screening for adolescents at higher risk • Lead screening for children at risk of exposure • Obesity screening and counseling • Phenylketonuria (PKU) screening for this genetic disorder in newborns • Tuberculin testing for children at higher risk of tuberculosis	• Hearing and vision screening for all children to determine the need for hearing and vision correction • Alcohol and drug use assessments for adolescents • Fluoride chemoprevention supplements for children without fluoride in their water source • Gonorrhea preventive medication for the eyes of all newborn • Height, weight and body mass index measurement s for children • Iron supplements for children ages 6 to 12 months at risk for anemia • Medical history for all children throughout development • Oral health risk assessment for young children • Sexually transmitted infection prevention counseling for adolescents at higher risk • Depression screening for adolescents • Blood pressure screening for children

Routine physical exams for women	
• Anemia screening on a routine basis for pregnant women • Bacteriuria urinary tract or other infection screening for pregnant women • BRCA counseling about genetic testing for women at higher risk • Breast cancer mammography screenings • Breast cancer chemoprevention counseling for women at higher risk • Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women • Cervical cancer screening for sexually active women • Pap smear; or screening using liquid-based cytology methods, either alone or in conjunction with a test approved by the United States Food and Drug Administration • 1 gynecological exam every 12 months • Chlamydia infection screening for younger women and other women at higher risk • Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs (see the contraception section, below for more detail) • Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test	• Domestic and interpersonal violence screening and counseling for all women • Folic acid supplements for women who may become pregnant • Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes • Gonorrhea screening for all women at higher risk • Hepatitis B screening for pregnant women at their first prenatal visit • Human immune deficiency virus (HIV) screening and counseling for sexually active women • Human papillomavirus (HPV) DNA test: high risk HPV DNA testing • Osteoporosis screening for women depending on risk factors • Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk • Tobacco use screening and Interventions for all women, and expanded counseling for pregnant tobacco users • Sexually transmitted infections counseling for sexually active women • Syphilis screening for all pregnant women or other women at increased risk • Well-women visits to obtain recommended preventative services

Covered services also include:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.

Covered services include:

- Annual routine 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.

We will cover the same type devices covered by Medicare. Your **provider** will tell us which device best fits your needs. But we cover it only if we **preauthorize** the device.

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
- Repairing or replacing the original device. Examples of these are:
  - Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage

The following are not **covered services**:

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

Reconstructive 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 and Prostheses
  - Unless you or your **physician** decide that a shorter time period for inpatient care is appropriate, **covered services** for reconstructive breast **surgery** include:
    - 48 hours of inpatient care following a mastectomy
    - 24 hours of inpatient care in a network health care facility after lymph node dissection for treatment of breast cancer
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.
- Your **surgery** corrects a craniofacial abnormality defect. This includes the abnormal structure that is caused by developmental deformities, congenital defects, trauma, tumors, infections or disease.
  - The purpose of the **surgery** is to improve function or attempt to create a normal appearance.

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation services

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

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

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

Inpatient and outpatient treatment for cognitive rehabilitation, physical, occupational, and speech therapy

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

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

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

The following are not **covered services**:

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

Inpatient and outpatient treatment for acquired brain injury

Covered services include treatment for an acquired brain **injury**. An acquired brain **injury** does not include a congenital or degenerative **illness** or **injury**. It means a neurological **injury** to the brain, after birth, that results in loss of:

- Physical function
- Sensory processing
- Cognition
- Psychological behavior

The therapy is coordinated with us as part of a treatment plan intended to:

- Maintain or restore previous cognitive function
- Slow further loss of function

Covered services include the following therapies related to an acquired brain **injury**:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment.
- Neurofeedback therapy
- Remediation
- Post-acute transition services
- Community reintegration services
- Post-acute care treatment due to, and related to, an acquired brain **injury.** If you have been unresponsive to treatment, this also includes checking from time to time to see if you become responsive.

Covered services also include care in an assisted living facility that is:

- Within scope of their license, and
- Within scope of the services provided under an accredited rehabilitation program for brain **injury.**

Skilled nursing facility

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

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

Important note:
Even if you receive **covered services** at a health care facility that is a **network provider**, not all services may be in network. Other services you receive may be from a **physician** or facility is an **out-of-network provider. Providers** that may not be **network providers** include anesthesiologist, radiologist, pathologist, and assistant surgeons. You may receive a bill for services from these **out-of-network providers** as we paid them at our usual and customary rate or an agreed rate. We will work with the **providers** so that all you pay is your appropriate network level **copayments.** Contact us if you receive a bill from the **out-of-network provider**.

Substance related disorders treatment

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

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

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

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 follow-up care related to newborn hearing screening
Covered services include necessary diagnostic follow-up care related to the newborn hearing screening test from birth through 24 months of age.

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

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

Covered services also include anti-cancer **prescription drugs** for chemotherapy. Coverage for oral anti-cancer **prescription drugs** will not be less favorable than for intravenously or injected anti-cancer **prescription drugs**. Your prescriber or your pharmacist may need to get approval from us before we will agree to cover the drug for you. See the *Preauthorization* section for details. If your group agreement includes an Outpatient prescription drug plan rider, oral anti-cancer **prescription drugs** will be covered under that rider.

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

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

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

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

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

Radiation therapy

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

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

Transplant services

Covered services include transplant services provided by a **physician** and **hospital** only when we **preauthorize** them.

This includes the following transplant types:

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

Network of transplant facilities

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

You must get transplant services from the IOE facility we designate to perform the transplant you need.

Important note:
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 care center" is a facility licensed as a freestanding medical facility to treat **urgent conditions**. **Urgent conditions** need prompt medical attention but are not life-threatening.

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

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

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

Vision care

Adult vision care

Covered services include:

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

The following are not **covered services**:

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

Pediatric vision care

Covered services include:

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

The following are not **covered services**:

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

Walk-in clinic

Covered services include health care services provided at a **walk-in clinic** for:

- Unscheduled, non-medical emergency illnesses and injuries
- Immunizations administered within the scope of the clinic's license
- Individual screening and counseling services that will help you:
  - With obesity or healthy diet
  - To stop using tobacco products

General plan exclusions

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

Abortion
Services and supplies provided for an abortion except when the pregnancy places the woman's life in serious danger or it poses a serious risk of substantial impairment of a major bodily function

Blood, blood plasma, synthetic blood, blood derivatives or substitutes (except as provided in the *Hospital care* section of the *Coverage and exclusions* section
Examples of these are:

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

For allogenic and autologous blood donations only administration and processing expenses are covered. We do not cover volunteer donation expenses for which there is no charge.

Cosmetic services and plastic surgery
Any treatment, **surgery** (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons. This cosmetic services exclusion does not apply to surgery after an accidental injury when performed as soon as medically feasible. Injuries that occur during medical treatments are not considered accidental injuries, even if unplanned or unexpected.

Counseling
Marriage, religious, family, career, social adjustment, pastoral or financial counseling

Court-ordered services and supplies
Includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding

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

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- Respite care, adult or child day care, or convalescent care

- Institutional care, including **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform

Educational services

Examples of these are:

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

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Foot care

Non-diabetic services and supplies for the following:

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

Growth/height care

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

Jaw joint disorder treatment

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

Maintenance care

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

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. These items are usually included in the cost of other services and are not billed separately. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Syringes, except for treatment of diabetes
  - Blood or urine testing supplies, except for treatment of diabetes
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Mental health treatment

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

- **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders, except as described in the *Coverage and exclusions – Preventive care* section
- Pathological gambling, kleptomania, pyromania
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Missed appointments

Any cost resulting from a canceled or missed appointment

Nutritional support

- Any food item, including:
  - Infant formulas
  - Vitamins
  - **Prescription** vitamins
  - Medical foods
  - Other nutritional items

  even if it is the sole source of nutrition

Obesity surgery and services

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

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

Other non-covered services

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

Other primary payer

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

Personal care, comfort or convenience items

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

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

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

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

Strength and performance

Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance, except when used to treat an **illness** or **injury**.

Telemedicine or telehealth

- Services given when you are not present at the same time as the **provider**
- Telephone calls for behavioral health services
- **Telemedicine** or **telehealth** kiosks
- Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

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

Treatment in a federal, state, or governmental entity

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

Voluntary sterilization

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

Wilderness treatment programs

See *Educational services* in this section

Work related illness or injuries

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

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

How your plan works

How your plan works while you are covered

Your HMO plan:

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

Providers

Our **provider** network is there to give you the care you need. You can find **network providers** and see important information about them most easily on our online **provider** directory. Just log in to the Aetna website.

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

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

Service area

Your plan generally pays for **covered services** only within a specific geographic area, called a service area. See *Appendix A-Service area map* for a **service area** map and a detailed list of counties within the **service area.** There are some exceptions, such as for **emergency services**, urgent care, and transplant services. See the *Who provide the care* section below.

Important note for dependents under a qualified medical support: if you are required to cover a dependent who lives outside the **service area** under a qualified medical support order, we will provide your dependent with coverage that is comparable health or dental coverage to that provided to other dependents.

Important note for other dependents (not under a qualified medical support order) outside the service area: If you have a dependent outside of the **service area**, their coverage outside of the **service area** will be limited to emergency and **urgent conditions** for both medical and **pharmacy** services.

Who provides the care

Network providers

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

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

- **Emergency services** – see the description of **emergency services** in the *Coverage and exclusions* section.
- Urgent care – see the description of urgent care in the *Coverage and exclusions* section.

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

We will make a decision as soon as your medical condition requires but no later than 5 working days after we receive all of the information we need from your **provider**. We may decide not to approve your request. Before we disapprove the request, a **specialist** of the same or similar specialty as the **provider** you are requesting to see will review your request. If access is approved, we will pay the **out-of-network** provider at our usual and customary charge or an agreed rate. We will work with the **provider** so that all you pay is the appropriate network level **copayment**. Contact us for assistance.

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

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

Your PCP

Your **PCP** can provide care for obstetrical or gynecological services. Or, you can choose an OB, GYN or OB/GYN **network provider** to provide care for those services. You can access an OB, GYN or OB/GYN network provider without a referral from your **PCP**. You may select an OB, GYN, or OB/GYN in addition to a **PCP**.

If you have a chronic, disabling or life-threatening illness, you can request to use a **network specialist** as your **PCP**. Your **network specialist** must let us know that they agree to act as your **PCP**. You can contact us for information as to how to apply for this exception.

Designation of your **network specialist** as your **PCP** will not be retroactive. If your request is denied, you may appeal the decision. See the *When you disagree – claim decisions and appeals procedures* section. You must get **covered services** through your **PCP**'s office. They will provide you with primary care.

How you choose your PCP

You can choose a **PCP** from the list of **PCP**s in our directory. See the *Who provides the care, Network providers* section.

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

What your PCP will do for you

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

Your **PCP** will give you a written or electronic **referral** to see other **network providers**. But you will never need a **referral** authorization from your **PCP** to go to an OB/GYN **network provider**.

Changing your PCP

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

If you do not select a PCP
Because having a **PCP** is so important, we may choose one for you. You will get an ID card in the mail. We will tell you the name, address and telephone number of your **PCP**.

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

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

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

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

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

	If you have a disability, acute condition, or life-threatening condition	**When your provider stops participation with Aetna**
Request for approval	You need to complete a transition of coverage request form and send it to us. You can get this form by contacting us.	You or your **provider** should call us for approval to continue any care.
Length of transitional period		Care will continue during a transitional period for up to 90 days. This date is based on the date the **provider** terminated their participation with us.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.	

	If you have a terminal illness	**When your provider stops participation with Aetna**
Request for approval	You need to complete a transition of coverage request form and send it to us. You can get this form by contacting us.	You or your **provider** should call us for approval to continue any care.
Length of transitional period		Care will continue during a transitional period for up to nine (9) months. This date is based on the date the **provider** terminated their participation with us.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.	

	If you are pregnant and have entered your second trimester	When your provider stops participation with Aetna
Request for approval	You need to complete a transition of coverage request form and send it to us. You can get this form by contacting us.	You or your **provider** should call us for approval to continue any care.
Length of transitional period		Care will continue during a transitional period through delivery, including the time required for postpartum care directly related to delivery. This includes a post-delivery checkup within six weeks.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.	

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

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

Medical necessity, referral and preauthorization requirements

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

- The service is **medically necessary**
- You get your care from:
  - Your **PCP**
  - Another **network provider** after you get a **referral** from your **PCP**
- You or your **provider preauthorizes** the service when required

Medically necessary, medical necessity

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

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

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

Referrals

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

Preauthorization

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

Your network **physician** or **PCP** is responsible for obtaining any necessary **preauthorization** before you get the care. **Network providers** cannot bill you if they fail to ask us for **preauthorization**. But if your **physician** or **PCP** requests **preauthorization** and we deny it, and you still choose to get the care, you will have to pay for it yourself. You have the right to appeal this decision. See the *When you disagree claim decisions and appeal procedures* section.

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

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

Type of care	Timeframe
Non-emergency admission	Call at least 3 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 3 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 **preauthorization** decision, where required by state law. An approval is valid for 180 days as long as you remain enrolled in the plan.

For an inpatient **stay** in a facility, we will tell you, your **physician** and the facility about your **preauthorized** length of **stay**. If your **physician** recommends that you stay longer, the extra days will need to be **preauthorized**. 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 **preauthorization** and we don't approve coverage, we will tell you why and explain how you or your **provider** may request review of our decision. See the *Complaints, claim decisions and appeal procedures* section.

Types of services that require preauthorization
Preauthorization is required for inpatient **stays** and certain outpatient services and supplies. Visit our website at https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html or contact us to get a list of the services that require **preauthorization**. The list may change from time to time.

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

What the plan pays and what you pay

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

The general rule

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

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

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

Negotiated charge

For health coverage:
This is the amount a **network provider** has agreed to accept or that we have agreed to pay them or a third-party vendor.

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

Paying for covered services – the general requirements

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

- The service is **medically necessary**
- You get your care from:
  - Your **PCP**
  - Another **network provider** after you get a **referral** from your **PCP**
- You or your **provider preauthorizes** the service when required

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

You pay the entire expense when:

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

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

Where your schedule of benefits fits in

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

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

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

Coordination of benefits

The Coordination of Benefits ("COB") provision applies when a person has health care 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). Plan is defined below *Key terms.*

Order of benefit determination rules

When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows:

• The primary plan pays according to its terms of coverage and without regard to the benefits under any other plan
• A plan does not have a COB provision is always primary unless the provisions of both plans state that the complying plan is primary, except: - Coverage that you have because of membership in a group that is designed to supplement part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are: o Major medical coverages that are superimposed over base plan **hospital** and **surgical** benefits o Insurance type coverages that are written in connection with a closed panel to provide **out-of-network** benefits.
• A plan may consider the benefits paid by another plan in calculating payment of its benefits only when it is secondary to that other plan.

• If the primary plan is closed panel plan and the secondary plan is not, the secondary plan must pay benefits as if it were the primary plan when a covered person uses an **out-of-network provider** or **physician** except for **emergency services** or authorized **referrals** that are paid or provided by the primary plan.
• When multiple contracts providing coordinated coverage are treated as a single plan, this applies only to the plan as a whole. Coordination among the component contract is governed by the terms of the contracts. If more than one carrier pays or provided benefits under the plan, the carrier designated ad primary within the plan must be responsible for the plan's compliance with these rules.
• If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of the secondary plan.

The order of benefit determination rules tell you the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms. Payment is made without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

Key Terms

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

Plan: A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.	
• Includes:	• Group blanket or franchise accident and health insurance policies, excluding disability income protection coverage • Individual and group health maintenance organization evidences of coverage • Individual accident and health insurance policies • Individual and group preferred provider benefit plans and exclusive provider benefit plans • Group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care • Medical care components of individual and group long-term care contracts • Limited benefit coverage that is not issued to supplement individual or group in-force

	policies • Uninsured arrangements of group or group-type coverage • The medical benefits coverage in automobile insurance contracts • Medicare or other governmental benefits as permitted by law
• It does not include:	• Disability income protection coverage • The Texas Health Insurance Pool • Workers' compensation insurance coverage • **Hospital** confinement indemnity coverage or other fixed indemnity coverage • Specified disease coverage • Supplemental benefit coverage • Specified accident coverage • School accident-type coverages that cover students for accidents only, including athletic injuries, either on "24-hour" or a "to and from school" basis • Benefits provided in Long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and **custodial care** or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services • Medicare supplement policies • A state plan under Medicaid • A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan • Other nongovernmental plan • An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable **deductible**
• Each plan for coverage is a separate plan, If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan	
This plan: This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans	
• How this plan coordinates with like benefits:	Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits,

	such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.
• The order of benefit determination rules for this plan:	The order of benefit determination rules determines whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. • When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits • When this plan is secondary, it determines its benefits after those of another plan an may reduce the benefits it pays so that all plan benefits equal 100% of the total allowable expense
Allowable expense: Allowable expense is a health or dental care expense, including **deductibles** and **copayments**, that is covered at least in part by any plan covering the person.	
• Allowable expense for benefits provided in the form of services:	When a plan provides benefits in the form of services the reasonable cash value of each service will be considered an allowable expense and a benefit paid.
• Expenses that are not allowable expenses:	An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a **provider** or **physician** by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense. Some expenses and services are not allowable expenses. Here are some examples: • The difference between the cost of a semi-private **hospital** room and a private **hospital** room is not an allowable expense, unless one of the plans provides coverage for private **hospital** room expenses. • If a person is covered by two or more plans that don't have a **negotiated charge** and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for

	specific benefit is not an allowable expense. • If a person is covered by two or more plans that provide benefits or services on the basis of **negotiated charges,** an amount in excess of the highest of the **negotiated charges** is not an allowable expense. • If a person is covered by one plan that does not have **negotiated charges** and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides it benefits or services based on **negotiated charges**, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care **provider** or **physician** has contracted with the secondary plan to provide the benefit or service for a specific **negotiated charge** or payment amount that is different that the primary plan's payment arrangement and if the health care **provider** or **physician** contract permits, the **negotiated charge** or payment must be the allowable expense used by the secondary plan to determine its benefits. • The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, **preauthorization** of admissions, and **network provider** and **physician** arrangements.

Allowed amount: Allowed amount is the amount of a billed charge that a carrier determines to be covered for services by an **out-of-network provider.** The amount includes both the carrier's payment and any applicable **deductibles** or **copayment** amounts for which the insured is responsible.
Closed panel plan: Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care **providers** and **physicians** that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care **providers** and **physicians**, except in cases of emergency or referral by a panel member.
Custodial parent: Custodial parent Is the parent with the right to designate the primary residence of a child by court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation

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, member, policyholder, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent
Child – parents married or living together, whether or not they have ever been married	Plan of parent whose birthday (month and day) is earlier in the calendar year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together, whether or not they have ever been 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 persons who are not his or her parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Child of: Persons who are not his or her parents	The rules shown for parents will apply, as if the persons were parents of the child	The rules shown for parents will apply, as if the persons were parents of the child

COB rule	Primary Plan	Secondary plan
Child of: Parents, who is also covered under a spouse's plan	The plan has covered the person longer is primary If the coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse.	The plan has covered the person longer is primary If the coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse.
Active or inactive employee This rule does not apply if: • The plan that covers you as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits • The "Non-dependent or Dependent" paragraph, above can determine the order of benefits	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 This rule does not apply if: • The other plan does not have the rule, and as a result, the plans do not agree on the order of benefits • The "Non-dependent or Dependent" paragraph, above can determine the order of benefits	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 This plan will not pay more than it would have paid had it been the primary plan.	Plans share expenses equally

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.

Recovery rights related to workers' compensation
If we pay more than we should have because workers' compensation benefits paid for the same **illness** or **injury** we may recover the excess from any of the following:

- Any person we paid or for whom we paid
- Any workers' compensation plan that is responsible for payment
- Any fund designed to provide benefits for workers' compensation claims

The recovery rights will be applied even if:

- The benefits are in dispute or are paid by means of settlement or compromise
- No decision has been made that the **illness** or **injury** was in the course of, or due to, your employment
- No agreement has been made by you, or the workers' compensation plan, about the amount of benefits due to health care
- The health care benefits are excluded from the workers' compensation settlement or compromise

By accepting benefits under this plan, you or your representatives agree to:

- Notify us of any workers' compensation claim made
- Reimburse us as described

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, or 1 business day, whichever is less.

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 **preauthorize** them.

Retrospective claim

A retrospective claim is a claim that involves health care services you have already received.

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**.

Concurrent care claim extension determination

You or your **provider** may ask for concurrent care claim extension to request more services. We will notify you when we make a determination for such a request. If we make an adverse determination, you will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an independent review organization, if the situation is eligible for independent review.

We will not reduce or deny coverage for services that we have already approved. During this concurrent claim extension period, you are still responsible for your share of the costs, such as **copayments** that apply to the service or supply. If your request for extended services is not approved after your adverse determination, and we uphold the decision to reduce or terminate such services, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of different types of claims we **preauthorize** and how much time we have to tell you about our decision.

Initial claim determinations				
Type of notice	**Initial determination (us)**	**Extensions**	**Additional information request (us)**	**Response to additional information request (you)**
Pre-service claim*	No later than 3 calendar days after we receive the request	Not applicable	Not applicable	Not applicable

Concurrent care claim* If you are hospitalized (may include concurrent care claim of **hospital stays)** If you are not hospitalized	No later than 24 hours after we receive the request followed by written notification within 3 business days No later than 3 calendar days after we receive the request	Not applicable Not applicable	Not applicable Not applicable	Not applicable Not applicable
Care to make sure you are stable following emergency treatment (post-stabilization) or for life threatening condition	No later than one (1) hour after we receive request	Not applicable	Not applicable	Not applicable
Requests for **step therapy** (non-emergency)	No later than 72 hours after we receive the request	Not applicable	Not applicable	Not applicable
Requests for **step therapy** exception (emergency)	No later than 24 hours after we receive request	Not applicable	Not applicable	Not applicable

*If we approve the care and services, we will send you a letter no later than 2 business days after we receive the request. The *Adverse determinations* section explains how and when we tell you about an adverse determination.

Filing a claim

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

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

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

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

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

A complaint is any oral or written expression of dissatisfaction regarding any aspect of our operation. You, someone who represents you, or your provider may file the 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. If your complaint is for services that you have not already received, we will provide you with a written response within 15 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

It is not a complaint if:

- We resolve a misunderstanding or misinformation, to your satisfaction, by providing an explanation or more information.
- You or your **provider** call or write to tell us you are unhappy with, or disagree with, an adverse determination. Instead, this is an appeal of the adverse determination. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determination* sections for more information

Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know that we have received your complaint within 5 business days. Our letter will tell you about our complaint procedures and timeframes. If you call us to complain, we will send you a complaint form to complete and return.

If your complaint concerns an emergency, or denial of continued hospitalization or **prescription drugs** and intravenous infusions, we will do an expedited appeal review. See the *Appeal of adverse determination*s and *Timeframes for deciding appeals of adverse determinations* sections for more information.

An Appeal

Your request to reconsider an adverse determination is an appeal of an adverse determination. It is also an appeal if you ask us to re-review a complaint because you are not happy with our initial response. The *Appeal of a complain*t and *Appeal of adverse determinations* sections below explain the appeal process for both types of appeals.

Appeal of a complaint

You can ask us to re-review your complaint. You can appeal to us by contacting us.

We will let you know that we have received your appeal within 5 business days. This notice will describe the appeals process and your rights. Part of this process is that we will assign a panel to review your appeal. You will have the opportunity to provide additional information for the panel to review your appeal. You will have the opportunity to provide additional information for the panel to consider. You or an authorized representative can attend the appeal hearing in person or by telephone.

The panel will include an equal number of:

- Non-employee HMO members.
- HMO representatives who were not involved in making the initial decision.
- **Providers** (including **specialists**) who were not involved in making the decision. We will use a **provider** with experience in the area of care that is disputed.

We will send you the following information at least 5 days before the appeal panel hearing, unless you agree otherwise:

- A copy of any documentation to be presented by our staff
- The specialties of the **physician** or **providers** consulted during the review
- The name and affiliation of all HMO representatives on the appeal panel

You may respond to this information. The appeal panel will consider your response in their review.

The panel will review the information and provide us with their decision. We will send you the final decision in writing within 30 calendar days of receiving the appeal. If your appeal is for services that you have not already received, we will send you the final decision in writing within 15 calendar days of receiving the appeal. The letter will include:

- The date we received the appeal request
- The panel's understanding of your complaint and the facts
- The clinical basis and criteria used to make the decision
- Documents supporting the decision
- If applicable, a statement of your right to request an independent review
- A statement of your right to appeal to the department of insurance at:

  Texas Department of Insurance
  P.O. Box 149104
  Austin, TX 78714-9104
  1-800-252-3439

If you ask, we will give you or your representative reasonable access to appeal information. This includes all documents, records and other information we used to decide the claim, or appeal. We will not charge you for the information.

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 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 determination. This is the internal appeal process. If you still don’t agree, you can also appeal that decision. There are times you may skip the one level of internal appeal. But in most situations you must complete that level before you can take any other actions, such as an external review.

Appeal of an adverse 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.

An adverse determination is our determination that the health care services you have received, or may receive are:

- **Experimental or investigational**
- Not **medically necessary**

If we deny health care services because your **provider** does not request **preauthorization** or a concurrent claim extension, it is not an adverse determination.

If we make an adverse determination, we will tell you in writing. Our written decision will tell you:

- The main reason for denial
- The clinical reason for denial
- The source of the screening criteria used as a guideline to make the decision
- How to ask for an appeal of the denial, including your right to appeal to an independent review organization (IRO) and how to obtain an independent review
- How to obtain an immediate review by the IRO when the claim denial involves:
  - A life-threatening condition
  - The provision of **prescription drugs** or intravenous infusions for which the patient is receiving health benefits under the EOC
  - Requests for **step therapy** exception

The chart below shows how much time we have to tell you about an adverse determination.

Type of notice	When you need care to make sure you are stable following emergency treatment (post-stabilization)	While you are in the hospital	When not hospitalized at the time of the decision	**Prescription drugs** or other intravenous infusions that you are currently receiving	Retrospective
Initial decision	No later than 1 hour after the request to the treating **provider**	Within 1 business day by phone or email to your **provider** followed by written notice within 3 business days to you and your **provider**	within 3 business days to you and your provider	No later than 30th day before on which the **prescription drugs** or intravenous infusions will be discontinued	Within 30 days after the date on which the claim is received
Extensions	Not applicable	Not applicable	Not applicable	Not applicable	15 days
Additional Information Request (us)	Not applicable	Not applicable	Not applicable	Not applicable	30 days
Response to additional information request (you)	Not applicable	Not applicable	Not applicable	Not applicable	45 days

Important note:
We will tell you about an adverse determination within the time appropriate to the circumstances relating to the delivery of the services and your condition. We will always tell no later than the times shown in the chart above.

Any other claim appeal

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

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

- Your name
- The contract holder's name
- A copy of the adverse 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 days for a post-service claim.

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

We will let you know that we have received your appeal of the adverse determination within 5 business days. This notice will describe the appeals process and your rights. If you call us to appeal, we will send you an appeal form to complete and return.

The review and decision of your appeal will be made by personnel not involved in making the initial adverse decision.

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

Expedited internal appeal

You are entitled to an expedited internal appeal process for emergency care denials, denials of care for life-threatening conditions, and denials of continued stays in a **hospital**. You can also ask for an expedited internal appeal if we deny a request for **step therapy** exception or a request for **prescription drugs** or intravenous infusions you are currently receiving.

Important note:
You can skip our standard and expedited internal appeal process to an independent review organization (IRO) in some situations. See the *Exhaustion of appeals* process section.

Timeframes for deciding appeals of adverse determination

The amount that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision. We may tell you about our decision orally or in writing. If we tell you orally, we will send you a letter within 3 calendar days after the oral notice.

Type of claim	Our response time from receipt of appeal
Urgent care claim	1 business day
Emergency medical condition	As soon as possible but no later than 1 business day
When you need care to make sure you are stable following emergency treatment (post-stabilization)	No later than (1) hour after the request
If you are hospitalized at the time of the adverse determination (may include concurrent care claim of **hospital** stays)	No later than 1 business day*
If you are receiving **prescription drugs** or intravenous infusions	As soon as possible but no later than 1 business day
Pre-service claim requiring **preauthorization**	As soon as possible but no later than 15 calendar day
Requests for **step-therapy** exception (non-emergency)	No later than 72 hours after we receive the request
Requests for step-therapy exception (emergency)	No later than 24 hours after we receive the request
Acquired brain **injury**	No later than 3 business after the request

*If your appeal is denied, your **provider** may ask us in writing to have a certain type of specialty **provider** review your case. The request must show good cause for specialty review. The request must be made no later than 10 business days after the appeal was denied. A **provider** of the same or a similar specialty who would typically manage this type of condition will do the review. A decision will be made within 15 working days of the date we receive such a request.

Exhaustion of appeal process

In most situations, you must complete an appeal with us before you can appeal through an external review process.

We encourage you to complete an appeal with us before you pursue voluntary arbitration, litigation or other type of administrative proceeding.

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

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the independent review process at the same time.
- We did not follow all of the claim determination and appeal requirements of Texas and the federal Department of Health and Human Services. But you will not be able to proceed directly to independent review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us
- You have a life-threatening condition. You can have your appeal reviewed through the independent review process.
- If you are receiving **prescription drugs** or intravenous infusion treatment and we deny them. You can have your appeal reviewed through the independent review process.

- Your request for a **step therapy** exception was denied. You can have your appeal reviewed through the independent review process.

Independent review

Independent review is a review done by people in an organization outside of Aetna. We call this an independent review organization (IRO).

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

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

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

You must submit the Request for Independent Review Form:

- To Aetna
- Within 120 calendar days 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 IRO. We will pay for information we send to the IRO plus the cost of the review.

Aetna will contact the IRO that will conduct the review of your claim. If your request is based on exigent circumstances your request will be sent as soon as possible. An “exigent circumstance” means when you are:

- Experiencing a health condition that may seriously jeopardize your life, health or ability to regain maximum function
- Undergoing a current course of treatment using a non-formulary drug

The IRO 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 IRO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an IRO decision?

We will tell you of the IRO decision not more than 45 calendar days after we receive your Notice of Independent Review Form with all the information you need to send in.

Sometimes you can get a faster independent review decision. Your **provider** must call us or send us a Request for Independent Review Form.

You may be able to get a faster independent review after an adverse determination if:

- Your **provider** tells us that a delay in your receiving health care services would:
    - Jeopardize your life, health or ability to regain maximum function
    - Be much less effective if not started right away (**experimental or investigational** treatment)
- The 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 or within 24 hours if your request is for an exigent circumstance.

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. But we will pay the fees or expenses incurred for the review of the IRO

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

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

When you can join the plan

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

You can enroll:

- At the end of any waiting period the contract holder requires
- Once each contract 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

If your plan includes coverage for dependents, you can enroll the following family members:

- Your legal spouse
- Dependent children – yours or your spouse's or partner's
  - Dependent children must be:
    - Under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children, including any children placed with you for adoption*
    - Foster children*
    - Children you are responsible for under a qualified medical or dental support order or court order
    - Grandchildren in your legal custody
    - Grandchild who is your dependent for federal tax purposes
    - A grandchild whose parent is already covered as a dependent on this plan

  *Your adopted child may be enrolled as shown in the *When you can join the plan* section, after the date:
    - You become a party in a suit for adoption, or
    - The adoption becomes final

Adding new dependents

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

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

- Birth – Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information. Or, you can call to notify us. You must provide the information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- Adoption or placement for adoption – A child that you, or that you and your spouse adopts is covered on your plan for the first 31 days after you become a party in a suit for adoption or the adoption is complete.
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after you become a party in a suit for adoption or the adoption is complete.
  - If you miss this deadline, your adopted child will not have health benefits after the first 31 days.
- Marriage
- Legal guardianship
- Court or administrative order

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

Special times you can join the plan

You can enroll in these situations:

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

We must receive the completed enrollment information within 31 days of the date when coverage ends.

You can also enroll in these situations:

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

We must receive the completed enrollment information within 60 days of the event date.

Notification of change in status

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

- Change of address

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

Starting coverage

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

Stopping coverage

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

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

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The contract holder asks to end coverage
- You are no longer eligible for coverage, including when you no longer reside, live, or work in the **service area**
- Your work ends
- You stop making required premium contributions, if any apply
- We end your coverage for one of the reasons shown in this section
- You choose to become covered under another health benefit plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage
- You stop making premium contributions, if any apply
- Your coverage ends for any of the reasons listed above except:
  - Exhaustion of your overall maximum benefit.

Your employer will notify Aetna of the date your coverage ends. You and your dependents will be covered until the end of the month after we receive the notice, unless any of the following occur:

- Your employer notifies you at least 30 days before coverage ends
- You and your dependents are covered under COBRA or state continuation
- You and your dependents are enrolled in another health plan that starts before the end of the month after received the notice

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:

- You no longer reside, live or work in the **service area**
- 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.

We will not end your coverage based on your health care status or needs, we also will not end your coverage, refuse to renew your coverage, or engage in any other retaliatory action because you used your rights under the *Complaints*, *claim decisions and appeals procedures* section of the EOC.

Special coverage options after your coverage ends

When coverage may continue under the plan

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

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

Consolidated Omnibus Budget Reconciliation Act (COBRA) rights

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

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

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

Continuation of coverage – State of Texas

Continuation privilege for certain dependents

There are events that may cause your dependents to lose coverage. For some events, certain dependents are eligible to continue their coverage for a time. Here are the events, eligible dependents and time periods.

Qualifying event causing loss of coverage	Covered persons eligible for continued coverage	Length of continued coverage (starts from the day you lose current coverage)
Death of employee Retirement of employee Divorce or legal separation	• Dependent who has been covered under the plan for at least one year • An infant under one year of age	3 years

When do I receive state continuation information?

The chart below lists who must give notice, the type of notice required, and the time period to give the notice.

Notice	**Requirement**	**Deadline**
You or your covered spouse	Send written notice to your employer	Within 15 days of the qualifying event
Your employer	Will provide you with an enrollment form to continue coverage	No later than 15 days after they receive notification
You or your covered spouse	Complete the enrollment form to continue coverage	Within 60 days of the qualifying event.

You must send the completed enrollment form from within 60 day of the qualifying event. If you don't, you will lose the right to continue coverage. We will cover your dependent during this period as long as the premiums and administrative charges are paid.

Group continuation privilege

You may continue coverage if your coverage ends for any reason except:

- Involuntary termination for cause
- Discontinuance of the group agreement

To continue coverage, you must be covered for at least 3 months in a row right before your coverage ends.

You must give your employer written election of continuation no more than 60 days following the later of the date:

- Your coverage ends or
- You are given notice by the contract holder

Your first **premium** payment must be made within 45 days after the date of the coverage election. After that, **premium** payments are due no later than the end of the grace period after the **premium** due date.

You can continue coverage until the earliest of:

- Six months after the end of the COBRA continuation period, if you are eligible for COBRA
- Nine months after the date election is made, if you are not eligible for COBRA
- The date you fail to pay **premiums**
- The date the group coverage terminates in its entirety
- The date you are covered for similar benefits by another health insurance policy or program
- The date you are covered (other than COBRA) for similar benefits by another plan

Continuation of coverage for other reasons

To request an extension of coverage, just contact us.

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

Your coverage may be extended if you are totally disabled when coverage ends.
Only the medical condition which caused the total disability is covered during your extension.

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

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

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

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

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

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

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

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

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

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

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

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

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

How you can extend coverage for a dependent after you die
Your dependents can continue coverage after your death if:

- You were covered at the time of your death
- The request is made within 30 days after your death, and
- Payment is made for coverage

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

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

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

General provisions – other things you should know

Administrative provisions

How you and we will interpret this EOC

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

If the EOC contains any provision or a part of a provision not in conformity with the Texas Insurance Codes (Insurance Code Chapter 1271) or other applicable laws, the remaining provision or parts of provisions are not rendered invalid. The remaining provisions or parts of provisions not invalid must be construed and applied as if they were in compliance with the Texas Insurance Codes (Insurance Code Chapter 1271) and other applicable 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

Your coverage is defined by the group agreement. This document may have amendments and riders too. Under certain circumstances, we, the contract holder or the law may change your plan. But only as permitted by the **HMO agreement.** When an emergency or epidemic is declared, we may modify or waive **preauthorization**, **prescription** quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the contract holder or provider, can do this. Any modifications made will be no less favorable than the current plan requirements.

If a service cannot be provided to you

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. But if we can't, we may refund any unearned premium.

Legal action

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

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

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

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

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

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

We also will not use any statement made to void, cancel or non-renew your coverage or reduce benefits unless it is in a written enrollment application, signed by the contract holder and furnished to you.

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

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

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage:

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

In the absence of fraud, any statement made on your application for coverage is considered a representation and not a warranty.

Some other money issues

Assignment of benefits

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

Financial sanctions exclusions

If coverage provided under this EOC 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.

Grace period

You will be allowed a grace period of 31 days after the due date for the payment of each contribution due after the first contribution payment. Coverage will continue during the grace period unless you give us written notice stating otherwise. If contributions are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period.

Premium – eligibility corrections

Our credit of premium is limited to 2 month's credit for a person whose loss of eligibility occurred more than 30 days before the date you notified us. We may reduce the credits by the amount of any benefit payments we may have made on behalf of such persons before you notified us that the person was not eligible for coverage.

Premium – rate increase

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

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 by a third party

If a third party caused you to need care – say, a careless driver who injured you in a car crash – you may have a legal right to get money for your injuries. If you have a legal right to get money from a third party for causing your injuries, we are entitled to that money, up to the amount we pay for your care.

When you have a legal right to get money from one or more third parties for causing your injuries and you pursue that legal right:

- You are agreeing to repay us from money you receive from those third parties because of your injury.
- You are giving us the right to seek money in your name, from those third parties because of your injuries.

- You are agreeing to cooperate with us so we can get paid back in full, up to the applicable amount noted below. For example, you'll tell us within 30 days of when you seek money from those third parties 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 our portion of the money you get, ahead of everyone else.
- You are 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. Notify us by contacting us.

We will only seek money from your own uninsured/underinsured motorist or medical payments coverage (if any) if you or your immediate family member did not pay premiums for the coverage.

If you are not represented by an attorney, then we can recover the lesser of:
- One-half of the money you receive, or
- The total amount paid by us

If you are represented by an attorney, then we can recover the lessor of:
- One-half of the money you receive, less attorney's fees and costs for the recovery, or
- The total amount paid by us, less attorney's fees and costs for the recovery

How will Attorney's fees be determined?	
If we do not use an attorney	• We (and any other payors) will pay your attorney a fee agreed to between us (and other payors) and your attorney plus a pro rata share of the recovery expenses • If no agreement exists, then the court will award your attorney a reasonable fee payable for our (and any other payors) share of the recovery not to exceed 1/3 of the recovery
If we use an attorney	• The court will award attorney's fees to our attorney and your attorney based on the benefit accruing as a result of each attorney's service. The total attorney's fees may not exceed 1/3 of our (and any other payors) recovery.
Payor means a plan issuer that: • Has a contractual right of subrogation, and • Pays benefits to you or on your behalf as a result of personal injuries caused by someone else's tortious conduct A payor includes, but is not limited to, an issuer of: • A health benefit that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness • A disability benefit plan • An employee welfare benefit plan	

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 your information with us. We need information about your physical and mental condition and care.

Glossary

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

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

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

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

Crisis stabilization unit
An institution licensed or certified by the Texas Department of Mental Health and Mental Retardation to provide 24-hour residential program to treat a moderate to severe psychiatric crisis. The program is prescribed by a **physician** or other **health professional** to provide short-term, intensive, structured care.

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

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

This can be done be done by metabolic or other means determined by a physician or a nurse practitioner working within the scope of their license. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Drug guide
A list of **prescription** drugs and devices established by us or an affiliate. It does not include all **prescription** drugs and devices. This list can be reviewed and changed by us or an affiliate only upon renewal and with 60 days' notice to you. A copy is available at your request. Go to https://www.aetna.com/individuals-families/find-a-medication.html.

Emergency medical condition
A severe medical condition that:
- Comes on suddenly
- Needs immediate medical care

- Leads a person with average knowledge of health and medicine to believe that, without immediate medical care, it could result in:
  - Danger to life or health
  - Loss of a bodily function
  - Loss of function to a body part or organ
  - Danger to the health of a fetus
  - Serious disfigurement

Emergency services

Treatment given in a **hospital's** emergency room, freestanding emergency facility, or comparable emergency facility. This includes evaluation of and treatment to stabilize the **emergency medical condition**.

Experimental or investigational

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

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

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

Formulary exclusions list

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

Generic prescription drug

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

- Dosage
- Safety
- Strength
- Quality
- Performance

It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Health professional

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

Home health care agency

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

Hospital

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

Infertile, infertility

A disease defined by 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

Jaw joint disorder

This is:

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

Mail order pharmacy

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

Maximum out-of-pocket limit

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

Medically necessary, medical necessity

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

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

- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

Generally accepted standards of medical practice means:

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

Mental disorder

A **mental disorder** as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. **Mental disorders** are usually associated with significant distress or disability in social, occupational, or other important activities.

Negotiated charge

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

Network provider

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

Out-of-network provider

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

Partial hospitalization treatment

Clinical treatment provided must be **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address **mental disorder** or **substance abuse** issues and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services as medication monitoring

Care is delivered according to accepted medical practice for the condition of the person.

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**).

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

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

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

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

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

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

- General practitioner
- Family **physician**
- Internist
- Pediatrician
- OB, GYN, and OB/GYN

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

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

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

Residential treatment facility
- An institution specifically licensed as a **residential treatment facility** by applicable laws to provide for mental health or **substance related disorder** residential treatment programs. It is

credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

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

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

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

For substance related residential treatment programs:

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

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

- An R.N. must be onsite 24 hours/day for 7 days/week within a residential setting
- Residential care must be provided under the direct supervision of a **physician**

Retail pharmacy

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

Room and board

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

Semi-private room rate

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

Skilled nursing facility

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

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

Skilled nursing facility does not include institutions that provide only:

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

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

Skilled nursing services

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

Specialist

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

Specialty prescription drugs

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

Specialty pharmacy

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

Stay

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

Step therapy

A form of **preauthorization** under which certain **prescription** drugs are excluded from coverage, unless a first-line therapy drug is used first by you. The list of **step therapy** drugs is subject to change by us or an affiliate. The list will only change when coverage is renewed. We will let you know about changes no later than 60 days before the change takes effect. An updated copy of the list of drugs subject to **step therapy** is available upon request or on our website at https://www.aetna.com/individuals-families/find-a-medication.html.

Substance related disorder

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

Surgery, surgical procedure

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

- Cutting
- Abrading

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

Telehealth

A health service, other than **telemedicine** medical service, delivered by a **health professional** licensed, certified or otherwise entitled to practice in the State of Texas and acting within the scope of their license, certification or entitlement to a patient at a different physical location than the **health professional** using telecommunications or information technology.

Telemedicine

A health care service delivered by a **physician** licensed, certified or otherwise entitled to practice in the State of Texas and acting within the scope of their license, certification or entitlement to a patient at a different physical location than the **health professional** using telecommunications or information technology.

Terminal illness

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

Urgent condition

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

Value prescription drugs

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

Walk-in clinic

A freestanding health care facility. The following are not considered a **walk-in clinic**:

- Emergency room
- Urgent care facility
- The outpatient department of a **hospital**

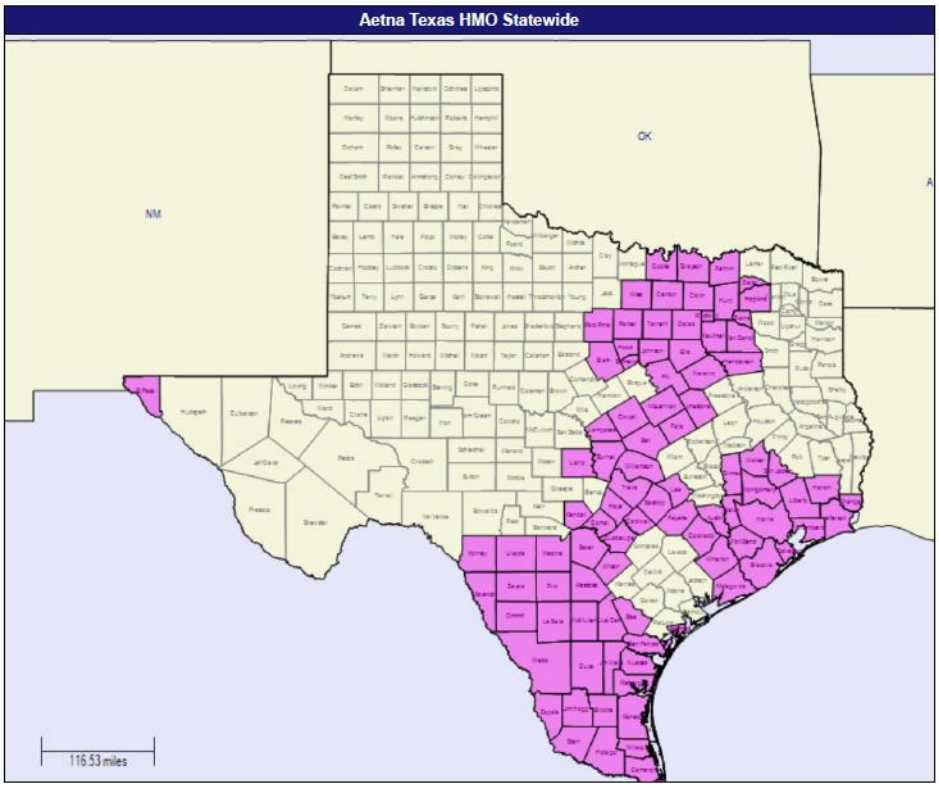
APPENDIX A - SERVICE AREA MAP

August 1, 2017

Service Areas

Texas HMO Statewide

116.53 miles



Aetna Health Inc.

Amendment

Contract holder: TEXAS OPERATORS ASSOCIATION

Amendment effective date: 01/01/2021

Your group agreement has changed. The Evidence of coverage, schedule of benefits and rider are revised to reflect this. This change is effective on the date shown above.

The changes are as follows:

The following language is added in the *Welcome* section of your Evidence of coverage (EOC):

Wellness and other rewards

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

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

The award of participation incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health status. Rather, you can obtain these benefits simply by participating in a wellness or health improvement program that we offer you. Once you earn benefits, you can accept or decline them. We won't charge you for choosing to accept any benefits you earn. You can earn benefits as long as we offer wellness and health improvement programs and you participate in them. If we stop offering a wellness and health improvement program or you stop participating in a program, you won't continue to earn these benefits. We will let you know at least 60 days in advance before we stop offering these benefits.

The following language is added in the *Coverage and exclusions*, *Short-term rehabilitation services* section of your Evidence of coverage (EOC):

Short-term rehabilitation services

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

The following important note is added below the *Coverage and Exclusions - Diagnostic x-ray and other radiological services* section.

> **Important Note:**
> Coverage for diagnostic mammograms will be considered the same as mammograms performed for routine cancer screenings as described in the Routine physical exams for women section.

The following language replaces the *Coverage and exclusions, Routine physical exams – Covered services include section* of the EOC.

Covered services include:

- Annual routine office visit to a physician
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns, an initial hospital checkup *and the administration of the newborn screening tests as required by applicable Texas law including the cost of a newborn screening test kit in the amount provided by the Department of State Health Services.*

The following language is removed from the *General plan exclusions* section of your Evidence of coverage (EOC):

Counseling

Marriage, religious, family, career, social adjustment, pastoral or financial counseling

The following language is revised within the *General plan exclusions* section of your Evidence of coverage (EOC):

Court-ordered services and supplies

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

The benefit exclusion named Mental health treatment within the General plan exclusions of your EOC is renamed to Behavioral health treatment and will be included in the EOC in the correct alphabetical order. In this renamed section, the following content has been added:

Behavioral health treatment

Services for the following categories (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 dementias or amnesia without a behavioral disturbance that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

The following new section is added to the *General plan exclusions* section of your EOC:

Mental health and substance use disorders treatment

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

- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions, Preventive care* section
- Pathological gambling, kleptomania, and pyromania
- Specific developmental disorders of scholastic skills (Learning Disorders/Learning Disabilities)
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language
- Other disorders of psychological development

The following language is added to the *How your plan works*, *If you do not select a PCP* section of your EOC:

If you do not select a PCP

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

The following language has been added to How your plan works under Paying for covered services – the general requirements section of your EOC:

NOTICE: "ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. IF YOU ARE IN RECEIPT OF A BALANCE BILL FOR COVERED SERVICES FROM ANY PHYSICIAN OR PROVIDER, INCLUDING A FACILITY-BASED PHYSICIAN OR OTHER HEALTH CARE PRACTITIONER PLEASE CONTACT US."

The following language is added to the *How your plan works*, *What the plan pays and what you pay*, *Negotiated charge* section of your EOC:

Negotiated charge

For health coverage:

This is the amount a **network provider** has agreed to accept or that we have agreed to pay them or a third-party vendor (including any administrative fee in the amount paid). We may enter into arrangements with **network providers** or others related to:

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

Some of these arrangements are called:

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

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

The following language is revised in the *Complaints, claim decisions and appeal procedures*, *Independent review* section of your EOC:

Independent review

Independent review is a review done by people in an organization outside of Aetna. This is called an Independent review organization (IRO).

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

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

If our claim decision is one for which you can seek independent 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 independent review process. It will include a copy of the request for independent review form at the final adverse determination level.

You must submit the Request for independent Review Form:

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

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

Aetna will contact the IRO that will conduct the review of your claim. If your request is based on exigent circumstances your request will be sent as soon as possible. An "exigent circumstance" means when you are:

- Experiencing a health condition that may seriously jeopardize your life, health or ability to regain maximum function

Undergoing a current course of treatment using a non-formulary drug
The IRO 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 IRO makes, unless we can show conflict of interest, bias or fraud.

The following sections are revised in the *Glossary* section of your Evidence of coverage (EOC):

Mental disorder

A **mental disorder** is in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of **mental disorder** is in the most recent edition of *The International Classification of Diseases, Tenth Edition (ICD-10)*.

Primary care physician (PCP)

A **physician** who:

- The directory lists as a **PCP**
- Is selected by a person from the list of **PCP**s in the directory
- Supervises, coordinates and provides initial care and basic medical services to a person

- Initiates **referrals** for **specialist** care, if required by the plan, and maintains continuity of patient care
- Shows in our records as your **PCP**

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

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

The following section is removed from the *Covered services*, *Habilitation therapy services* section of your schedule of benefits:

Habilitation therapy

Description	In-network
Habilitation therapy	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this Schedule of benefits

The following limits have been added to the Short-term rehabilitation services section of your schedule of benefits:

Physical, occupational and speech therapies

Description	In-network
Visit limit per day	1
Visit limit per year	60

The following language is revised in the *Transplant services* section of your schedule of benefits:

Transplant services

Description
Inpatient services and supplies

The following language is replaced for the adult vision care and pediatric vision care visit limitation in the *Vision* section of your schedule benefits:

Visit limit	1 visit(s) every 24 months

The following language is added within the *What you need to know about the prescription drug plan* section of the Prescription drug rider:

Prescription drug synchronization

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

Important Information about the Affordable Care Act (ACA)

Non-discrimination Rule

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

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

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

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

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

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

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

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

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

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

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

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.
- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 515 Congress Avenue, Suite 1875 Austin, TX 78701	**Texas Department of Insurance** P.O. Box 149104 Austin, TX 78714-9104

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

Aetna Health Inc.
HMO Disclosure Notice

- A health maintenance organization (HMO) plan provides no benefits for services you receive from **out-of-network physicians** or **providers**, with specific exceptions as described in your evidence of coverage and below.

- You have the right to an adequate network of in-network **providers** (known as network **physicians** and **providers**).

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.

- If your HMO approves a **referral** for out-of-network services because no **network physician** or **provider** is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network **physician's** or **provider's** bill so that you only have to pay any applicable in-network **copayment** and **deductible** amounts.

- You may obtain a current **directory** of **network physicians** or **providers** at the following website: www.aetna.com or by calling **Aetna** Member Services at the toll-free number on your ID card for assistance in finding available **network physicians** and **providers**. If you relied on materially inaccurate **directory** information, you may be entitled to have a claim by an out-of-network **physician** or **provider** paid as if it were from a network **physician** or **provider**, if you present a copy of the inaccurate **directory** information to the HMO, dated no more than 30 days before you received the service.

AETNA HEALTH INC. Rider

Prescription drug plan

Rider effective date: January 01, 2021

This **prescription** drug plan rider is added to your EOC. It describes your **prescription** drug benefits. This rider is subject to all other requirements described in your EOC, including general exclusions and defined terms.

What you need to know about the prescription drug plan

Read this rider carefully so you will know:

- How to access network pharmacies
- How to get an emergency **prescription** filled
- Coverage and exclusions
- How to access your benefit
- Where your schedule of benefits fits in
- **Preauthorization** requirements that apply
- Utilization review
- Requesting a formulary exception request
- General provisions – other things you should know
- How to read your schedule of benefits

This plan doesn't cover all **prescription** drugs and some coverage may be limited. This doesn't mean you can't get **prescription** drugs that aren't covered; you can, but you have to pay for them yourself. For more information, see the schedule of benefits.

Important note about filling a prescription:
A pharmacist may refuse to fill a **prescription** order or refill when, in their professional judgement, the **prescription** should not be filled.

How to access network pharmacies

How to find a network pharmacy

You can find a network pharmacy online or by phone. See the *Contact us* section for how.
You may go to any of our network pharmacies. If you don't get your **prescription** at a network pharmacy, it will not be a **covered service** under the plan.
Network pharmacies include a:

- **Retail pharmacy**
- **Mail order pharmacy**
- **Specialty pharmacy**

When the pharmacy you use leaves the network

When your pharmacy leaves the network, you will have to get your **prescriptions** at another network pharmacy. You can use your **provider** directory or call the number on your ID card to find and select another network pharmacy in your area.

How to get an emergency prescription filled

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

Type of pharmacy	Your cost share will be
A network pharmacy	The plan cost share
Out-of-network pharmacy	The full cost of the **prescription**

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

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

Coverage and exclusions

Providing covered services

Your **prescription** drug plan provides **covered services**. For covered pharmacy services:

- You need a **prescription** from the prescribing **provider**
- You need to show your ID card to the network pharmacy when you get a **prescription** filled

Covered services

Anti-cancer drugs taken by mouth, including chemotherapy drugs

Covered services include any drug prescribed for the treatment of cancer if it is recognized in a standard reference publication or recommended in the medical literature for this use. This applies even if the drug is not approved by the U.S. Food and Drug Administration (FDA) for the same use.

Contraceptives (birth control)

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

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

We also cover **brand-name prescription drugs** and devices. If you choose a **brand-name prescription drug** or device when a **generic prescription drug** or device is available, you may have to pay a cost share, See the *Schedule of benefits*.

Preventive contraceptives important note:
You may qualify for a formulary exception request if your **provider** determines that the contraceptives covered standardly as preventive **covered services** under the plan are not medically appropriate for you. Your **provider** may request a formulary exception request and submit it to us for review.

Diabetic supplies

Covered services include items such as:

- Diabetic needles, syringes and pens
- Test strips for blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs

See the *Diabetic services, supplies, equipment, and education* section of the EOC for more information.

Immunizations

Covered services include preventive immunizations as required by the Affordable Care Act guidelines when administered at a network pharmacy. You can call the number on your ID card to find a participating network pharmacy. You should contact the pharmacy for vaccine availability, as not all pharmacies will stock all available vaccines.

Infertility drugs

Covered services include oral **prescription** drugs used primarily for the purpose of treating the underlying medical cause of **infertility**.

Nutritional supplements

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease or disorder of amino and organic acids. This includes coverage for amino-acid based elemental formula.

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 are covered to the same extent that the plan covers drugs that are available only on the orders of a **physician**.

Over-the-counter drugs

Covered services include certain OTC medications, as determined by the plan. Coverage of these medications requires a **prescription**. You can access a list of these OTC medications. See the *Contact us* section for how.

Preventive care drugs and supplements

Covered services include preventive care drugs and supplements, including OTC drugs and supplements, as required by the ACA.

Risk reducing breast cancer prescription drugs

Covered services include **prescription** drugs used to treat people who are at:

- Increased risk for breast cancer
- Low risk for adverse medication side effects

Tobacco cessation prescription and OTC drugs

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

Exclusions

The following are not **covered services**:

- Abortion drugs
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a **covered service**
- Drugs or medications
    - Administered or entirely consumed at the time and place it is prescribed or provided
    - Which do not require a **prescription** by law, even if a **prescription** is written
    - That include the same active ingredient or a modified version of an active ingredient as a covered **prescription** drug unless we approve a formulary exception request
    - That is therapeutically the same or an alternative to a covered **prescription** drug, unless we approve a formulary exception request
    - That is therapeutically the same or an alternative to an OTC drug unless we have approved a formulary exception request
    - Not approved by the FDA or not proven safe or effective
    - Provided under your medical plan while inpatient at a healthcare facility
    - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee
    - That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
    - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a **covered service**
    - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
    - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **preauthorization** and clinical policies
- Duplicative drug therapy, for example, two antihistamines for the same condition
- Genetic care including:
    - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes.
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule or the EOC

- Implantable drugs and associated devices except as specifically stated in the schedule or the EOC
- **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 as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Insulin pumps, tubing or other ancillary equipment and supplies for insulin pumps
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription** drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or **prescription** drugs for the treatment to a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which is illegal, unethical, imprudent, abusive, not **medically necessary** or otherwise improper and drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- Treatment, drug, service or supply to stop or reduce smoking or the use of tobacco products or to treat or reduce nicotine addiction, dependence or craving including medications, nicotine patches and gum unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

How to access your benefit

We base your **prescription** drug plan on the drugs in the **drug guide**. We exclude **prescription** drugs listed on the **formulary exclusions list** unless we approve a formulary exception request. 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 formulary exception request. See the *Requesting a formulary exception* section for more information.

Retail pharmacy

A **retail pharmacy** may be used for up to a 90 day supply of **prescription** drugs. A network **retail pharmacy** will submit your claim. You will pay your cost share directly to the pharmacy. There are no claim forms to complete or submit.

Mail order pharmacy
The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Each **prescription** and refill is limited to a maximum 90 day supply.

Specialty pharmacy
We cover **specialty prescription drugs** when filled through a network **retail** or **specialty pharmacy**. Each **prescription** is limited to a maximum 30 day supply. You can view the list of **specialty prescription drugs**. See the *Contact us* section for how.

Prescription eye drops
You may refill **prescription** eye drops to treat a chronic eye disease or condition if:

- The original **prescription** states that additional quantities are needed
- The refill does not exceed the total quantity of dosage units stated on the original **prescription**, including refills
- The refill dispensed on or before the last day of the prescribed dosage period and not earlier than the:
  - 21st day after the date a 30-day supply is dispensed
  - 42nd day after the date a 60-day supply is dispensed
  - 63rd day after the date a 90-day supply is dispensed

Where your schedule of benefits fits in
You are responsible for paying your part of the cost share for **prescription** drugs covered under the plan. This schedule of benefits lists the **deductibles**, limits and **copayments**, if any, that apply to the **covered services** you receive under the **prescription** drug plan.

Your **prescription** drug costs are based on:

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

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

When you get **prescription drugs** from a **pharmacy**, the **pharmacy** will only require you at that time to pay the lowest amount out of the following:

- The applicable **copayment**
- The allowable claim amount for the **prescription drug**
- The amount you would pay for the **prescription drug** if your bought it without using your plan or any other **prescription drug** benefits or discounts

Preauthorization requirements that apply
For certain drugs, your **provider** needs to get approval from us before we will cover the drug. This is called **preauthorization**. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**.

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

Call us or go online to get the most up-to-date **preauthorization** requirements and list of **step therapy** drugs. See the *Contact us* section for how.

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

Requesting a formulary exception

Sometimes you or your **provider** may ask for a formulary exception request for drugs that are not covered or 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 on the individual and is a case-by-case decision.

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

- Contacting our **preauthorization** Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716
- Submitting the request in writing to:
  - CVS Health
    ATTN: Aetna PA
    1300 E Campbell Road
    Richardson, TX 75081

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

General provisions – other things you should know

Some **prescription** drugs are subject to quantity limits. This helps your **provider** and pharmacy ensure your **prescription** drug is being used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these limits.

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

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

Partial fill dispensing for certain prescription drugs

We allow a partial fill of your **prescription** if:

- Your **pharmacy** or **prescriber** tells us that:
  - The quantity requested is to synchronize the dates that the **pharmacy** fills your **prescription drugs**
  - The synchronization of the dates is in your best interest
- You agree to the synchronization

Your out-of-pocket expenses will be prorated based on the number of days' supply.

How to read your schedule of benefits

How your cost share works

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

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

How your cost share works

Your **copayment** is the amount you pay for each **prescription** fill or refill. The schedule of benefits shows you the cost share you need to pay for a specific **prescription** fill or refill. You will pay any cost share directly to the network pharmacy.

How your prescription drug maximum out-of-pocket limit works

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

Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand name prescription drug** for that method will be paid at 100%.

The **prescription** drug **deductible** and cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a formulary exception request. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

Maximum out-of-pocket limit

Maximum out-of-pocket type	In-network
Individual	$6,000 per calendar year
Family	$12,000 per calendar year

General coverage provisions

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

Prescription drug maximum out-of-pocket limits provisions

Covered services that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

Individual prescription drug maximum out-of-pocket limit

Once the amount of the cost share you and your covered dependents pay for **covered services** during the year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charges for **covered services** that apply toward the limit for the rest of the year for that person.

Family prescription drug maximum out-of-pocket limit

After the amount of the cost share and **deductible** you and your covered dependents pay for **covered services** during the year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charges for **covered services** that apply toward the limit for the rest of the year for all covered family members.

After the amount of the cost share you and your covered dependents pay for **covered services** during the year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charges for **covered services** that apply toward the limit for the rest of the year for all covered family members.

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

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **prescription** drug **maximum out-of-pocket limit** is met by a combination of family members with no single person in the family contributing more than the individual **maximum out-of-pocket limit** in a year

When this happens, the individual **maximum out-of-pocket limit** is met for the rest of the year.

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

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

- All costs for non-**covered services**

Covered services

Preferred generic prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$15
90 day supply at a **retail pharmacy**	$37.50
90 day supply at **mail order pharmacy**	$37.50

Preferred brand name prescription drugs

Description	In-network
30 day supply at **retail pharmacy**	$50
90 day supply at **retail pharmacy**	$125
90 day supply at a **mail order pharmacy**	$125

Non-preferred generic prescription drugs

Description	In-network
30 day supply at **retail pharmacy**	$90
90 day supply filled at **retail pharmacy**	$225
90 day supply at a **mail order pharmacy**	$225

Non-preferred brand name prescription drugs

Description	In-network
30 day supply at **retail pharmacy**	$90
90 day supply at **retail pharmacy**	$225
90 day supply at a **mail order pharmacy**	$225

Specialty prescription drugs

Description	In-network
30 day supply at a **specialty pharmacy** or **retail pharmacy**	$200

Nutritional Supplements

Description	In-network
For each fill up to 30 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits above.
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits above.
For each fill up to a 30 day supply filled at a **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits above.
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits above.

Anti-cancer prescription drugs taken by mouth

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

Contraceptives (birth control)

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

Description	In-network
90 day supply of generic and OTC drugs and devices	$0
90 day supply of **brand name prescription drugs** and devices	Paid based on the tier of drug in the schedule

Diabetic supplies, drugs and insulin

Description	In-network
30 day supply at **retail pharmacy**	Paid based on the tier of drug in the schedule
90 day supply at a **retail pharmacy**	Paid based on the tier of drug in the schedule
90 day supply at **mail order pharmacy**	Paid based on the tier of drug in the schedule

Preventive care drugs and supplements

Description	In-network
Preventive care drugs and supplements	$0

Limit	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered drugs and supplements or more information see the *Contact us* section.

Risk reducing breast cancer prescription drugs

Description	In-network
Risk reducing breast cancer **prescription** drugs	$0
Limit	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered risk reducing breast cancer drugs or more information, see the *Contact us* section.

Tobacco cessation drugs

Description	In-network
Tobacco cessation **prescription** and OTC drugs	$0
Limit	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.

If a **provider** prescribes a covered **brand name prescription drug** when a **generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost share for the brand name drug. If a **provider** does not specify DAW and you request a covered **brand name prescription drug**, you will be responsible for the cost difference between the brand name drug and the generic drug, plus the cost share that applies to the **generic** drug. The cost difference related to a **prescription** not specified as DAW does not apply toward your **prescription** drug **maximum out-of-pocket limit**.

HMO

Schedule of benefits

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

Prepared exclusively for:
Contract holder: TEXAS OPERATORS ASSOCIATION
Contract holder number: 0170207
HMO group agreement effective date: January 01, 2021
Plan effective date: January 01, 2021

Schedule of benefits

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

How your cost share works

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

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

Important note:
Instead of a specific **copayment**, you will sometimes see language that reads:

"Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits"*

This means that your **copayment** will vary, depending on who provides the service to you and where you receive the service.

Example 1: When you receive *Allergy testing and treatment services* in a **specialist's** office, then you will pay the applicable **copayment** listed in the *Specialist office visits* section.

Example 2: When you receive *Reconstructive breast surgery services* in an outpatient setting, then you will pay the applicable **copayment** listed in the *Outpatient surgery* section. However, if you receive these services while inpatient in a **hospital**, then you will pay the applicable *Hospital care* **copayment.**

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

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **coinsurance** you pay when you get **covered services** from a network **provider**. This schedule of benefits shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will

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

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from the **PCP** you select. You will pay a higher cost share when you get **covered services** from a **PCP** that is not your **PCP**. If you did not select a **PCP**, you will pay a higher cost share for **covered services** from any **PCP**, network **physician** or **specialist**.

How your maximum out-of-pocket works

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

Contact us

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

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

Plan features

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	In-network
Individual	$3,000 per calendar year
Family	$6,000 per calendar year

Deductible waiver

There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

Maximum out-of-pocket limit*

Maximum out-of-pocket type	In-network
Individual	$6,000 per calendar year
Family	$12,000 per calendar year

*Your **copayments** will not exceed 50% of the total cost of services provided or 200% of the total annual **premium** cost. If your **copayments** have exceeded 200% of the total annual **premium** cost, you must submit a detailed explanation of benefits (EOB) showing the dates and total amount of the **copayments** paid.

General coverage provisions

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

Deductible provisions

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

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**, 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.

Copayment*

This is a specified dollar amount or percentage that must be paid by you at the time you receive **covered services** from a **network provider**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

*Your **copayments** will not exceed 50% of the total cost of services provided or 200% of the total annual premium cost. If your **copayments** have not exceeded 200% of the total annual **premium** cost, you must submit a detailed explanation of benefits (EOB) showing the dates of total amount of the **copayments** paid.

Maximum out-of-pocket limit provisions

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments** and **deductible**, if any, for **covered services**. **Covered services** that are subject to the **maximum out-of-pocket limit** may include those provided under the medical plan and the outpatient **prescription** drug plan.

Individual maximum out-of-pocket limit

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

Family maximum out-of-pocket limit

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

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

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

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

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

- All costs for non-covered services which are identified in the EOC and the SOB

Your financial responsibility and decisions regarding benefits

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

Covered services

Alzheimer's disease

Description	In-network
Alzheimer's disease	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Ambulance services

Description	In-network
Emergency services	$0 per trip
	after **deductible**
	after **deductible**

Applied behavior analysis

Description	In-network
Applied behavior analysis	$0 per visit
	no **deductible** applies

Autism spectrum disorder

Description	In-network
Diagnosis and testing	$50 per visit
	no **deductible** applies
Treatment	$50 per visit
	no **deductible** applies
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	$0 per visit
	no **deductible** applies

Services for children with developmental delays

Description	In-network
Services for children with developmental delays	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Cardiovascular disease testing

Description	In-network
Cardiovascular disease testing	$60 per visit
Maximum visits per calendar year	1 screening every 5 years Limited to: Men age 45 and over but less than 76 and women age 55 and over but less than 76

Clinical trials

Description	In-network
Experimental or investigational therapies	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*
Routine patient costs	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Dental care services and anesthesia

Description	In-network
Hospital or **surgery** center	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Diabetic services, supplies, equipment, and education

Description	In-network
Diabetic services	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*
Diabetic supplies	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*
Diabetic education	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*
Diabetic equipment	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Diagnostic follow-up care related to newborn hearing screening

Description	In-network
Diagnostic follow-up care related to newborn hearing screening	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Durable medical equipment (DME)

Description	In-network
DME	10% per item
	after **deductible**

Emergency services

Description	In-network
Emergency room/freestanding emergency medical care facility or comparable emergency facility	$250 per visit
	no **deductible** applies
Complex imaging, lab and radiology services performed during emergency room/freestanding emergency medical care facility visit or comparable emergency facility	No charge
Non-emergency care in a **hospital** emergency room/freestanding emergency medical care facility visit or comparable emergency facility	$250plus 10% per visit
	after **deductible**

Emergency services important note:
Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.

A separate **hospital** emergency room/freestanding emergency medical care facility or comparable emergency facility **copayment** will apply for each visit to an emergency room/freestanding emergency medical care facility or comparable emergency facility. If you are admitted to the **hospital** as an inpatient **stay** right after a visit to an emergency room/freestanding emergency medical care facility or comparable emergency facility, your emergency room/freestanding emergency medical care facility or comparable emergency facility **copayment** will be waived and your inpatient **copayment** will apply.

Foot orthotic devices

Description	In-network
Orthotic devices	10% per item

	after **deductible**

Habilitation therapy services

Habilitation therapy

Description	In-network
Habilitation therapy	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Physical, occupational therapies

Description	In-network
PT, OT therapies	$0 per visit

	no **deductible** applies

Speech therapy

Description	In-network
Speech therapy	$0 per visit

	no **deductible** applies

Hearing aids and cochlear implants and related services

Description	In-network
Hearing aids and cochlear implants and related services	10% per visit

	after **deductible**

Hearing aids	One per ear every three years
Replacement of cochlear implants external speech processor and controller components	Once every three years

Limit	One per ear every 3 years

Home health care

A visit is a period of 4 hours or less

Description	In-network
Home health care	$50 per visit no **deductible** applies

Visit limit per day	3 intermittent visits
Limit per year	120

Hospice care

Description	In-network
Inpatient services - **room and board**	10% per admission
	after **deductible**
Day limit per year	unlimited days
Limit per year	unlimited
Limit per lifetime	unlimited
Outpatient services	10% per visit
	after **deductible**
Visit limit per year	unlimited
Limit per year	unlimited
Limit per lifetime	unlimited

Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8-12 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8-12 hours a day.

Hospital care

Description	In-network
Inpatient services – **room and board**	10% per admission
	after **deductible**
Other inpatient services	No charge

Infertility services

Description	In-network
Treatment of basic **infertility**	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Maternity and related newborn care

Includes complications

Description	In-network
Inpatient services – **room and board**	10% per admission

	after **deductible**
Other inpatient services	No charge
Services performed in **physician** or **specialist** office or a facility	$50 per visit
	no **deductible** applies
Other services and supplies	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

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

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services-**room and board** including **residential treatment facility**	10% per admission
	after **deductible**
Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** or **telehealth** consultation	$50 per visit
	no **deductible** applies
Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** or **telehealth** cognitive behavioral therapy consultations	$0 per visit no **deductible** applies

Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program Coverage is provided under the same terms and conditions as any other illness. The cost share doesn't apply to in-network peer counseling support services	$0 per visit

	no **deductible** applies

Nutritional support

Description	In-network
Nutritional support	$0 per item
	after **deductible**

Oral anti-cancer prescription drugs

Description	In-network
Oral anti-cancer prescription drugs	Depending upon where the **covered service** is provided, benefits will be same as those stated under each **covered service** category in this *Schedule of Benefits.*

Outpatient surgery

Description	In-network
At **hospital** outpatient department	10% per visit after **deductible**
At facility that is not a **hospital**	10% per visit after **deductible**
At the **physician** office	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of Benefits.*

Physician and specialist services

Including surgical services

Your PCP

Description	In-network
Physician office hours (not surgical, not preventive)	$25 per visit
	no **deductible** applies
Immunizations that are not considered preventive care	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of Benefits.*
Physician home visit (not preventive)	$25 per visit
	no **deductible** applies
Physician surgical services	$25 per visit
	no **deductible** applies

Physician telemedicine or **telehealth** consultation	$25 per visit
	no **deductible** applies

Specialist

Description	In-network
Specialist office hours (not surgical, not preventive)	$50 per visit
	no **deductible** applies
Specialist home visit (not preventive)	$50 per visit
	no **deductible** applies
Specialist surgical services	$50 per visit
	no **deductible** applies
Specialist telemedicine or **telehealth** consultation	$50 per visit
	no **deductible** applies

Preventive care

Description	In-network
Preventive care services	$0 no **deductible** applies
Breast feeding counseling and support	$0 no **deductible** applies
Breast feeding counseling and support limit per year	• 6 visits in a group or individual setting • Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies	$0 no **deductible** applies
Breast pump, accessories and supplies limit	• Electric pump: 1 every 3 years • 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: 3 years to replace an existing electric pump
Counseling for alcohol or drug misuse, obesity, healthy diet, sexually transmitted infection, tobacco cessation	$0 no **deductible** applies
Counseling for alcohol or drug misuse visit limit per day	1

Counseling for alcohol or drug misuse visit limit per year	5 visits/12 months
Counseling for obesity, healthy diet visit limit per day	1
Counseling for obesity, healthy diet visit limit per year	• 26 visits/12 months • Of the total visits allowed per year, 10 may be used for high cholesterol and other known risk factors for heart disease and diet-related chronic diseases
Counseling for sexually transmitted infection visit limit per year	2 visits/12 months
Counseling for tobacco cessation visit limit per day	1
Counseling for tobacco cessation visit limit per year	8 visits/12 months
Family planning services (female contraceptive counseling)	$0 no **deductible** applies
Family planning services (contraceptive counseling) limit per year	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	$0 no **deductible** applies
Immunizations limit	• Covered persons age 0-99 • Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention • For details, contact your **physician**
Preventive care contraceptives (birth control)	$0 no **deductible** applies
Preventive care drugs and supplements	$0 no **deductible** applies
Preventive care drugs and supplements limit	• Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the U.S. Preventive Services Task Force (USPSTF) • For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care risk reducing breast cancer **prescription** drugs	$0 no **deductible** applies
Preventive care risk reducing breast cancer **prescription** drugs limit	• Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF • For a current list of covered risk reducing breast cancer drugs or more information, see the *Contact us* section
Preventive care tobacco cessation **prescription** and OTC drugs	$0 no **deductible** applies

Preventive care tobacco cessation **prescription** and OTC drugs limit	• Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF • For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section • A visit is equal to a session of up to 15 minutes
Routine cancer screenings	$0 no **deductible** applies
Routine cancer screening limits	• Subject to any age, family history and frequency guidelines as set forth in the most current: – Evidence-based items that have a rating of A or B in the current recommendations of the (USPSTF) – The comprehensive guidelines supported by the Health Resources and Services Administration • For more information contact your **physician** or see the *Contact us* section of your EOC
Routine lung cancer screening limit	• 1 screening every 12 months • Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	$0 no **deductible** applies
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 0-12 months, 3 exams age 1-2, 3 exams age 2-3 and 1 exam every 12 months after that age, up to age 22, 1 exam every 12 months after age 22 • High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months
Well woman routine GYN exam	$0 no **deductible** applies
Well woman GYN exam visits limit Additional Maximums	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
Gynecological exam that includes a rectovaginal pelvic exam	One exam every 12 months

Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test	Limited to: Pap smear or screening using liquid based cytology methods 1 pap smear every 12 months for women age 18 and older
Screening for osteoporosis	For women over age 60 depending on risk factors
Human papillomavirus (HPV) DNA test; high risk HPV DNA testing	Every three years for women with normal cytology results who are 30 or older
Routine physical exams for adults age 18 or more Maximum age and visit limits per calendar year	
Screening for abdominal aortic aneurysm	One time for men aged 65-75 who have ever smoked
Screening for cholesterol at increased risk for coronary heart disease	Men age 35 and older Men under 35 who have heart disease or risk factors for heart disease Women who have heart disease or risk factors for heart disease
Colorectal cancer screening	For adults over 50
Screening for aspirin use as recommended by their physician	For men age 45 to 79 years of age For women ages 55 to 79 years of age
Routine physical exams for children from birth to age 18 Maximum visits per calendar year	
Autism screening	At intervals of 18 and 24 months
Developmental screening	Under age 3 and surveillance throughout childhood
Blood pressure screenings at certain intervals	0 to 11 months 1 to 4 years 5 to 10 years 11 to 14 years 15 to 17 years
Additional maximum age and visit limits per calendar year	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 guidelines for children and adolescents*. For details, contact your physician or Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.

Prosthetic devices

Includes medical wigs

Description	In-network
Prosthetic devices	$0 per item

	after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network
Surgery and supplies	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of Benefits*.

Short-term rehabilitation services

Cardiac rehabilitation

Description	In-network
Cardiac rehabilitation	$50 per visit no **deductible** applies

Pulmonary rehabilitation

Description	In-network
Pulmonary	$50 per visit no **deductible** applies

Cognitive rehabilitation

Description	In-network
Cognitive rehabilitation	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of Benefits*.

Physical, occupational and speech therapies

Description	In-network
PT, OT and ST	$50 per visit
	no **deductible** applies

Spinal manipulation

Description	In-network
Spinal manipulation	$25 per visit
	no **deductible** applies
Visit limit per day	1
Visit limit per year	20

Skilled nursing facility

Description	In-network
Inpatient services – **room and board**	10% per admission
	after **deductible**
Day limit per year	100
Other inpatient services and supplies	No charge

Substance related disorders treatment

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

Description	In-network
Inpatient services – **room and board** during a **hospital stay**	10% per admission
	after **deductible**
Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** or **telehealth** consultation	$50 per visit
	no **deductible** applies
Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** or **telehealth** cognitive behavioral therapy consultations	$0 per visit no **deductible** applies
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program Coverage is provided under the same terms and conditions as any other illness. The cost share doesn't apply to in-network peer counseling support services	$0 per visit
	no **deductible** applies

Tests, images and labs - outpatient

Diagnostic complex imaging services

Description	In-network
At facility that is not a **hospital**	$250 per visit no **deductible** applies
At **hospital** outpatient department	$250 per visit no **deductible** applies

Diagnostic lab work

Description	In-network
At facility that is not a **hospital**	$30 per visit no **deductible** applies

Description	In-network
At **hospital** outpatient department	$30 per visit no **deductible** applies

Diagnostic x-ray and other radiological services

Description	In-network
At facility that is not a **hospital**	$60 per visit no **deductible** applies
At **hospital** outpatient department	$60 per visit no **deductible** applies

Therapies

Chemotherapy

Description	In-network
Chemotherapy services	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of Benefits*.

Infusion therapy

Outpatient services

Description	In-network
In **physician** office	$50 per visit
	no **deductible** applies
At an infusion location	10% per visit
	after **deductible**
In the home	$50 per visit
	no **deductible** applies
At **hospital** outpatient department	10% per visit
	after **deductible**
At facility that is not a **hospital**	10% per visit
	after **deductible**

Radiation therapy (therapeutic radiology)

Description	In-network
Radiation therapy	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of Benefits*.

Transplant services

Description	Network (IOE facility)	Network (non-IOE facility)
Inpatient services – **room and board**	10% per admission	Not covered
	after **deductible**	Not covered
Other inpatient services and supplies	No charge	Not covered
Outpatient services performed at **hospital** outpatient department	See Inpatient services, above	Not covered
Outpatient services performed at facility other than **hospital** outpatient department	See Inpatient services, above	Not covered
Physician services	See Inpatient services, above	Not covered
Limit per lifetime	Unlimited	Not covered

Transplant important note:
See the *Transplant services* benefit in the *Coverage and exclusions* section of the EOC for more information. The limit applies to all transplant services received while you are a member of an Aetna plan or one associated with Aetna. The plan **lifetime maximum**, if any, will not apply to transplant services. The transplant limit will apply.

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**
A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network
Urgent care facility	$75 per visit
	no **deductible** applies
Complex imaging, lab and radiology services	No charge
Non-urgent use of an urgent care facility or **provider**	10% per visit
	no **deductible** applies

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Adult vision care

Description	In-network
Adult vision exam	$0 per visit

	no **deductible** applies

Limit	Limited to covered persons age 19 and older

Visit limit	1 visit(s) per 24 months

Pediatric vision care

Description	In-network
Pediatric vision exam	$0 per visit

	no **deductible** applies

Limit	Limited to covered persons through the end of the month in which the person turns 19

Visit limit	1 visit(s) per 24 months

Walk-in clinic

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

Description	In-network
Non-emergency services	$25 per visit

	no **deductible** applies

Preventive immunizations No **copayment** applies for children through age 6	$0 per visit no **deductible** applies
Immunizations and routine physical exams limited to:	
For immunizations for adults 18 or more	As shown on EOC
For immunizations for children from birth to age 18	As shown on EOC
Additional immunization, maximum age and visit limits per calendar year	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician**
Screening and counseling services	$0 per visit no **deductible** applies
Screening and counseling limits	See the Preventive care services section of the SOB